Reference Committee J

Report(s) of the Council on Medical Service

01 ACO REACH
02 Health Insurers and Collection of Patient Cost-Sharing
03 Strengthening Network Adequacy
05 Medicaid Unwinding Update
06 Rural Hospital Payment Models
07 Sustainable Payment for Community Practices

Resolutions

801 Improving Pharmaceutical Access and Affordability
802 Improving Nonprofit Hospital Charity Care Policies
803 Improving Medicaid and CHIP Access and Affordability
804 Required Clinical Qualifications in Determining Medical Diagnoses and Medical Necessity
805 Medication Reconciliation Education
806 Evidence-Based Anti-Obesity Medication as a Covered Benefit
807 Any Willing Provider
808 Prosthodontic Coverage after Oncologic Reconstruction
809 Outsourcing of Administrative and Clinical Work to Different Time Zones – An Issue of Equity, Diversity, and Inclusion
811 Expanding the Use of Medical Interpreters
812 Indian Health Service Improvements
813 Strengthening Efforts Against Horizontal & Vertical Consolidation
814 Providing Parity for Medicare Facility Fees
815 Long-Term Care and Support Services for Seniors
817 Expanding AMA Payment Reform Work and Advocacy to Medicaid and other non-Medicare payment modules for Pediatric Healthcare and Specialty Populations
818* Amendment to AMA policy on healthcare system reform proposals
819 Amend Virtual Credit Card Policy
820 Affordability and Accessibility of Treatment of Overweight and Obesity

***Not yet reviewed for consideration by the Resolution Committee**

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-I-23

Subject: ACO REACH
(Resolution 822-I-22)

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee J

At the 2022 Interim Meeting, the House of Delegates referred Resolution 822, Monitoring of Alternative Payment Models within Traditional Medicare. Introduced by the Medical Student Section, the resolution asked the American Medical Association (AMA) to: 1) "monitor the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) program for its impacts on patients and physicians in Traditional Medicare, including the quality and cost of health care and patient/provider choice, and report back to the House of Delegates on the impact of the ACO REACH demonstration program annually until its conclusion; " 2) "advocate against any Medicare demonstration project that denies or limits coverage or benefits that beneficiaries would otherwise receive in Traditional Medicare; " and 3) "develop educational materials for physicians regarding the ACO REACH program to help physicians understand the implications of their or their employer's participation in this program and to help physicians determine whether participation in the program is in the best interest of themselves and their patients."

The report of Reference Committee J from the 2022 Interim meeting recommended that Policies H-160.915, D-385.953, H-373.998, and D-160.923 be reaffirmed in lieu of Resolution 822-I-22. In this report, the Council provides background information on the ACO REACH program and addresses common misconceptions about the program, summarizes extensive AMA policy and concurs with the sentiment of Reference Committee J at the 2022 Interim meeting regarding reaffirmation of policy in lieu of Resolution 822-I-22.

BACKGROUND

Accountable Care Organizations (ACOs) were developed to reform the regular Medicare payment system by making a model available that links payment to the quality of care and not just the number of services delivered. Holistically, the goal of the ACO programs is to improve the patient care experience, improve population health, and reduce per capita costs of health care. The Medicare Physician Group Practice Demonstration program, which began in 2005, was the Centers for Medicare & Medicaid Services' (CMS) first attempt at an ACO model. Under this model, physicians were awarded bonus payments for improving cost efficiency and for their performance on different care quality measures. Results for this program were mixed. In 2010, the Affordable Care Act (ACA) formally introduced the ACO model as a permanent addition to the Medicare program, not just a demonstration. The ACA also created the CMS Innovation Center, which has evaluated ACO models, in addition to the permanent Medicare Shared Savings Program (MSSP). For example, in January 2012, Medicare launched the Pioneer ACO program, and this was followed by the introduction of the Global and Professional Direct Contracting (GPDC) Model, which preceded ACO REACH.[1]

© 2023 American Medical Association. All rights reserved.

ACO REACH is a voluntary Centers for Medicare and Medicaid Innovation (CMMI) model scheduled to operate for four years from January 2023 to December 2026. ACO REACH is a redesign of the GPDC model in response to feedback and Administration priorities. ACO REACH is intended to better reflect CMMI's focus on advancing health equity and improving beneficiary care. ACO REACH retains the basic design elements of the GPDC global and professional tracks and adds new requirements to advance equity, promote physician governance, and protect beneficiaries. To continue participation in ACO REACH, participants in the GPDC model needed to meet ACO REACH model requirements by January 1, 2023. Appendix A provides a summary of the differences between the GPDC and ACO REACH models.

Changes to the ACO REACH governance structure include an increase in physician and other participating health professionals' membership on each ACO's governing board from 25 percent to 75 percent. Each board must also include a separate beneficiary and consumer advocate with voting rights. In the ACO REACH model, CMS has increased monitoring and compliance requirements to track and respond to issues that may arise.[2]

The ACO REACH model has specific health equity requirements for participation. CMS requires all participating ACOs to develop a health equity plan and collect beneficiary-reported demographic and social needs data. Additionally, CMS has implemented an enhanced health equity benchmark to incentivize care delivery to underserved populations and has increased the range of services that can be provided by nurse practitioners under the model. For example, in ACO REACH, nurse practitioners can certify the need for hospice care; certify the need for diabetic shoes; order and supervise cardiac rehabilitation; establish, review, sign, and date home infusion therapy plans of care; and make referrals for nutrition therapy. The Council encourages continued monitoring of these expanded services and emphasizes that all patient care be performed under the supervision of a physician. Finally, under the ACO REACH model, CMS has reduced the benchmark discount from a maximum of 5 percent to 3.5 percent and has reduced the quality withhold from 5 percent to 2 percent.[3]

ACO REACH MISCONCEPTIONS

The Council believes it is crucial to address misconceptions about ACO REACH in order to effectively evaluate the program's impact.

First, it is important to recognize that this model is a time-limited model test and does not replace regular Medicare. During its implementation from January 2023 to December 2026, ACO REACH will be continuously evaluated to monitor its impact. Only if the model is shown to improve quality without increasing costs, reduce costs without negatively impacting quality, or improve quality and reduce costs will expansion or extension of the program be considered.

Second, ACO REACH beneficiaries continue to be covered by regular Medicare, and not Medicare Advantage (MA). Beneficiaries may receive care from any Medicare physician of their choice and can switch physicians at any time.[4]

Third, beneficiaries will only be included in the program if they already receive a majority of their primary care services from an ACO REACH participating physician or if they voluntarily notify CMS that they wish to be assigned to an ACO REACH participating physician. Accordingly, attribution in ACO REACH is similar to that in existing MSSP models. ACOs must alert beneficiaries who have been aligned to an ACO and inform them of their right to opt-out of CMS data sharing with the ACO.[5] It should be noted that despite their data not being shared with CMS

directly, these patients will still be included in ACO REACH as long as they receive a majority of their care from a physician participating in ACO REACH. Program enrollment does not change covered benefits and patients can still see and receive any service covered by fee-for-service Medicare.

Fourth, CMS has implemented a monitoring plan to protect beneficiaries and address potential program integrity risks from bad actors. ACO REACH participants will be subject to audits of charts, medical records, implementation plans, and other data.[6]

DIRECT CONTRACTING ENTITIES AND CODING CONCERNS

The transition to ACO REACH addresses issues with the GPDC model and transparency, specifically related to upcoding. Under the Direct Contracting Entity (DCE) model, there were strong incentives for plans to "upcode" patient diagnoses, which affects the risk-adjusted payments plans receive. A 2020 study from the Department of Health and Human Services (HHS), shows that enrollees in Medicare Advantage plans generate 6 percent to 16 percent higher diagnosis-based risk scores than they would under regular Medicare where diagnoses do not affect most provider payments.[7] The HHS study estimates that upcoding generates billions of dollars in excess public spending and significant distortions to both health care entity and individual consumer behavior. Critics of GPDC caution that these newer ACO models could employ similar tactics to those used by MA where plans add unnecessary diagnosis codes to inflate risk scores of Medicare beneficiaries, resulting in a higher payment from Medicare.[8]

Lawmakers in Congress expressed concern with automatically including DCEs with a history of fraudulent behavior and suggested that CMS halt participation by any organizations that have committed health care fraud and terminate DCEs that do not meet the new standards for the program. Under the implementation of ACO REACH, CMMI will more stringently monitor compliance to ensure that there are no inappropriate coding practices.[9] Additionally, in February 2022, the AMA signed on to a letter encouraging ongoing transparency and stability in all value-based care models.

AMA POLICY AND ADVOCACY

The AMA has an extensive policy portfolio regarding ACOs and alternative payment models (APMs). Policy H-160.915 affirms the AMA's ACO principles. These principles are inclusive of all aspects of participating in an ACO, and this policy addresses many of the concerns raised by Resolution 822-I-22. Importantly, H-160.915 affirms that the goal of an ACO is to increase access to care, improve the quality of care, and ensure the efficient delivery of care, with the physician's primary ethical and professional obligation being the well-being and safety of the patient. Additionally, the principles affirm that physician and patient participation in an ACO should be voluntary rather than a mandatory assignment to an ACO by Medicare. Any physician organization (including an organization that bills on behalf of physicians under a single tax identification number) or any other entity that creates an ACO must obtain the written affirmative consent of each physician to participate in the ACO. Physicians should not be required to join an ACO as a condition of contracting with Medicare, Medicaid, or a private payer or being admitted to a hospital medical staff. Furthermore, H-160.915 addresses concerns about equity by affirming that the ACO benchmark should be risk-adjusted for the socioeconomic and health status of the patients that are assigned to each ACO, such as income/poverty level, insurance status prior to Medicare enrollment, race, and ethnicity and health status.

Policy D-160.923 states that the AMA will seek objective, independent data on ACOs and release a whitepaper regarding their effect on cost savings and quality of care. In response to this policy, the AMA released Accountable Care Organizations: How to Perform Due Diligence and Evaluate Contractual Agreements.

Policy H-373.998 affirms the AMA's support for patient choice in their health care. Specifically, this policy states that individuals should have freedom of choice of physician and/or system of health care delivery and where the system of care places restrictions on patient choice, such restrictions must be clearly identified to the individual prior to their selection of that system.

Policy H-160.892 states that the AMA encourages studies into the effect of hospital integrated system ACOs' ability to generate savings and the effect of these ACOs on medical staff and potential consolidation of medical practices.

Policy D-385.963 states that the AMA advises physicians to make informed decisions before starting, joining, or affiliating with an ACO. Additionally, this policy states that the AMA will develop a toolkit that provides physicians best practices for starting and operating an ACO, such as governance structures, organizational relationships, and quality reporting and payment distribution mechanisms.

Policy H-180.944 affirms that health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

Policy D-385.952(2) was recently amended at the 2023 Annual Meeting and states that the AMA supports APMs that link quality measures and payments to outcomes specific to vulnerable and high-risk populations, reductions in health care disparities, and functional improvements, if appropriate, and will continue to encourage the development and implementation of physician-focused APMs that provide services to improve the health of vulnerable and high-risk populations and safeguard patient access to medically necessary care, including institutional post-acute care.

Finally, Policy H-160.912 defines "team-based health care" as the provision of health care services by a physician-led team who works collaboratively to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care.

DISCUSSION

Referred Resolution 822-I-22 asked the AMA to: 1) "monitor the ACO REACH program for its impacts on patients and physicians in Traditional Medicare, including the quality and cost of health care and patient/provider choice, and report back to the House of Delegates on the impact of the ACO REACH demonstration program annually until its conclusion;" 2) "advocate against any Medicare demonstration project that denies or limits coverage or benefits that beneficiaries would otherwise receive in Traditional Medicare;" and 3) "develop educational materials for physicians regarding the ACO REACH program to help physicians understand the implications of their or their employer's participation in this program and to help physicians determine whether participation in the program is in the best interest of themselves and their patients." The first Resolve clause is addressed by ongoing AMA Advocacy efforts and the Council's ongoing work to review these programs and keep the House informed of any concerns with this or any other demonstration project. The Council will continue to monitor the outcomes of ACO REACH and continue to update the House as needed. The second Resolve clause is addressed by Policy

D-385.952(2), which the Council recommends reaffirming. The third Resolve clause is addressed by the 2019 AMA whitepaper titled: "Accountable Care Organizations: How to Perform Due Diligence and Evaluate Contractual Agreements."

The AMA has longstanding, overarching principles to guide ACO participation. The Council believes that it is not necessary to develop novel policy referencing each new ACO model, as the guidelines apply to each new model in perpetuity. The AMA's principles affirm that patient and physician participation in an ACO should be voluntary – one of the concerns articulated in Resolution 822-I-22. These principles are inclusive of all aspects of participating in an ACO.

Resolution 822-I-22 raised several concerns with the ACO REACH model, including that the model could worsen the quality of patient care and increase costs by incentivizing ACO REACH entities to restrict care and engage in upcoding, which can be built into MA plans. Under ACO REACH, CMMI will closely monitor compliance with coding practices, addressing upcoding concerns laid out by the resolution.

CMS plans to continuously monitor the ACO REACH program and AMA policy encourages studies into the effect of hospital integrated system ACOs' ability to generate savings (H-160.892) and affirms that the 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 (D-385.963). As an example of monitoring the ongoing program, CMS received stakeholder feedback and has announced changes to address concerns beginning in 2024. The changes include financial protections for midyear changes to benchmarks, additions to the Health Equity Benchmark Adjustment to account for more patient characteristics, and updates to its risk adjustment policies. Specifically, there was concern that the current model favored patients who live in rural areas, which tend to be less racially and ethnically diverse. CMS has updated the formula to determine payments to physicians to better account for patients who live in urban areas. The new formula will take into account the number of beneficiaries who get a Medicare Part D low-income subsidy as well as the state-based version of the Area Deprivation Index, not just the national version.[10,11]

Additionally, Resolution 822-I-22 expressed concern about the equity of the ACO REACH model. Not only was this model designed with a specific focus on health equity, the AMA has policy clearly affirming support for promoting health equity (H-180.944).

Given the scope expansion under ACO REACH that allows nurse practitioners to certify the need for hospice care, certify the need for diabetic shoes, order and supervise cardiac rehabilitation, establish, review, sign, and date home infusion therapy plans of care, and make referrals for medical nutrition therapy, the Council recommends reaffirming Policy H-160.912 which highlights the importance of a physician-led care team.

Finally, it is important to recognize that ACO REACH took effect in January 2023. There is not yet sufficient data to analyze the impact of this model, and it would be premature to draw any conclusions at this time. The Council supports continued AMA monitoring of the effects of ACO REACH, a request sufficiently supported by the AMA policy we recommend for reaffirmation.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 822-I-22, and the remainder of the report be filed:

1. That our American Medical Association reaffirm the following policies:
    a. Policy H-160.915, "Accountable Care Organization Principles"
    b. Policy H-373.998, "Patient Information and Choice"
    c. Policy H-160.892, "Effects of Hospital Integrated System Accountable Care Organizations"
    d. Policy D-385.963, "Health Care Reform Physician Payment Models"
    e. Policy H-180.944, "Plan for Continued Progress Toward Health Equity"
    f. Policy H-160.912, "The Structure and Function of Interprofessional Health Care Teams"
    g. Policy D-385.952, "Alternative Payment Models and Vulnerable Populations" (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1]Tu, T, et al. Origins and Future of Accountable Care Organizations. Brookings Institution and Leavitt Partners. May 2015. https://www.brookings.edu/wp-content/uploads/2016/06/impact-of-accountable-careorigins-052015.pdf
[2]CMS.gov. ACO REACH Overview. Accessed: July 6, 2023. https://innovation.cms.gov/innovation-models/aco-reach#:~:text=The%20ACO%20Realizing%20Equity%2C%20Access%2C%20and%20Community%20Health%20(REACH,Accountable%20Care%20Organization%2C%20or%20ACO.
[3]*Ibid.*
[4]The ACO Reach Model: Myths and Facts. Health Care Transformation Task Force. Accessed: July 18, 2023. https://hcttf.org/wp-content/uploads/2022/04/ACO-REACH-Myths-and-Facts.pdf
[5]*Ibid.*
[6]*Ibid.*
[7]Geruso, M. and Timothy Layton. Upcoding: Evidence from Medicare on Squishy Risk Adjustment. HHS Public Access. March 2020. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7384673/pdf/nihms-1007327.pdf
[8]King, R. CMS Overhauls Direct Contracting Model to include new requirements on governance, health equity in 2023. Fierce Healthcare. February 24, 2022. https://www.fiercehealthcare.com/payers/cms-overhauls-direct-contracting-model-include-new-requirements-governance-and-health-equity
[9]*Ibid.*
[10]Healthcare Finance News. ACO REACH now includes financial protections from midyear benchmark changes. August 15, 2023. https://www.healthcarefinancenews.com/news/aco-reach-now-includes-financial-protections-midyear-benchmark-changes
[11]Politico Pro. CMS to change health equity measures for key payment model. August 14, 2023. https://subscriber.politicopro.com/article/2023/08/cms-to-change-health-equity-measures-for-key-payment-model-00111182

Appendix A
Comparing GPDC to the ACO REACH Model

Comparing GPDC to the ACO REACH MODEL		
	Original Global Professional Direct Contracting (GPDC) Model (PY2021-PY2022)	**ACO Realizing Equity, Access, and Community Health (REACH) Model (PY2023-PY2026)**

Model Goals	• Improve beneficiary access to providers who are personally engaged in their healthcare delivery.
	• Provide strong incentives to improve quality of care by shifting payment away from fee-for-service towards value-based capitated payments.
	• Allow organizations with prior ACO experience, innovative organizations taking risk in MA or Managed Medicaid, and organizations that focus on complex beneficiary populations to participate.
		• Improve the focus on:
		  • Promoting health equity and addressing historical healthcare disparities for underserved communities.
		  • Continuing the momentum of provider-led organizations in risk-based models.
		  • Protecting beneficiaries and the model with more participant vetting, monitoring and greater transparency

Participants	• Model participants are called Direct Contracting Entities (DCEs) but are equivalent to ACOs.	• Model participants referred to as REACH ACOs.
Governance	• Participating providers generally must hold at least 25% of the governing board voting rights. • Each DCE's governing board must include a beneficiary representative and a consumer advocate, though these representatives may be the same person and neither is required to hold voting rights.	• Participating providers generally must hold at least 75% of the governing board voting rights. • Each REACH ACO governing board must include a beneficiary representative and a consumer advocate, who must hold governing board voting rights and must be different people.
Health Equity	• No policies explicitly promoting health equity.	• Requirement for all REACH ACOs to develop a Health Equity Plan that must include identification of health disparities and specific actions intended to mitigate the health disparities identified. • Introduction of a health equity benchmark adjustment to better support care delivery and coordination for patients in underserved communities. • Requirement for all ACOs to collect beneficiary-reported demographic and social needs data. • New Benefit Enhancement to increase the range of services that may be ordered by Nurse Practitioners to improve access.
Discount for Global	• Global DCEs receive 100% of gross savings/losses. A discount is applied to the benchmark before gross savings/losses are calculated, which helps guarantee shared savings for CMS. There is no discount for Professional DCEs.	• Reduced discount rate for Global ACOs to 3-3.5% beginning in PY2023 will further CMS' goal of increasing participation in full risk FFS initiatives.
Quality Withhold	• The quality withhold applied to the benchmarks of both Professional DCEs and Global DCEs is 5%.	• Quality hold for both Professional ACOs and Global ACOs is reduced to 2%.

Risk Adjustment	• Two policies protect against risk coding growth:
	  • The "Coding Intensity Factor" (CIF) limits risk score growth across the entire model. The CIF applies to all DCEs to limit risk score growth to the average prior to the start of the model.
	  • A "Risk Score Growth Cap" limits a DCE's risk score growth to +/- 3% over a 2-year period. The DCE-specific caps on over-coding ensure DCEs are coding appropriately and limit gaming.
		• Two changes to the "Risk Score Growth Cap" further mitigate potential inappropriate risk score gains:
		  • Adopt a static reference year population for the remainder of the model performance period.
		  • Cap the REACH ACO's risk score growth relative to the DCE's demographic risk score growth, so the +/- 3% cap is appropriately adjusted based on demographic changes in the underlying population over time. (Currently risk score cap is based on HCC growth – this would cap HCC growth relative to demographic growth.)

Monitoring/ Compliance	• Robust monitoring of all DCEs includes:
	  • Monitoring for all levels of care provided,
	  • Compliance audits conducted throughout the year,
	  • Investigation of beneficiary complaints, and
	  • Collection of beneficiary surveys (CAHPS) annually to measure changes in beneficiary satisfaction.
		• Additional monitoring and compliance efforts and analytics will:
		  • Assess annually whether beneficiaries are being shifted into or out of MA.
		  • Examine ACO's risk score growth to identify inappropriate coding practices.
		  • Monitor for noncompliance with prohibitions against anti-competitive behavior and misuse of beneficiary data.
		  • Increase use of data analytics to monitor use of services over time and compared to a reference population to assess changes in beneficiaries' access to care, including stinting on care.
		  • Review marketing materials regularly to ensure information on the Model is accurate and beneficiaries understand their rights and freedom of choice.
		  • Verify annually that REACH ACO websites are up to date and provide required information.
		  • Audit annually REACH ACO contracts with providers to learn more about their downstream arrangements and identify any concerns.
		  • Investigate on a rolling basis any beneficiary and provider complaints and grievances in coordination with 1-800-Medicare, the Innovation Center liaison on models in the Medicare Beneficiary Ombudsman team, CMS regional offices, and others as appropriate.

Benefits and Protections for Medicare Beneficiaries	• Benefits (applies to all Performance Years of the model) include:
	  • A higher quality of care and greater clinical support and care coordination for beneficiaries.
	  • "Benefit Enhancements" and "Beneficiary Engagement Incentives" offered under the model (e.g., telehealth, post-discharge home visits and waiver of the homebound requirement, Part B cost-sharing support, concurrent care for beneficiaries that elect hospice care).
	• Beneficiary protections (applies to all Performance Years of the model:
	  • All aligned beneficiaries retain full Original Medicare benefits and can see any Medicare physician.
	  • Beneficiaries are proactively notified on an annual basis of their alignment to a DCE/ACO and that their benefits have not changed.
	  • Beneficiaries retain all FFS Medicare channels for raising concerns or reporting complaints.	

Modified from: CMS.gov. Comparing GPDC to the ACO REACH Model. Accessed: July 26, 2023. https://innovation.cms.gov/media/document/gpdc-aco-reach-comparison

Appendix B
ACO Comparison Chart

ACO Comparison Chart

This chart details the main elements of Medicare Shared Savings Program (MSSP) and Realizing Equity, Access, and Community Health (REACH) ACOs

Reflects policies in effect for 2023

	MSSP Basic Level A	MSSP Basic Level B	MSSP Basic Level C	MSSP Basic Level D	MSSP Basic Level E	MSSP Enhanced	REACH Professional	REACH Global
Number of ACOs	27	124	9	10	125	161	24	108
Length of contract	Five years						2021 starters = 5 years + 9 months 2022 starters = 5 years 2023 starters = 4 years	
Participation opportunities	Annual MSSP application cycle opens each spring. ACOs must submit a notice of intent to apply (NOIA) in order to be eligible to submit a full application.						No future application cycles planned at this time.	
Status under MACRA	MIPS APM				Advanced APM			
Governance requirements	ACO participants must hold at least 75% control over the governing board. Each ACO's governing board must include at least one Medicare FFS beneficiary who is served by the ACO, and this beneficiary representative must have full voting rights.						Participant providers must hold at least 75% of governing board voting rights. Each ACO's governing board must include a beneficiary representative and a separate consumer advocate, each with full voting rights.	
Financial Structure								
	MSSP Basic Level A	**MSSP Basic Level B**	**MSSP Basic Level C**	**MSSP Basic Level D**	**MSSP Basic Level E**	**MSSP Enhanced**	**REACH Professional**	**REACH Global**
Risk-sharing arrangement	1st dollar savings up to 40% No loss sharing	1st dollar savings up to 40% No loss sharing	1st dollar savings up to 50% 1st dollar losses at 30%	1st dollar savings up to 50% 1st dollar losses at 30%	1st dollar savings up to 50% 1st dollar losses at 30%	1st dollar savings up to 75% 1st dollar losses at 40– 75%	1st dollar savings and losses at 50%	1st dollar savings and losses at 100%
Shared savings cap	10% of updated benchmark					20% of updated benchmark	Gross (S/L): / Cap (S/L): < 5% / 50% 5%-10% / 35% 10%-15% / 15% > 15% / 5%	Gross (S/L): / Cap (S/L): < 25% / 100% 25%-35% / 50% 35%-50% / 25% > 50% / 10%
Shared losses cap	Not applicable		Lesser of 2% of total Medicare Parts A & B FFS revenue or 1% of updated benchmark	Lesser of 4% of total Medicare Parts A & B FFS revenue or 2% of updated benchmark	Lesser of 8% of total Medicare Parts A & B FFS revenue or 4% of updated benchmark	15% of updated benchmark		
Discount or MSR/MLR	MSR will be 2% to 3.9% depending on number of assigned beneficiaries. Smaller ACOs have higher MSR (5,000 assigned beneficiaries = 3.9% MSR) and larger ACOs have lower MSR, (2% MSR for ACOs with 60,000+ assigned beneficiaries). MLR not applicable.		Prior to entering a two-sided model, the ACO must select its MSR/MLR as part of the application cycle. The choices are: • 0% MSR/MLR • Symmetrical MSR/MLR in a 0.5 percent increment between 0.5 and 2.0% • Symmetrical MSR/MLR that varies based on the number of beneficiaries assigned to the ACO.				• No MSR/MLR • No discount	○ No MSR/MLR ○ Discount applied to the PY benchmark: 3% (PY2023-2024) 3.5% (PY2025-2026)

NAACOS. ACO Comparison Chart. Accessed: August 16, 2023. https://www.naacos.com/assets/docs/pdf/2023/ACO-ComparisonChart2023.pdf

	Beginning in 2024, low revenue ACOs in the Basic Track may share in a portion of savings if the MSR is not exceeded; Levels A & B at 20%; Levels C, D, & E at 25%			
Transition to two-sided model	New, inexperienced ACOs may participate in Basic Level A for a full 5-year agreement period. In a subsequent agreement period, inexperienced ACOs that remain eligible are permitted to progress through Basic Levels A-E, which provides 2 additional years under upside-only (7 years total before downside risk). If ineligible to continue in the glidepath for the second agreement period, ACOs can participate in Level E for all 5 years of the agreement period.	Optional for all ACOs. ACOs may transition back to Level E from Enhanced.	No one-sided model under ACO REACH.	

Benchmark	CMS establishes and rebases MSSP ACO benchmarks based on expenditures from three benchmark years leading up to an agreement period using four beneficiary categories (ESRD, disabled, aged/dual, and aged/non-dual). CMS incorporates regional expenditures into benchmarks starting in an ACO's initial performance year. ACOs with spending higher than their region have a regional adjustment weight of 15%, ACOs with spending lower than their region receive a weight of 35% in the first agreement year. If an ACO is considered a re-entering ACO, CMS will apply the regional adjustment weight that was used in the most recent agreement.
	
	Beginning in 2024, CMS will:
	• Incorporate a prospective administrative growth factor based on US per capita cost to update an ACO's benchmark each performance year, creating a new three-way blend. The new update factor would look as follows:
	  ▪ Two-way blend = (National Update Factor x National Weight) + (Regional Update Factor x (1 – National Weight))
	  ▪ Three-way blend = [PY1 ACPT x (1/3)] + [PY1 Two-Way Blend x (2/3)]
	• Account for an ACO's prior savings when establishing benchmarks for renewing and re-entering ACOs.
	• Reduce the cap on negative regional adjustments from -5 to -1.5 percent.
			Prospective blend of historical spending and adjusted Medicare Advantage Rate Book
			• Standard ACOs using claims-based alignment: fixed 3-year baseline period (2017-19), with application of a trend adjustment and geographic adjustment
			• Standard ACOs using voluntary alignment, New Entrant ACOs, & High Needs ACOs: only regional expenditures through PY2024 (historical expenditures incorporated beginning PY2025)
			A health equity benchmark adjustment will be applied based on aligned beneficiaries' social risk. Additional details on benchmark calculations	

Risk adjustment	CMS uses an ACO's prospective HCC risk score to adjust the benchmark for changes in severity and case mix in the assigned beneficiary population between BY3 and the performance year. Positive adjustments in prospective HCC risk scores are subject to a cap of 3 percent for each agreement period. Beginning in 2024, CMS will account for changes in demographic risk scores before applying the 3 percent cap and the +3 percent cap will apply in aggregate across the four enrollment types (ESRD, disabled, aged/dual, and aged/non-dual)		CMS will risk adjust historical baseline, regional expenditures, and capitated payments • For Standard & New Entrant ACOs: CMS-HCC prospective risk adjustment model • High Needs ACOs: CMMI-HCC concurrent risk adjustment model for aged & duals, CMS-HCC prospective risk adjustment model for ESRD To control potential increases in coding intensity and risk score growth, CMS will use a normalization factor, a Coding Intensity Factor, and a risk score cap. Additional details on risk adjustment	
Payment options	CMS makes all FFS payments		Primary Care Capitation (PCC) = monthly payments for certain primary care services ~2-7% of TCOC (CMS pays	Optional PCC or Total Care Capitation (TCC) = 100% Parts A & B services for aligned beneficiaries

							claims for all other services) • Fee reduction required for Participant Providers, optional for Preferred Providers • Optional Advanced Payment (APO) up to 100% of benchmark w/ reconciliation	• Fee reduction required for Participant Providers, optional for Preferred Providers
Reconciliation	Full performance year reconciliation following full claims run out period						Capitation payments not reconciled against actual claims. APO payments reconciled against actual claims. For ACOs electing TCC, CMS will reconcile TCC withhold against actual expenditures incurred by aligned beneficiaries for services provided outside of TCC arrangement.	
Beneficiaries and Alignment								
	MSSP Basic Level A	**MSSP Basic Level B**	**MSSP Basic Level C**	**MSSP Basic Level D**	**MSSP Basic Level E**	**MSSP Enhanced**	**REACH Professional**	**REACH Global**
Minimum number of beneficiaries	5,000						**Standard ACOs:** 5,000 (≥ 3,000 "alignable" beneficiaries in at least one base year) **New Entrant ACOs:** 2,000 in PY23, 3,000 in PY24, 5,000 in PY25-26 (max. 3,000 "alignable" beneficiaries in any base year) **High Needs Population ACOs:** 500 in PY23, 750 in PY24, 1,200 in PY25, 1,400 in PY26	
Beneficiary alignment	• Prospective or preliminary prospective with retrospective reconciliation (elected annually) • Claims-based and voluntary ○ Voluntary alignment takes precedence over claims-based						• Prospective • Claims-based and voluntary (may market voluntary alignment) ○ Voluntary alignment takes precedence over claims-based ○ Voluntary alignment through MyMedicare.gov takes precedence over Attestation-Based Voluntary Alignment ○ Option to add voluntarily aligned beneficiaries quarterly	

Beneficiary notification requirements	ACOs must include posted signs in all ACO participant facilities notifying beneficiaries that its providers are participating in MSSP. Each agreement period, ACOs must furnish a written notice to beneficiaries prior to or at the first primary care visit: • For ACOs under preliminary prospective assignment—send to all FFS beneficiaries prior to or at the first primary care visit during the first performance year that the beneficiary is seen by an ACO participant. • For ACOs under prospective assignment—send to all assigned beneficiaries prior to or at the firs primary care visit. Within 180 days of providing the notice or at the next primary care visit, ACOs must follow-up with beneficiaries and offer a meaningful opportunity to ask questions and engage with an ACO representative.						Each performance year, ACOs must send CMS-drafted and/or approved letters to all prospectively aligned patients by the date specified by CMS.	
Quality								
	MSSP Basic Level A	**MSSP Basic Level B**	**MSSP Basic Level C**	**MSSP Basic Level D**	**MSSP Basic Level E**	**MSSP Enhanced**	**REACH Professional**	**REACH Global**
Measures	GPRO Web Interface (WI) reporting will sunset after PY 2024. Now through PY 2024, ACOs may report WI, eCQMs/MIPS CQMs, or both (those reporting both will receive the higher of the two scores). The WI will no longer be a reporting option for PY 2025 or later. • WI reporting: 10 total measures (7 clinical quality measures, 2 administrative claims measures, CAHPS for MIPS) • eCQMs/MIPS CQMs: 6 total measures (3 clinical quality measures, 2 administrative claims measures, CAHPS for MIPS) *Note: CMS may suppress certain measures in certain performance years* NAACOS remains concerned with the timeline and strategy to shift to all payer/eCQM reporting and the NAACOS Digital Quality Measurement Task Force has provided recommendations to CMS on this issue.						• Standard & New Entrant ACOs: assessed on 4 measures (3 administrative claims measures and the ACO CAHPS Survey) • High Needs ACOs: Timely Follow-Up measure is replaced with Days at Home for Patients with Complex, Chronic Conditions	
Scoring	In order to earn maximum shared saving, an ACO must meet or exceed the 30th percentile among all MIPS quality performance category scores in 2021-2023 and meet or exceed the 40th percentile each year after. ACOs that do not meet this threshold may share in a portion of savings by achieving a quality performance score equivalent to the 10th percentile (individual measure performance benchmark) or higher on at least one outcome measure. The ACO's final sharing rate would be scaled by multiplying the maximum sharing rate for the ACO's track/level by the ACO's quality performance score, which includes any health equity bonus points.						• 2% benchmark withhold can be earned back through quality scores • Total Quality Score (0-100%) = initial quality score adjusted for continuous improvement/sustained exceptional performance (CI/SE) and health equity data reporting (HEDR) • Highest performers eligible for a bonus	
EHR use	At least 75% of ACOs' eligible clinicians as defined under MACRA must use Certified EHR Technology (CEHRT), using an annual attestation process.						ACOs must document that at least 75% of Participant Providers that are eligible clinicians use Certified EHR Technology (CEHRT)	
Compliance and Waivers								
	MSSP Basic Level A	**MSSP Basic Level B**	**MSSP Basic Level C**	**MSSP Basic Level D**	**MSSP Basic Level E**	**MSSP Enhanced**	**REACH Professional**	**REACH Global**
Compliance programs	ACO must have a compliance plan that meets the requirements of 42 C.F.R. § 425.300, including: a designated compliance official who is not legal counsel to the ACO; anonymous reporting of suspected compliance violations, both by ACO members, employees and contractors regarding internal ACO matters and to law enforcement where the law may be violated; and compliance training.							
Monitoring efforts	CMS monitors and assesses the performance of ACOs, their ACO participants, and ACO providers/suppliers through: • Analysis of financial and quality data reported by the ACO as well as aggregate annual and quarterly reports • Analysis of any beneficiary/provider complaints • Audits (i.e., analysis of claims, chart review, beneficiary survey reviews, coding audits, on-site compliance reviews)						In addition to MSSP monitoring, CMS will monitor REACH ACOs for: • Beneficiaries being shifted to MA • Excessive risk score growth/ inappropriate coding practices • Service use over time Full list of monitoring efforts	

Available waivers	Not applicable	• **SNF 3-day Rule**—Waives 3-day inpatient stay requirement prior to SNF admission. CMS waives 3-star quality rating requirement for providers under swing bed arrangements. • **Telehealth**—Waives typical geographic restrictions count patients' homes as originating sites. (*Only available to ACOs under prospective assignment*)	• **SNF 3-day Rule**—SNF must be Participant or Preferred Provider and have quality rating of 3+ stars • **Telehealth**—Same as MSSP • **Home visits** – care management and post-discharge • **Chronic Disease Management Reward Program** • **Provision of home health** services to beneficiaries not "homebound" • **Nurse Practitioner Services Benefit** ****Hospice Benefit**— Waive requirement to give up curative care (****only for Global*)
Allowable beneficiary incentives	Not applicable	**Beneficiary Incentive Program** —Allows ACOs to provide a limited "cash equivalent" incentive to eligible beneficiaries who receive qualifying primary care services. May not be limited to a subset of beneficiaries or services. **In-kind incentives** — There must be a reasonable connection between items/services and beneficiary's medical care; must be preventive care items/services or advance a clinical goal of the beneficiary; must not be a Medicare-covered item/service	• **Cost sharing support** for Part B services tailored to specific categories of services and/or beneficiaries • **In-kind items or services**—may include home blood pressure monitors, vouchers for OTC medications, transportation vouchers, wellness programs, etc.
Policies to promote health equity	**Health equity quality adjustment:** Beginning PY2023, CMS will award up to 10 bonus points to the quality performance score for ACOs delivering high quality care to underserved populations. Bonus points are only available to ACOs reporting eCQMs/MIPS CQMs. Additional details on the bonus calculation can be found on p. 14-15 here. **Advance Investment Payments (AIPs):** Beginning PY2024, CMS will provide advance shared savings payments to new, inexperienced, low revenue ACOs, modeled after the ACO Investment Model (AIM). AIPs will consist of a one-time upfront payment $250,000 and quarterly payment calculated per beneficiary over the first 2 years of an ACO's agreement period. ACOs will be able to apply for AIPs as part of the MSSP application cycle. More information can be found on p. 9-12 here.		• Health Equity Plan requirement • Health equity benchmark adjustment • Requirement to collect and report beneficiary-reported demographic and SDOH data • Application scores include ACOs' demonstrated ability to provide high quality care to underserved communities

Additional Resources								
	MSSP Basic Level A	**MSSP Basic Level B**	**MSSP Basic Level C**	**MSSP Basic Level D**	**MSSP Basic Level E**	**MSSP Enhanced**	**REACH Professional**	**REACH Global**
NAACOS resources	NAACOS MSSP webpage, NAACOS Analysis of the 2023 MPFS, NAACOS Quality webpage						NAACOS ACO REACH webpage, Summary of REACH Financial Specifications, REACH FAQs	
CMS resources	Shared Savings Program webpage, Information for ACOs, Information for Providers, Program Guidance & Specifications, Program Data, MSSP News						REACH Model webpage, Model Factsheet, Financial operating guide, Quality measurement methodology, Provider management guide	

Appendix C – Policy Appendix
Policies Recommended for Reaffirmation

Accountable Care Organization Principles H-160.915
Our AMA adopts the following Accountable Care Organization (ACO) principles:
1. Guiding Principle - The goal of an ACO is to increase access to care, improve the quality of care and ensure the efficient delivery of care. Within an ACO, a physician's primary ethical and professional obligation is the well-being and safety of the patient.
2. ACO Governance - ACOs must be physician-led and encourage an environment of collaboration among physicians. ACOs must be physician-led to ensure that a physician's medical decisions are not based on commercial interests but rather on professional medical judgment that puts patients' interests first.
A. Medical decisions should be made by physicians. ACOs must be operationally structured and governed by an appropriate number of physicians to ensure that medical decisions are made by physicians (rather than lay entities) and place patients' interests first. Physicians are the medical professionals best qualified by training, education, and experience to provide diagnosis and treatment of patients. Clinical decisions must be made by the physician or physician-controlled entity. The AMA supports true collaborative efforts between physicians, hospitals and other qualified providers to form ACOs as long as the governance of those arrangements ensures that physicians control medical issues.
B. The ACO should be governed by a board of directors that is elected by the ACO professionals. Any physician-entity [e.g., Independent Physician Association (IPA), Medical Group, etc.] that contracts with, or is otherwise part of, the ACO should be physician-controlled and governed by an elected board of directors.
C. The ACO's physician leaders should be licensed in the state in which the ACO operates and in the active practice of medicine in the ACO's service area.
D. Where a hospital is part of an ACO, the governing board of the ACO should be separate, and independent from the hospital governing board.
3. Physician and patient participation in an ACO should be voluntary. Patient participation in an ACO should be voluntary rather than a mandatory assignment to an ACO by Medicare. Any physician organization (including an organization that bills on behalf of physicians under a single tax identification number) or any other entity that creates an ACO must obtain the written affirmative consent of each physician to participate in the ACO. Physicians should not be required to join an ACO as a condition of contracting with Medicare, Medicaid or a private payer or being admitted to a hospital medical staff.
4. The savings and revenues of an ACO should be retained for patient care services and distributed to the ACO participants.
5. Flexibility in patient referral and antitrust laws. The federal and state anti-kickback and self-referral laws and the federal Civil Monetary Penalties (CMP) statute (which prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible to allow physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs. This is particularly important for physicians in small- and medium-sized practices who may want to remain independent but otherwise integrate and collaborate with other physicians (i.e., so-called virtual integration) for purposes of participating in the ACO. The ACA explicitly authorizes the Secretary to waive requirements under the Civil Monetary Penalties statute, the Anti-Kickback statute, and the Ethics in Patient Referrals (Stark) law. The Secretary should establish a full range of waivers and safe harbors that will enable independent physicians to use existing or new organizational structures to participate as ACOs. In addition, the Secretary should work with the Federal Trade Commission to provide explicit exceptions to the antitrust laws for ACO participants. Physicians cannot completely transform their practices only for their Medicare patients, and antitrust enforcement could prevent them from creating clinical integration structures involving their privately insured patients. These waivers and safe harbors should be allowed where appropriate to exist beyond the end of the initial agreement between the ACO and CMS so that any new

organizational structures that are created to participate in the program do not suddenly become illegal simply because the shared savings program does not continue.
6. Additional resources should be provided up-front in order to encourage ACO development. CMS's Center for Medicare and Medicaid Innovation (CMI) should provide grants to physicians in order to finance up-front costs of creating an ACO. ACO incentives must be aligned with the physician or physician group's risks (e.g., start-up costs, systems investments, culture changes, and financial uncertainty). Developing this capacity for physicians practicing in rural communities and solo-small group practices requires time and resources and the outcome is unknown. Providing additional resources for the up-front costs will encourage the development of ACOs since the 'shared savings' model only provides for potential savings at the back-end, which may discourage the creation of ACOs (particularly among independent physicians and in rural communities).
7. The ACO spending benchmark should be adjusted for differences in geographic practice costs and risk adjusted for individual patient risk factors.
A. The ACO spending benchmark, which will be based on historical spending patterns in the ACO's service area and negotiated between Medicare and the ACO, must be risk-adjusted in order to incentivize physicians with sicker patients to participate in ACOs and incentivize ACOs to accept and treat sicker patients, such as the chronically ill.
B. The ACO benchmark should be risk-adjusted for the socioeconomic and health status of the patients that are assigned to each ACO, such as income/poverty level, insurance status prior to Medicare enrollment, race, and ethnicity and health status. Studies show that patients with these factors have experienced barriers to care and are more costly and difficult to treat once they reach Medicare eligibility.
C. The ACO benchmark must be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating cost factors (i.e., hospital wage index) and physician HIT costs.
D. The ACO benchmark should include a reasonable spending growth rate based on the growth in physician and hospital practice expenses as well as the patient socioeconomic and health status factors.
E. In addition to the shared savings earned by ACOs, ACOs that spend less than the national average per Medicare beneficiary should be provided an additional bonus payment. Many physicians and physician groups have worked hard over the years to establish systems and practices to lower their costs below the national per Medicare beneficiary expenditures. Accordingly, these practices may not be able to achieve significant additional shared savings to incentivize them to create or join ACOs. A bonus payment for spending below the national average would encourage these practices to create ACOs and continue to use resources appropriately and efficiently.
8. The quality performance standards required to be established by the Secretary must be consistent with AMA policy regarding quality. The ACO quality reporting program must meet the AMA principles for quality reporting, including the use of nationally-accepted, physician specialty-validated clinical measures developed by the AMA-specialty society quality consortium; the inclusion of a sufficient number of patients to produce statistically valid quality information; appropriate attribution methodology; risk adjustment; and the right for physicians to appeal inaccurate quality reports and have them corrected. There must also be timely notification and feedback provided to physicians regarding the quality measures and results.
9. An ACO must be afforded procedural due process with respect to the Secretary's discretion to terminate an agreement with an ACO for failure to meet the quality performance standards.
10. ACOs should be allowed to use different payment models. While the ACO shared-savings program is limited to the traditional Medicare fee-for-service reimbursement methodology, the Secretary has discretion to establish ACO demonstration projects. ACOs must be given a variety of payment options and allowed to simultaneously employ different payment methods, including fee-for-service, capitation, partial capitation, medical homes, care management fees, and shared savings. Any capitation payments must be risk-adjusted.

11. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient Satisfaction Survey should be used as a tool to determine patient satisfaction and whether an ACO meets the patient-centeredness criteria required by the ACO law.
12. Interoperable Health Information Technology and Electronic Health Record Systems are key to the success of ACOs. Medicare must ensure systems are interoperable to allow physicians and institutions to effectively communicate and coordinate care and report on quality.
13. If an ACO bears risk like a risk bearing organization, the ACO must abide by the financial solvency standards pertaining to risk-bearing organizations.
(Res. 819, I-10; Reaffirmation: A-11; Reaffirmed: Res. 215, A-11; Reaffirmation: I-12; Reaffirmed: CMS Rep. 6, I-13; Reaffirmed: Sub. Res. 711, A-15; Reaffirmation: I-15; Reaffirmation: A-16; Reaffirmation: I-17; Reaffirmation: A-19)

Patient Information and Choice H-373.998
Our AMA supports the following principles:
1. Greater reliance on market forces, with patients empowered with understandable fee/price information and incentives to make prudent choices, and with the medical profession empowered to enforce ethical and clinical standards which continue to place patients' interests first, is clearly a more effective and preferable approach to cost containment than is a government-run, budget-driven, centrally controlled health care system.
2. Individuals should have freedom of choice of physician and/or system of health care delivery. Where the system of care places restrictions on patient choice, such restrictions must be clearly identified to the individual prior to their selection of that system.
3. In order to facilitate cost-conscious, informed market-based decision-making in health care, physicians, hospitals, pharmacies, durable medical equipment suppliers, and other health care providers should be required to make information readily available to consumers on fees/prices charged for frequently provided services, procedures, and products, prior to the provision of such services, procedures, and products. There should be a similar requirement that insurers make available in a standard format to enrollees and prospective enrollees information on the amount of payment provided toward each type of service identified as a covered benefit.
4. Federal and/or state legislation should authorize medical societies to operate programs for the review of patient complaints about fees, services, etc. Such programs would be specifically authorized to arbitrate a fee or portion thereof as appropriate and to mediate voluntary agreements and could include the input of the state medical society and the AMA Council on Ethical and Judicial Affairs.
5. Physicians are the patient advocates in the current health system reform debate. Efforts should continue to seek development of a plan that will effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients' freedom to select physicians and/or health plans of their choice.
6. Efforts should continue to vigorously pursue with Congress and the Administration the strengthening of our health care system for the benefit of all patients and physicians by advocating policies that put patients, and the patient/physician relationships, at the forefront.
(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. E, A-93; Reaffirmed: CMS Rep. G, A-93; Reaffirmed: Sub. Res. 701, A-93; Sub. Res. 125, A-93; Reaffirmation: A-93; Reaffirmed: BOT Rep. 25, I-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: CMS Rep. 5, I-93; Reaffirmed: CMS Rep. 10, I-93; Reaffirmed: Sub. Res. 107, I-93; Reaffirmed: BOT Rep. 46, A-94; Reaffirmed: Sub. Res. 127, A-94; Reaffirmed: Sub. Res 132, A-94; Reaffirmed: BOT 16, I-94; BOT Rep. 36, I-94; Reaffirmed: CMS Rep. 8, A-95; Reaffirmed: Sub. Res. 109, A-95; Reaffirmed: Sub. Res. 125, A-95; Reaffirmed by Sub. Res. 107, I-95; Reaffirmed: Sub. Res. 109, I-95; Reaffirmed by Rules & Credentials Cmte., A-96; Reaffirmation: I-96; Reaffirmation: A-97; Reaffirmed: Rules & Credentials Cmte., I-97; Reaffirmed: CMS Rep. 3, I-97; Reaffirmation: I-98; Reaffirmed: CMS Rep. 9, A-98; Reaffirmation: A-99; Reaffirmation: A-00; Reaffirmation: I-00; Reaffirmation: A-04; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmation: A-07;

Reaffirmation: A-08; Reaffirmed: CMS Rep. 4, A-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmation: I-14; Reaffirmed: CMS Rep. 4, A-15; Reaffirmation: A-17; Reaffirmed: Res. 108, A-17; Reaffirmation: A-19; Reaffirmed in lieu of: Res. 112, A-19)

Effects of Hospital Integrated System Accountable Care Organizations H-160.892
Our AMA encourages studies into the effect of hospital integrated system Accountable Care Organizations' (ACOs) ability to generate savings and the effect of these ACOs on medical staffs and potential consolidation of medical practices.

Health Care Reform Physician Payment Models D-385.963
1. Our AMA will: (a) work with the Centers for Medicare and Medicaid Services and other payers to participate in discussions and identify viable options for bundled payment plans, gain-sharing plans, accountable care organizations, and any other evolving health care delivery programs; (b) develop guidelines for health care delivery payment systems that protect the patient-physician relationship; (c) make available to members access to legal, financial, and ethical information, tools and other resources to enable physicians to play a meaningful role in the governance and clinical decision-making of evolving health care delivery systems; and (d) work with Congress and the appropriate governmental agencies to change existing laws and regulations (e.g., antitrust and anti-kickback) to facilitate the participation of physicians in new delivery models via a range of affiliations with other physicians and health care providers (not limited to employment) without penalty or hardship to those physicians.
2. Our AMA will: (a) work with third party payers to assure that payment of physicians/healthcare systems includes enough money to assure that patients and their families have access to the care coordination support that they need to assure optimal outcomes; and (b) will work with federal authorities to assure that funding is available to allow the CMMI grant-funded projects that have proven successful in meeting the Triple Aim to continue to provide the information we need to guide decisions that third party payers make in their funding of care coordination services.
3. Our AMA advises physicians to make informed decisions before starting, joining, or affiliating with an ACO. Our AMA will provide information to members regarding AMA vetted legal and financial advisors and will seek discount fees for such services.
4. Our AMA will develop a toolkit that provides physicians best practices for starting and operating an ACO, such as governance structures, organizational relationships, and quality reporting and payment distribution mechanisms. The toolkit will include legal governance models and financial business models to assist physicians in making decisions about potential physician-hospital alignment strategies. The toolkit will also include model contract language for indemnifying physicians from legal and financial liabilities.
5. Our AMA will continue to work with the Federation to identify, publicize and promote physician-led payment and delivery reform programs that can serve as models for others working to improve patient care and lower costs.
6. 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.
7. Our AMA will work with states to: (a) ensure that current state medical liability reform laws apply to ACOs and physicians participating in ACOs; and (b) address any new liability exposure for physicians participating in ACOs or other delivery reform models.
8. Our AMA recommends that state and local medical societies encourage the new Accountable Care Organizations (ACOs) to work with the state health officer and local health officials as they develop the electronic medical records and medical data reporting systems to assure that data needed by Public Health to protect the community against disease are available.
9. Our AMA recommends that ACO leadership, in concert with the state and local directors of public health, work to assure that health risk reduction remains a primary goal of both clinical practice and the efforts of public health.

10. Our AMA encourages state and local medical societies to invite ACO and health department leadership to report annually on the population health status improvement, community health problems, recent successes and continuing problems relating to health risk reduction, and measures of health care quality in the state.

Plan for Continued Progress Toward Health Equity H-180.944
Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity. (BOT Rep. 33, A-18; Reaffirmed: CMS Rep. 5, I-21)

The Structure and Function of Interprofessional Health Care Teams H-160.912
1. Our AMA defines 'team-based health care' as the provision of health care services by a physician-led team of at least two health care professionals who work collaboratively with each other and the patient and family to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care.
2. Our AMA will advocate that the physician leader of a physician-led interprofessional health care team be empowered to perform the full range of medical interventions that she or he is trained to perform.
3. Our AMA will advocate that all members of a physician-led interprofessional health care team be enabled to perform medical interventions that they are capable of performing according to their education, training and licensure and the discretion of the physician team leader in order to most effectively provide quality patient care.
4. Our AMA adopts the following principles to guide physician leaders of health care teams:
a. Focus the team on patient and family-centered care.
b. Make clear the team's mission, vision and values.
c. Direct and/or engage in collaboration with team members on patient care.
d. Be accountable for clinical care, quality improvement, efficiency of care, and continuing education.
e. Foster a respectful team culture and encourage team members to contribute the full extent of their professional insights, information and resources.
f. Encourage adherence to best practice protocols that team members are expected to follow.
g. Manage care transitions by the team so that they are efficient and effective, and transparent to the patient and family.
h. Promote clinical collaboration, coordination, and communication within the team to ensure efficient, quality care is provided to the patient and that knowledge and expertise from team members is shared and utilized.
i. Support open communication among and between the patient and family and the team members to enhance quality patient care and to define the roles and responsibilities of the team members that they encounter within the specific team, group or network.
j. Facilitate the work of the team and be responsible for reviewing team members' clinical work and documentation.
k. Review measures of ‘population health’ periodically when the team is responsible for the care of a defined group.
5. Our AMA encourages independent physician practices and small group practices to consider opportunities to form health care teams such as through independent practice associations, virtual networks or other networks of independent providers.
6. Our AMA will advocate that the structure, governance and compensation of the team should be aligned to optimize the performance of the team leader and team members.
(Joint CME-CMS Report., I-12; Reaffirmation: I-13; Reaffirmed: CMS Rep. 1, I-15; Reaffirmed: BOT Action in Response to Referred for Decision: Res. 718, A-17)

Alternative Payment Models and Vulnerable Populations D-385.952
Our AMA: (1) supports alternative payment models (APMs) that link quality measures and payments to outcomes specific to vulnerable and high-risk populations, reductions in health care disparities, and functional improvements, if appropriate; (2) will continue to encourage the development and implementation of physician-focused APMs that provide services to improve the health of vulnerable and high-risk populations and safeguard patient access to medically necessary care, including institutional post-acute care.
(CMS Rep. 10, A-19; Modified: Rep. 04, A-23; Reaffirmation: Res. 111, A-23)

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-I-23

Subject: Health Insurers and Collection of Patient Cost-Sharing (Resolution 823-I-22)

Presented by: Sheila Rege, MD Chair

Referred to: Reference Committee J

At the November 2022 Interim Meeting, the House of Delegates referred Resolution 823, "Health Insurers and Collection of Co-pays and Deductibles," which was sponsored by the Private Practice Physicians Section and asked:

> That our American Medical Association (AMA) advocate for legislation and/or regulations to require insurers to collect co-pays and deductibles in fee-for-service arrangements directly from patients with whom the insurers are contractually engaged and pay physicians the full contracted rate unless physicians opt-out to collect on their own.

This report provides an overview of cost-sharing, highlights the impact of cost-sharing collection for physicians, including unique concerns for emergency physicians, explores alternatives to cost-sharing collections, and presents a policy recommendation consistent with Resolution 823-I-22.

DEDUCTIBLES AND OTHER COST-SHARING

Cost-sharing is a general term for the portion of annual health care costs that patients are responsible for paying "out-of-pocket" and may include deductibles, copays and/or coinsurance. Deductibles are paid before the full insurance coverage begins, while copays and coinsurance limit patient costs once the deductible is met.[1] Patients are responsible for all of these forms of cost-sharing and typically they are collected by the physician, practice, or hospital where the care was provided. Cost-sharing began in the United States in the mid-20th century as a response to patient desire for coverage beyond inpatient care and insurer concern that first-dollar comprehensive insurance could result in unsustainably high premiums. Since cost-sharing was collected at the point-of-service, physicians' offices and hospitals have traditionally been responsible for the collection of cost-sharing.[2]

A deductible is the amount that a patient must pay annually before the insurance plan covers the cost of care. Deductible amounts vary significantly by plan, but the average deductible for individual employer-provided coverage is just under $1,800.[3] High-deductible health plans (HDHPs) often have higher deductibles with individual health plans ranging between $1,500 and $7,500. Marketplace health plans range significantly by metal rating with "Bronze" plans annual deductible averaging just under $7,500 and "Platinum" plans averaging just $45. The Medicare Part B deductible is currently $226 annually. Plans with lower monthly premiums tend to have higher deductible amounts and those with higher monthly premiums tend to have lower deductible amounts. Often plans have both individual and family deductibles. Importantly, many plans cover certain services before the patient has met the deductible. For example, all Marketplace and many

© 2023 American Medical Association. All rights reserved.

private plans cover the full cost of certain preventive services before the beneficiary meets the deductible.[4] During the deductible phase, patient out-of-pocket charges are limited to the approved contracted rate of their health plan.

A copay is a fixed amount that patients pay for a covered health service once the deductible has been met.[5] Copays typically range from $15-$25 for a routine, in-network visit to the physician's office and are paid at the time of the visit. Patients who have not met their deductibles will pay the full allowable amount for the visit to the physician's office. The amount of a copay varies by plan and by the service rendered. As with deductibles, typically health insurance plans that have lower monthly premiums have higher copays and those with higher monthly premiums have lower copayments. Coinsurance is the percentage of costs paid by the patient for covered health care services after the deductible has been met. Coinsurance rates average approximately 20 percent for employer-sponsored insurance and is exactly 20 percent for Medicare Part B plans. Cost-sharing cannot be routinely waived or reduced by physicians/practices for either public or private plans, but payment plans may be acceptable in cases of financial hardship.

Cost-sharing may also vary by site of service (inpatient vs outpatient vs emergency). For patients who are receiving inpatient care, cost-sharing is typically based on length of stay, per-stay, or per-day basis once the patient has been formally admitted for inpatient care. All of the aforementioned specifics hinge on the patient receiving care from an in-network physician/provider. Should an out-of-network physician provide care, many insurance plans have additional/higher cost-sharing responsibilities for the patient.

PHYSICIAN IMPACT

While many physicians experience the adverse impact of collecting cost-sharing, private practices, especially small and rural practices, tend to face more extreme challenges. Net physician practice revenue is often reduced not only from unpaid cost-sharing, but also from the administrative overhead associated with billing and collection. These activities take staff away from more direct patient care activities and can be a drain on a practice's financial resources. Small private and rural practices often have smaller operating budgets and struggle more than larger practices to cover these increased administrative costs.

Uncompensated and partially paid care, such as when cost-sharing payments are not made, can stem from a number of factors with uninsured or underinsured patients often having the largest impact.[6] Regardless of the root cause of uncompensated care, it is estimated that the lost revenue can reach billions annually.[7] Patients with HDHPs, which typically have higher deductibles have significantly contributed to the growth in uncompensated care.[8]

Another factor behind uncompensated care in the United States is the lack of affordability of health care nationally.[9] Not only are these costs high, but they are also on the rise. For example, in 2021, health care costs accounted for 18 percent of the U.S. Gross Domestic Product, up from five percent in 1960.[18] As a result, many Americans have experienced medical debt. Twenty-three million American adults, about 9 percent, hold medical debt with about half of those reporting owing more than $2,000.[10] The lack of affordability of American health care is a contributor to the issues that many physicians face when seeking to collect co-pays and deductibles from patients.

COST-SHARING AND EMTALA

While the collection of cost-sharing is not prohibited by the Emergency Medical Treatment and Labor Act (EMTALA), any collection done during an emergency department (ED) visit cannot

interfere, impede, or delay the medical screening exam (MSE) or stabilizing care. The collection of patient cost-sharing in EDs is complicated and, in some situations, nearly impossible to pursue. As a result, many EDs determine that the collection of cost-sharing is not worth the investment that is needed to ensure that collection is done in a legal and respectful manner.

The regulation around ED copay collection, combined with Medicaid underfunding, Medicare's lack of an inflation adjustment, and uninsured patients seeking care, lead to emergency physicians providing uncompensated care about 55 percent of the time.[11] While the collection of copays and coinsurance are complicated in an emergency setting, the principles remain the same. A copay is still a set amount, typically between $50-$200 for an ED visit, and coinsurance is still a set percentage that the patient pays, usually ranging from 10-50 percent, as long as the deductible has been met. The collection of cost-sharing can be difficult enough in non-emergency settings, and the regulations around prevention of delay to MSE/stabilizing care further complicate the issue making it even harder to collect in emergency settings.

ALTERNATIVE COST-SHARING COLLECTIONS STRATEGIES AND OPTIONS

Some physician practices routinely use collections services. While this alternative still involves physician responsibility in collecting the cost-sharing, the onus of the specific collections actions falls on the agency. Collections agencies are contracted with the physician practice to collect on past-due or delinquent accounts.[12] Typically, agencies are paid via a contingency fee, which is only collected after the overdue account is settled. For physicians who are experiencing considerable financial challenges due to writing off accounts receivable as bad debt, or the difference between what patients are billed and what is actually paid, collections agencies may provide a viable alternative.

However, it is important that physicians are careful to ensure that selected agencies represent practices in a responsible manner and will not engage in undue patient harassment. Concerns surrounding the impact of overly aggressive collections agencies on not only patient financials, but also on the patient-physician relationship, are widespread and unfortunately founded.[19] Additionally, it is not uncommon for physicians to see minimal returns on collections sent to agencies as these agencies can charge significant fees to collect debts. On average, collections agencies charge a fee between 20 percent and 40 percent of what is collected. However, in certain situations, like when a debt is older, the collections agency may charge a higher percentage. When charging a percentage of the debt, agencies will only be paid if the debt is collected. Some agencies use a flat fee system where they charge between $15-$25 per account regardless of if the debt is actually collected.[13] Finally, collections agencies are utilized only after the physician/office has made attempts to collect payment, meaning that the physician/practice has already accrued costs to attempt collections. Due to the lack of return and the potential harms to patient financials, physician and practice reputation, and the patient-physician relationship collections agencies may not be the best alternative method for many physicians/practices to collect cost-sharing.

Another potential solution to physicians' collection of cost-sharing is the use of insurance-controlled collection systems. Collections systems like InstaMed, Flywire, Zelis, and MedPilot are patient payment programs that work to collect payments from patients for physicians, primarily through electronic means. These systems, utilized by companies like UnitedHealthcare, Blue Cross Blue Shield, and other major insurance companies, allow physicians to avoid the potential for bad debt.

Although these types of systems may help physicians and their practices in collecting cost-sharing, they can result in unintentional adverse impacts. For example, physicians may find that there is a

loss of business autonomy in turning over control of collections to insurers. Physicians often do not have a choice in if they want to receive payments in this manner, which further limits physician autonomy. Additionally, while there is little price transparency as to the specific cost to the practice, these services do come at an additional cost to the provider. Finally, as mentioned in CMS Report 9-A-19 physicians utilizing these programs are often pressured to sign up to receive costs via standard electronic fund transfers (EFTs). Should a physician choose not to sign up for EFTs, payments will be issued through a virtual credit card, which often comes with a substantial fee, often between 2-5 percent of the total payment. Due to the potential impacts on physician autonomy, this may not be the best solution to the collection of cost-sharing for most practices. More detailed information about this business model and its impacts can be found in CMS Report 9-A-19.

RELEVANT AMA POLICY AND RESOURCES

The AMA has a number of policies that work to ensure that care is affordable and patients are able to maintain affordable insurance coverage. Policy H-165.838 works to reform health systems to ensure that all Americans have coverage that is affordable and minimizes unnecessary costs and administrative burden. Additionally, Policy H-165.828 focuses more specifically on ensuring the affordability of health insurance for all Americans. This policy outlines the AMA's support for the ACA and suggests modifications to ensure that Americans are both educated about insurance choices and have access to coverage. Each of these policies work to ensure that coverage is expanded and help to reduce the cost of health care to patients as well as uncompensated care.

AMA policy also supports physician autonomy in practice type. Policy H-385.926 encourages physician practice autonomy through the growth of the patient-physician contract, support for physician choice in method of earning (fee-for-service, salary, capitation, etc.), and physician choice over charged fees. Finally, the AMA has policy that specifically addresses HDHPs and the complications that physicians face when collecting cost-sharing from patients covered by these plans. Policy H-165.849 outlines the AMA's opposition to plans that require physicians to bill patients, instead of more efficient methods, and outlines plans to engage with HDHP representatives to discuss the increasing difficulty for physicians to collect cost-sharing.

The AMA also has developed a variety of resources to help physicians navigate the complicated world of collecting cost-sharing. First, the AMA has a set of tools that are designed to help physicians manage patient payments, including a point-of-care pricing toolkit, resources on maximizing post-visit collections, and a how-to-guide for selecting a practice management system. Second, the AMA has developed a resource to support physicians in contracting with payers, Contracting 101 and hosted two webinars related to payer contracting, Payor and Contracting 101 Webinar and Payor and Contracting 201 Webinar. Each of these contracting resources are a part of the AMA's larger Private Practice Playbook: Resources.

DISCUSSION

The collection of cost-sharing is an extremely complicated and taxing process that physicians are required to navigate in order to receive full contracted compensation for services rendered. The Council believes that requiring physicians to engage in collecting cost-sharing negatively impacts physicians, with a particularly strong impact on those working in smaller private and rural practices. Accordingly, the Council concurs with the sentiment of Resolution 823-I-22.

AMA efforts to support physicians practicing in the current system of cost-sharing have included a series of resources, which were created to guide physicians in the steps of not only collecting cost-

sharing, but also in establishing fair and manageable contracts with payers. In addition to the guidance on payer contracting, the AMA has also established relatively extensive resources to assist physicians in navigating the collection of cost-sharing from patients. For example, these resources outline methods of point-of-care collections that have been shown to increase cash flow while also reducing billing and overhead costs, administrative burdens, and bad debt. In addition to the point-of-care collection resources, the AMA also provides information on how to maximize collections post-visit and how to select a practice management system. All of these resources are designed to assist physicians in navigating the complex and taxing process of collecting cost-sharing. However, it is clear that physicians still struggle with cost-sharing collection.

While cost-sharing seems to be a permanent fixture in health care payments, there are potential methods of collection that could ease the burden placed on physicians. As mentioned in this report, physicians are able to utilize collections agencies as a means to collect cost-sharing from patients. However, this may not be a method that all physicians are comfortable utilizing due to the potential negative impacts on patients and the physician-patient relationship. Another existing alternative to the traditional physician-collected cost-sharing system is insurance-controlled systems. These aforementioned systems are run by insurers, which may limit physician autonomy and may increase cost, but may be advantageous for physicians who struggle to collect cost-sharing. The Council specifically believes that alternative methods of collecting cost-sharing in which the onus is placed on insurers is likely to be advantageous for physicians and their practices.

Therefore, the Council recommends the adoption of an amended resolution 823-I-22. Specifically, the Council's recommended amendment allows for enduring policy to support insurers collecting patient cost-sharing, rather than physicians. The Council agrees that physicians should have the ability to opt-out of insurer collection.

Finally, in order to ensure that there are no unexpected adverse impacts on the health insurance coverage status of Americans, the Council recommends the reaffirmation of Policy H-165.838 which outlines the AMA's commitment to enact health insurance coverage for all Americans in a manner that is both affordable and accessible. The reaffirmation of this policy will reiterate the AMA's support to ensure that all Americans have access to affordable health insurance and that this would not be negated by the implementation of an insurance-controlled cost-sharing collections system.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 823-I-22, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support requiring health insurers to collect patient cost-sharing and pay physicians their full contracted amount for the health care services provided, unless the physicians opt-out to collect such cost-sharing on their own. (New HOD Policy)

2. That our AMA reaffirm Policy H-165.838, which details the AMA's ongoing support for affordable and accessible insurance coverage. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] Deductible. Health Care.gov. 2023. https://www.healthcare.gov/glossary/deductible/
[2] Hoffman B. Restraining the Health Care Consumer: The History of Deductibles and Co-payments in U.S. Health Insurance. *Social Science History.* 2006 Dec. doi: 10.1215/01455532-2006-007. https://www.cambridge.org/core/journals/social-science-history/article/abs/restraining-the-health-care-consumer/7DBF541C18ACCE37FDA26DFEFC7F0B02
[3] Health Insurance Deductible. Health Insurance.org. 2023. https://www.healthinsurance.org/glossary/health-insurance-deductible/
[4] Medicare Costs. Medicare.gov. 2023. https://www.medicare.gov/basics/costs/medicare-costs
[5] Copayment. *Health Care.gov*. 2023. https://www.healthcare.gov/glossary/co-payment/
[6] Under D. Resolving Uncompensated Care: Artificial Intelligence Takes on One of Healthcare's Biggest Costs. *Health Catalyst.* 2018. https://www.healthcatalyst.com/insights/uncompensated-care-resolving-major-healthcare-cost
[7] Coughlin T A, Samuel-Jakubos H, Garfield R. Sources of Payment for Uncompensated Care for the Uninsured. *Kaiser Family Foundation.* 2021 April 06. https://www.kff.org/uninsured/issue-brief/sources-of-payment-for-uncompensated-care-for-the-uninsured/
[8] Smith M. High-deductible and skinny health insurance plans drive medical debt. American Hospital Association. 2023 March 20. https://www.aha.org/news/blog/2023-03-20-high-deductible-and-skinny-health-insurance-plans-drive-medical-debt
[9] Culter D. The World's Costliest Health Care and What America Might Do About It. *Harvard Magazine.* 2020 May-June. https://www.harvardmagazine.com/2020/05/feature-forum-costliest-health-care
[10] Rae M, Claxton G, Amin K, Wager E, Ortaliza J, Cox C. The Burden of Medical Debt in the United States. *Kaiser Family Foundation.* 2022 March 10. https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/
[11] Kang H, Bastian ND, Riordan JP. Evaluating the Relationship between Productivity and Quality in Emergency Departments. J Healthc Eng. 2017; 2017:9626918. doi:10.1155/2017/9626918. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5559952/
[12] How to Select a Collection Service. *American Medical Association.* 2019. https://shorturl.at/afgIY
[13] How Much Do Collections Agencies Charge. *Fair Capital.* 2023. https://www.thefaircapital.com/post/collection-agencies-fee#:~:text=How%20much%20can%20you%20expect,profit%20margins%20for%20the%20agency.

REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (I-23)
Strengthening Network Adequacy
(Reference Committee J)

EXECUTIVE SUMMARY

Almost a decade after presenting Council on Medical Service Report 4-A-14, the Council self-initiated this report to strengthen and supplant existing American Medical Association (AMA) policy on the adequacy of health plan networks and the accuracy of provider directories. Although network adequacy must be monitored across all types of health plans, the use of limited networks has become increasingly common in Medicare Advantage, Medicaid managed care, and Affordable Care Act marketplace plans. This report provides an overview of federal and state network adequacy requirements and oversight; addresses the role of telehealth in network adequacy; describes efforts to use network adequacy requirements to improve health equity; summarizes AMA policy and advocacy; and presents policy recommendations.

Network adequacy refers to a health plan's ability to provide access to in-network physicians and hospitals to meet enrollees' health care needs. While acknowledging the challenges involved to ensuring network adequacy without adding substantially to the cost of insurance, the Council believes that regulators should take a multilayered approach that includes meaningful standards, transparency of network breadth and in-network physicians and hospitals, parameters around out-of-network care, and effective monitoring and enforcement. Among the large number of AMA policies addressing network adequacy, out-of-network care, and provider directory accuracy, four are recommended for reaffirmation: Policies H-285.908, H-285.904, H-285.902, and H-285.911, which are appended to this report.

Seven recommendations for new AMA policy ask our AMA to encourage and/or support: 1) a minimum federal network adequacy standard; 2) the use of multiple criteria to evaluate the sufficiency of provider networks; 3) the development and promulgation of assessment tools that allow consumers to compare insurance plans; 4) requirements for reporting to regulators and prominently displaying important network adequacy information, including the breadth of a plan's network and instructions for filing complaints; 5) the use of claims data, audits, secret shopper programs, and complaints to monitor network adequacy, and appointment wait times; 6) counting in-network physicians who provide both in-person and telehealth services towards network adequacy requirements on a very limited bases when their physical practice does not meet time and distance standards (while affirming the AMA does not support counting telehealth-only physicians towards network adequacy requirements); and 7) regulation to hold health plans accountable for network inadequacies, including through the use of corrective action plans and substantial financial penalties.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-I-23

Subject: Strengthening Network Adequacy

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee J

During the development of Council on Medical Service Report 6-A-23, Health Care Marketplace Plan Selection, the Council identified provider network adequacy as a key factor in maintaining healthy competition and choice in Affordable Care Act (ACA) marketplace plans. In that report, the Council highlighted concerns about the ability of patients to see certain physicians who are listed in provider directories as in-network but for whom access is limited because they are not accepting new patients or do not have timely appointments available. Because similar critiques have plagued other types of plans—most notably Medicare Advantage (MA) and Medicaid managed care organization (MCO) plans—the Council developed this self-initiated report on strengthening network adequacy, which provides overviews of federal and state network adequacy requirements, summarizes AMA policy and advocacy, and presents policy recommendations.

BACKGROUND

Access to physicians, hospitals, and other health care providers to obtain evidence-based, high-quality health care depends on a range of factors, including the breadth, size, and distribution of a plan's provider network. Health insurers manage the quantity and quality of providers and facilities in their networks and may limit the number of those in-network, or contract with less expensive providers and facilities, to manage utilization and contain costs. Although network adequacy should be monitored across all health plans, the use of narrow networks has become increasingly common in MA, Medicaid, and ACA marketplace plans as insurers compete for customers by offering lower-cost plans with limited networks.

According to a recent Kaiser Family Foundation survey, more than a quarter (26 percent) of insured adults reported that an in-network physician they wanted to see in the last year did not have appointments available and 14 percent of respondents said their insurance did not cover a particular physician or hospital they needed.[1] Additionally, nearly a quarter (23 percent) of survey respondents indicated that it was at least somewhat difficult to understand where to find out which physicians and hospitals are covered in their plan's network.[2] Provider directory inaccuracies also remain problematic for patients and physicians as some plans' networks may appear more robust by including physicians who are not in-network or who are unavailable or unwilling to provide services. While directory inaccuracies and network inadequacy are two different problems, directory inaccuracy may complicate efforts to address network inadequacy and is often considered along with network adequacy efforts.

Network adequacy generally refers to a health plan's ability to provide access to in-network physicians, other clinicians, and facilities to meet enrollees' health care needs. Establishing network adequacy standards is an important regulatory tool used to ensure that health plans

© 2023 American Medical Association. All rights reserved.

contract with an appropriately sized and distributed provider population. Federal and state qualitative standards generally require health plans to attest that networks include sufficient physicians and facilities to enable enrollees to access care within reasonable distances and timeframes. Notably, no national standard exists for network adequacy or network size, or what constitutes a sufficient network, and standards—and their enforcement—can vary significantly across states and plan types. The most common measures are time and distance standards outlining the maximum length of time and distance a patient should have to travel in order to see an in-network physician. Alternative network adequacy measures attempting to more accurately reflect the experience of a patient seeking in-network services include requirements that plans use secret shopper surveys to evaluate provider availability or employ maximum appointment wait times to ensure that appointments are available in a timely manner. Although midlevel providers may be in a provider network if permitted under state law, health plans must meet network adequacy requirements for physicians and measurement should be limited to physicians for physician services.

As described in the following sections, regulation and oversight of network adequacy vary by insurance type. Although MA plans are federally regulated, states are primarily responsible for regulating commercial plans offered in individual and small group markets; federal minimum requirements may apply, including in states relying on the federally facilitated marketplace rather than a state-based marketplace. States also regulate network adequacy in Medicaid in accordance with federal standards and generally have broad discretion to oversee Medicaid MCOs. Self-insured plans are exempt from most state insurance laws but must comply with a limited set of federal regulations.

The AMA maintains that although state regulators should have flexibility to regulate health plan provider networks, minimum federal standards are also needed, especially in light of inaction in many states to update and/or enforce network adequacy requirements. A state's network adequacy standards affect patients' access to care and also health insurance markets, and regulators overseeing insurer networks must try to balance access to care concerns and premium costs without interfering in local market dynamics.[3,4]

Medicare Advantage (Part C) Plans

Although traditional Medicare generally allows seniors to visit any physician or hospital that accepts Medicare patients, access for MA (Part C) beneficiaries is limited to physicians and hospitals within a plan's network. A 2017 analysis found that one in three MA enrollees were in a narrow physician network, defined as participation of less than 30 percent of physicians in the county, with access most restricted for psychiatrists.[5] A 2023 study found that almost two-thirds of psychiatrist networks in MA plans were narrow in 2019, and significantly narrower than in Medicaid MCO and marketplace plans. Further, more than half of the counties that had data available had no MA network psychiatrists.[6] Inadequate MA networks across all specialty and facility types are concerning since more than 30 million people were enrolled in MA plans this year, representing half of the total Medicare population.[7]

Network Adequacy Requirements: While it is accepted practice for MA plans to establish provider networks, federal regulations require these plans to demonstrate that a network is sufficient to provide access to covered services.[8] If patients need services that are not available within the plan's network, the Centers for Medicare & Medicaid Services (CMS) requires plans to arrange for patients to obtain services outside of the plan's network at in-network cost-sharing.

MA network adequacy criteria include 29 provider specialty types and 13 facility types that must be available to enrollees consistent with federal minimum number, time, and distance standards. MA network adequacy is assessed at the county level, and standards vary by county type (large metro, metro, micro, rural or counties with extreme access issues) based on population and density thresholds. Minimum physician and other health provider ratios, or the number of providers required per 1,000 enrollees, are determined annually for each specialty type based on Medicare utilization patterns.[9] In large metro and metro counties, for example, plans must contract with at least 1.67 primary care physicians per 1,000 enrollees and 1.42 primary care physicians per 1,000 enrollees in all other counties.[10] Beginning in 2024, plans must include an adequate supply of clinical psychologists, licensed clinical social workers, and prescribers of medication for opioid use disorder in their networks subject to time, distance, and minimum provider standards.

Maximum time (in minutes) and distance (in miles) standards require MA plans to ensure that at least 85 percent of enrollees in micro, rural, or counties with extreme access issues, and 90 percent of enrollees in large metro, metro, and micro counties, have access to at least one provider/facility of each specialty type within the published time and distance standards. Maximum time and distance standards (Table 1) and minimum provider ratios (Table 2) can be found in the Code of Federal Regulations, Title 42, Chapter IV, Subpart B, Part 422, Subpart C § 422.116.[11]

AMA Advocacy: The AMA has consistently advocated that CMS adopt a suite of policy proposals to enhance network adequacy, provider directory accuracy, network stability, and communication with patients about MA plans' physician networks. In recent communications with CMS, the AMA has urged the agency to:

- Require plans to report the percentage of physicians in the network, broken down by specialty and subspecialty, who actually provided services to plan members during the prior year;
- Publish the research supporting the adequacy of minimum provider ratios and maximum time and distance standards;
- Measure the stability of networks by calculating the percentage change in the physicians in each specialty in an MA plan's network compared to the previous year and over several years;
- Ban no-cause terminations of MA network physicians during the initial term or any subsequent renewal term of a physician's participation contract within an MA plan; and
- Update the Health Plan Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey to include questions assessing patients' actual access to care, including whether they are able to find in-network physicians accepting new patients and maintain utilization of physicians who have longitudinally provided them treatment; the distance needed to travel to obtain care; the average time to get an appointment; and the ability to obtain care at an in-network hospital where the patient's physician has staffing privileges.

The AMA has also recommended that CMS create a network adequacy task force that would allow CMS to engage with patients, physicians (including those in-network), and other stakeholders to review and strengthen MA network adequacy policies. Finally, the AMA has recommended that CMS adopt several policy changes to improve communications with consumers about MA plans so that people shopping for plans can more easily discern differences among provider networks and understand what they are purchasing.

Medicaid Managed Care Plans

Medicaid MCOs, which manage the care of more than 70 percent of Medicaid patients,[12] have also faced ongoing criticisms regarding network adequacy and true access to care. For example, a recent

Health Affairs study found that care was highly concentrated in Medicaid managed care networks, with a small number of primary care and specialty physicians providing most of the care to enrollees in the four states that were studied. The authors concluded that current network adequacy standards might not reflect actual access and that new methods are needed to account for physicians' willingness to serve Medicaid patients.[13] Additionally, a meta-analysis of 34 audit studies showed that Medicaid is associated with a 1.6-fold lower likelihood in successfully scheduling a primary care appointment and a 3.3-fold lower likelihood in successfully scheduling a specialty appointment when compared with private plans.[14] As the AMA has consistently noted in communications to CMS, access to primary and specialty care is a perennial issue faced by Medicaid enrollees which can be especially problematic in rural and underserved areas.

Network Adequacy Requirements: Network adequacy standards for Medicaid MCOs differ by state, but must meet standards set forth in federal regulations specifying that state Medicaid agencies must develop and publish a quantitative network adequacy standard for different provider types (adult and pediatric), including primary care, OB/GYN, mental health and substance use disorder (SUD), specialists as designated by the state, hospital, and pharmacy. In developing network adequacy standards, states are supposed to consider numerous elements related to network adequacy, including anticipated Medicaid enrollment; the expected utilization of services; characteristics and health care needs of specific Medicaid populations; the numbers and types of network providers required to furnish the contracted Medicaid services; numbers of network providers who are not accepting new Medicaid patients; and the geographic location of network providers and Medicaid enrollees, considering distance, travel time, and the means of transportation ordinarily used by Medicaid patients.[15]

Most states have time and distance standards in place along with a range of other network adequacy requirements that vary by state. In recent rulemaking for Medicaid and Children's Health Insurance Program managed care plans, CMS proposed requiring states to implement maximum appointment wait times for primary care (15 business days), outpatient mental health/SUD (10 days), and OB/GYN care (15 days); use secret shopper surveys to evaluate whether wait times and provider directory requirements are being met; conduct payment analyses that compare Medicaid MCO payment rates for certain services as a percentage of Medicare rates; implement a remedy plan for any MCO that has an access issue; and enhance existing state website requirements for content and ease of use.

Federal regulations currently require state Medicaid agencies to monitor MCO compliance with network adequacy standards, including through an annual validation of the adequacy of each network (by the external quality review organization engaged by the state agency) and annual submission of documentation of the adequacy of its MCO networks to CMS. CMS does not require minimum provider ratios for Medicaid managed care plans, as it does for MA plans, although some states have established such ratios that apply to Medicaid plans.

AMA Advocacy: The AMA has advocated for strong network adequacy standards at the federal level, and in states, at the request of state medical associations. Among other things, the AMA has advocated for active approval of networks prior to insurance products going to market; state enforcement of network adequacy requirements; transparency of network standards; and the use of quantitative standards, including time and distance standards, minimum provider-to-enrollee ratios, wait time maximums, and access to alternative office hour (e.g., evening and weekend) requirements. The AMA has also encouraged CMS to require that time and distance standards incorporate travel on public transportation to access services and has noted that additional quantitative and qualitative standards would help enable regulators to also assess the adequacy of a network and whether there is sufficient diversity among providers to meet the needs and

preferences of enrollees. The AMA has encouraged CMS to closely monitor state implementation of network adequacy standards and consider federal minimum requirements in the future.

ACA Marketplace Plans

CMS has previously acknowledged the proliferation of narrow networks among exchange plans, and the U.S. Government Accountability Office (GAO) has cited several studies demonstrating varying degrees of challenges facing enrollees attempting to access in-network providers, most commonly mental health specialists.[16] While marketplace plans with restricted networks may be popular with some consumers because their premium prices are lower, purchasers of these plans may not be aware that the provider network is narrow and that they may have trouble getting needed care from in-network physicians, hospitals, and other providers.

Network Adequacy Requirements: The ACA requires that health plans certified as Qualified Health Plans (QHPs) in ACA marketplaces maintain provider networks that are sufficient in number and types of providers to assure that all services, including mental health and SUD services, are accessible to enrollees without unreasonable delay.[17] Provider networks of marketplace plans also must include "essential community providers" (ECPs) to serve predominately lower-income and medically underserved individuals. Additionally, QHPs participating in the federally facilitated exchange must comply with time and distance standards and, beginning in 2025, they must meet maximum appointment wait time standards.[18]

Similar to MA network adequacy regulations, time and distance standards for plans on the federally-facilitated exchange are based on county type and are outlined for provider and facility types in Tables 3.1 and 3.2, on pages 12-14, of CMS' guidance for plan year 2023.[19] The AMA has supported the time and distance standards, suggested additional provider types, and further urged CMS to separate outpatient clinical behavioral health into outpatient clinical mental health and outpatient treatment for SUD to ensure patient access to appropriate providers. For plan year 2023, CMS also proposed assessing network adequacy using appointment wait time standards (15 days for routine primary care; 30 days for specialty care; and 10 days for behavioral health at least 90 percent of the time), although implementation of this requirement has been delayed until 2025.[20]

QHPs participating in the federally facilitated marketplace had in earlier years been required to submit provider networks to CMS for review; however, 2018 rulemaking by CMS ended this practice, effectively deferring most oversight to states, accreditation bodies, and the issuers themselves. After a federal court ruled against this change, CMS resumed its reviews and currently oversees the network adequacy of QHPs on the federally facilitated marketplace through annual certification and compliance reviews, targeted reviews stemming from complaints, and provider directory reviews.[21]

In 2016, CMS began implementing a network breadth pilot for QHPs in four states (Maine, Ohio, Tennessee, and Texas) intended to help CMS understand how consumers use network breadth information in making plan choices. During open enrollment, consumers in the four states see information classifying the relative breadth of the plans' provider networks, as compared to other exchange plans in the county, for adult primary care providers, pediatricians, and hospitals. Network breadth is classified as either "basic" (less than 30 percent of available providers), "standard" (between 30 and 70 percent of providers), or "broad" (70 percent or more of providers).[22] Data from this pilot would be useful to policymakers and regulators across all plan types; however, it had not yet been made publicly available at the time this report was written.

AMA Advocacy: Although CMS stated earlier this year that additional time was needed to develop guidance for appointment wait time standards, the AMA has strongly supported wait time requirements and urged CMS to implement them as soon as possible. The AMA maintains that maximum wait time standards are critical because they address access problems related to in-network physicians and other clinicians who are not accepting new patients or do not have appointments available in the timeframe needed. Importantly, the AMA has also urged CMS to consider additional tools to measure sufficiency of networks that move beyond insurer attestation including audits, secret shopper programs, and patient interviews and surveys.

The AMA also strongly supported CMS rulemaking for plan year 2024 that added two new ECP categories—mental health facilities and SUD treatment centers—so that all communities, including those that are lower income or medically underserved, have affordable, convenient, and timely access to mental health and SUD treatment. The AMA further urged CMS to consider additional ways to expand access to mental health and SUD services in underserved communities, including through network adequacy and mental health and SUD parity enforcement. The AMA also supported rulemaking by CMS for 2024 and beyond to extend the 35 percent provider participation threshold to two major ECP categories: Federally Qualified Health Centers and family planning providers. These changes will increase provider choice and access to care for low-income and medically underserved consumers, and with regard to family planning providers, are especially important in states that have banned abortion services.

Finally, the AMA has supported CMS' proposals to strengthen network adequacy standards for QHPs and has repeatedly advocated for the establishment of a federal minimum standard for QHPs. The AMA has urged CMS not to limit network adequacy requirements to QHPs in federally facilitated exchanges but to apply them to all marketplace plans.

State Network Adequacy Standards

In addition to federal standards, many states have established network adequacy standards for various types of health plans. Historically, most states monitored the network adequacy of health maintenance organization plans more closely than plans with broader networks, such as preferred provider organizations, although some states have put strong standards in place to supplement the aforementioned federal requirements. In part because of state variability in network adequacy oversight, the National Association of Insurance Commissioners (NAIC) revised its network adequacy model law in 2015 and urged states to adopt it; however, few states have done so and efforts to establish and enforce substantive network adequacy standards has been somewhat limited. The NAIC model law includes a general qualitative standard that requires networks to be sufficient in numbers and appropriate types of providers to assure that all covered services are accessible without unreasonable travel or delay, as well as several positive provisions. The AMA has offered a redlined version to state medical associations as a model bill, under which regulators would be required to review and approve networks before they go to market; network adequacy would be measured using multiple, measurable standards; and telehealth would not be used to meet network adequacy requirements.

State implementation of quantitative network adequacy standards has increased over the years and, as of 2021, 30 states had established at least one such standard, most commonly time and distance standards (in 29 states) while at least 15 states had established maximum wait times.[23] A handful of states now require a minimum ratio of certain types of providers to enrollees, although these requirements vary depending on the state. For example, West Virginia requires one primary care provider per 500 enrollees; Colorado and Illinois require a primary care provider to enrollee ratio of 1:1,000; New Mexico requires a ratio of one primary care provider for every 1,500 people; and a

minimum ratio of 1:2,000 is required in California, Connecticut, Delaware, Maine, and South Carolina.[24] A table summarizing state network adequacy laws can be found on the National Association of State Legislatures' website.

Importantly, the content and strength of state network adequacy standards, and state monitoring and compliance efforts, vary significantly across states, as do the tools used to enforce the standards. Some states require plans in violation of standards to take corrective action but typically do not take more punitive action, even if authorized to do so. The Illinois Department of Insurance stands out as an exception, as recent enforcement efforts included assessing fines against a major insurer for excluding a large clinic from its network.[25]

Although states have often relied on patient complaints and insurer attestation to comply with state standards, interest in the use of data to assess network adequacy is increasing. For example, some states require plans to submit certain data elements annually and whenever the composition of a plan substantively changes to help regulators identify network access problems. Additionally, regulators in some states review claims data, such as from an all-payer claims database (APCD), to assess utilization norms, patterns of out-of-network care, who is (and is not) providing care to enrollees, and the network's overall stability and adequacy. New Hampshire was the first state to use APCD data to determine the network breadth of private health plans by calculating the share of all available providers in a county that participate in a plan's network.[26] The New Hampshire Insurance Department also reviews APCD data to identify the services being provided in order to assess utilization and categorize providers. When APCD data are available, the use of claims-based metrics can play an important role in improving the accuracy of network adequacy assessments.

Mental Health and Substance Use Disorder and Network Adequacy

There are many complexities as to why individuals with a mental illness or SUD do not receive care, but network inadequacy and the high cost of out-of-network care are among the key reasons[27] and, notably, inadequate networks are even more pervasive for children seeking behavioral health care.[28] Networks for mental health and substance use disorders present unique issues given that patients with a mental illness or substance use disorder may be at increased risk of acute harm without evidence-based care. Although treatment for mental health conditions and substance use disorder may begin in the emergency department, it is essential that in-network care is available in the patient's community.

In Colorado, regulators require plans to report multiple quantitative elements to help analyze network adequacy for substance use disorder providers, including the number of substance use disorder and opioid treatment programs in the network and the type of medications for opioid use disorder (MOUD) provided.[29] The Colorado regulation requires plans to submit this information for each county, which may not guarantee network adequacy but is essential data for regulators—and health plans—to understand where gaps may exist, and how regulators, the medical community and plans can work together to fill those gaps.

Telehealth and Network Adequacy

Increases in telehealth use since the Covid-19 pandemic have prompted ongoing policy discussions of the role telehealth plays in network adequacy and to what extent telehealth services and providers should count towards network adequacy standards. Although the AMA strongly supports integrating telehealth into the delivery of health care when clinically appropriate, integrating telehealth into network adequacy standards could potentially lead to fewer in-person physicians in a network and thereby limit access to in-person care. The AMA maintains that telehealth should be

a supplement to, and not a replacement for, in-person provider networks so that patients can always access in-person care if they choose. Moreover, telehealth is not appropriate for all services or patients, and it is often impossible for a physician to know whether a telehealth visit may necessitate in-person care. As such, the AMA has advocated that telehealth-only providers should generally not count towards network adequacy requirements.

State and federal regulators have taken a variety of approaches to account for the provision of telehealth in contracted networks and ensure that all care is clinically appropriate. Certain regulators have allowed plans some leniency to count telehealth towards network adequacy for specialties in short supply or if other conditions are met. In 2020, for example, CMS began allowing MA plans to use telehealth providers in several specialties (e.g., dermatology, psychiatry, endocrinology, otolaryngology, and others) to account for a 10 percent credit towards meeting network adequacy time and distance requirements. This year, CMS rulemaking for Medicaid MCOs proposed that telehealth appointments be counted towards network adequacy calculations only if the provider offers in-person appointments.

Depending on the state, insurers may be prohibited from using telehealth to demonstrate network adequacy or allowed to count telehealth towards time and distance standards, similar to MA plans. Still other states require only that plans report how they intend to use telehealth to meet network adequacy standards. Finally, some states may allow plans to use telehealth-only providers as an exception to network adequacy standards so that where in-person care is otherwise not available, telehealth-only providers can be used to support patients.

PROVIDER DIRECTORY ACCURACY

Provider directories are the most public-facing data that health plans provide and may be used by regulators to evaluate compliance with network adequacy standards. Patients obviously depend on accurate directories to successfully access care and, conversely, inaccurate or misleading provider information prevents patients from making informed decisions when selecting a plan. For physicians, directories are important resources for referrals and contracting and, as noted in the AMA's 2023 statement to the Senate Finance Committee, are plagued by high rates of inaccuracies that incorrectly state physicians' office locations and phone numbers, specialty, network status, and availability to see new patients. Substantial inaccuracies have been identified in provider directories across all types of insurance products, including employer-sponsored plans as well as MA, Medicaid, and marketplace plans. In the lead-up to a hearing on ghost networks and mental health care, Senate Finance Committee staff reviewed directories from 12 plans in 6 states and called 10 providers from each plan. Of the 120 providers contacted by phone, 33 percent were inaccurate, non-working numbers or unreturned calls and staff were only able to make appointments 18 percent of the time.

The AMA continues to advocate that policymakers and other stakeholders must take action to improve the data, reduce burden on physician practices, and protect patients from errors in real time. In response to a 2022 CMS Request for Information seeking public input on the concept of CMS establishing a National Directory of Healthcare Providers and Services, the AMA doubled down on its call for increased data standardization and highlighted a lack of data reporting standards as a barrier to accuracy. For example, each payer's directory requires that physicians provide different types of data, similar but named differently, or requires that physicians report their information using different data formats. The AMA advocates that CMS and state regulators should consider standardizing data elements as a means of improving accuracy. Because most enforcement of directory inaccuracies relies on patient reporting, which likely underestimates the problem, the AMA has also urged regulators to take a more active role in regularly reviewing and

assessing directory accuracy. As such, the AMA has advocated that regulators should: require plans to submit accurate network directories every year prior to the open enrollment period and whenever there is a significant change to the status of the physicians included in the network; audit directory accuracy more frequently for plans that have had deficiencies; take enforcement action against plans that fail to either maintain complete and accurate directories or have a sufficient number of in-network physician practices open and accepting new patients; encourage stakeholders to develop a common system to update physician information in their directories; and require plans to immediately remove from network directories physicians who no longer participate in their network.

The AMA also acknowledges that physicians and practices have a role to play in achieving accuracy but emphasizes that updating directories should not add to physicians' administrative burdens. In 2021, the AMA collaborated with CAQH to examine the pain points for both physicians and health plans in achieving directory accuracy and published Improving Health Plan Provider Directories: And the Need for Health Plan-Practice Alignment, Automation, and Streamlined Workflows, which identifies best practices and recommends practical approaches that both health plans and practices can implement. At a minimum for patients with mental illness or an SUD, health plans must ensure that provider directories provide accurate, timely information about whether a mental health or substance use disorder professional is accepting new patients. For substance use disorder providers, the directory also must state whether MOUD is offered, and if so, what type of MOUD is offered. Research indicates that 43 percent of people in substance use disorder treatment for nonmedical use of prescription painkillers have a diagnosis or symptoms of mental health disorders, particularly depression and anxiety, underscoring the importance of having available counseling and psychiatric care.[30]

IMPROVING HEALTH EQUITY

Patients and other health care stakeholders have expressed interest in including physician race and ethnicity data (REI) in provider directories and as a component of network adequacy requirements to advance health equity and ensure culturally competent care. The AMA recognizes that there are many reasons why patients may want to consider REI when choosing a physician, including connecting with physicians with whom they may relate and selecting plans that can help them accomplish their health goals. Although federal regulations do not require QHPs to have culturally diverse provider networks, Medicaid regulations require states developing MCO network adequacy standards to address the ability of network providers to communicate with limited English proficient enrollees in their preferred language and to accommodate enrollees with disabilities.[31] Federal regulations also require provider directories maintained by Medicaid MCOs to include information on the provider's cultural and linguistic capabilities, including languages offered, and this year CMS proposed similar requirements for MA plans. The AMA has supported such measures so that a patient can more easily determine in advance whether a provider can deliver care that will meet their cultural and linguistic needs.

The use of network adequacy standards to improve health equity has also been discussed by some states as well as the NAIC, whose special committee on race and insurance has been looking at access and affordability issues, including the use of network adequacy and provider directory information to promote equitable access to culturally competent health care.[32] As noted in an AMA letter to NAIC, designation of a physician's race was historically used as a tool to discriminate and exclude physicians and displaying REI and/or other personal information in provider directories has the potential to expose minoritized physicians to discrimination. The AMA has argued that guardrails be included in regulatory guidance so that the use of REI data by an insurer is limited,

transparent to the physician, evaluated for potential benefits and harms, and quickly discontinued if it causes harm.[33]

Legislation passed by the Colorado General Assembly creating the "Colorado Option" program required insurers offering standardized "Colorado Option" plans to have provider networks that are culturally responsive and reflect the diversity of the communities they serve.[34] Regulations implementing this provision require plans to collect demographic information—on race and ethnicity, sexual orientation, gender identity, and ability status—voluntarily submitted by network providers and their front office staff as well as plan enrollees who voluntarily provide such data.[35] Insurers are required to report that demographic data—in aggregate—to the state and describe their efforts to build a diverse and culturally responsive provider network. State regulations further require network provider directories to identify providers who are multilingual or employ multilingual front office staff and the languages spoken; whether a provider offers extended and weekend hours; and the accessibility of a provider's office and examination rooms for people with disabilities.[36]

Some network directories also provide REI information and/or proximity to public transportation, experience with specific patient populations, languages offered, and the ability to provide specific services. Although the AMA has generally supported the ability of physicians to voluntarily specify information that they want included in a provider directory, caution has been advised regarding the use of REI and other data in directories so that data collection is voluntary and appropriate safeguards are in place. The AMA has further advocated that insurers consider other ways to support diversification and health equity, such as investing in pathway programs from elementary schools to residency/fellowship programs.[37]

RELEVANT AMA POLICY

Network adequacy is addressed in Policy H-285.908, established via Council on Medical Service Report 4-I-14, which supports state regulators as the primary enforcer of network adequacy requirements, sets parameters for out-of-network care and insurer termination of in-network providers, and advocates that plans be required to document to regulators that they have met requisite network adequacy standards and that in-network adequacy is timely and geographically accessible. Policy H-285.911 similarly states that health insurance provider networks should be sufficient to provide meaningful access to all medically necessary and emergency care at the preferred, in-network level on a timely and geographically accessible basis.

Policy H-285.984 states that plans or networks that use criteria to determine the number, geographic distribution, and specialties of physicians be required to regularly report to the public on the impact that the use of such criteria has on the quality, access, cost, and choice of health care services. Policy D-285.972 supports monitoring the development of tiered, narrow, or restricted networks to ensure they are not inappropriately driven by economic criteria by the plans and that patients are not caused health care access problems based on the potential for a limited number of specialists in the resulting networks. Policy H-450.941 strongly opposes the use of tiered and narrow physician networks that deny patient access to, or attempt to steer patients towards, certain physicians based on cost of care factors. Under Policy D-180.984, the AMA will work with state medical associations and other groups to evaluate on an annual basis and recommend measures for payers that should be publicly reported by payers including the number of primary and specialty physicians and consumer complaints.

Policy H-285.904 adopts principles related to unanticipated out-of-network care, including minimum coverage standards and payment parameters that insurers must meet, and also affirms

that state regulators should enforce such standards through active regulation of health plans. Policy H-180.952 opposes penalties implemented by insurers against physicians when patients independently choose to obtain out-of-network services.

Policy H-285.924 states that health plans should provide patients with a current directory of participating physicians through multiple media and continue to cover services provided by physicians who involuntarily leave a plan until an updated directory is available. Among several provisions regarding MA plans' provider directories, Policy H-285.902 urges CMS to conduct accuracy reviews and publicly report accuracy scores. Policy H-330.878 advocates for better enforcement of MA network regulations and maintenance by CMS of a publicly available database of physicians in network that states whether these physicians are accepting new patients.

Under Policy H-290.985, the AMA advocates that certain criteria be used in federal and state oversight of Medicaid managed care plans, including geographic dispersion and accessibility of participating physicians and other providers, and the ability of plan participating physicians to determine how many patients and which medical problems they will care for. Policy H-345.975 supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment as well as enforcement of the Mental Health Parity Act. H-160.949 addresses scope of practice and advocates for appropriate physician supervision of non-physician clinical staff. Policy H-480.937 opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians.

DISCUSSION

Network adequacy refers to a health plan's ability to provide access to in-network physicians and hospitals to meet enrollees' health care needs. Because inadequate networks create obstacles for patients seeking new or continued care and limit their choice of physicians and facilities, network adequacy standards and other requirements are used by regulators to ensure that health plan subscribers are able to access in-network care within reasonable distances and timeframes. Physicians and other providers are also impacted by the adequacy of a network and, although strong network adequacy standards should incentivize health plans to negotiate fairly, inadequate networks can negatively impact physicians' bargaining power. Furthermore, network inadequacies often lead to excessive appointment wait times and overburden many in-network physicians, contributing to increased burden and potential liability for delayed care. While acknowledging the challenges involved to ensuring network adequacy without adding substantially to the cost of insurance, the Council believes that regulators should take a multilayered approach to network adequacy that includes meaningful standards, transparency of network breadth and in-network physicians, hospitals, and other providers, parameters around out-of-network care, and effective monitoring and enforcement efforts.

The Council recommends seven new AMA policies to supplant and strengthen our existing network adequacy policies, and reaffirmation of four existing policies. Although state regulators are the primary enforcer of network adequacy requirements (Policy H-285.908), the Council recommends that our AMA support establishment and enforcement of a minimum federal network adequacy standard requiring health plans to contract with sufficient numbers and types of physicians and other providers, including for mental health and substance use disorders, such that both scheduled and unscheduled care may be provided without unreasonable travel or delay. The Council also recommends encouraging the use of multiple criteria to evaluate the sufficiency of health plan provider networks, including minimum physician-to-enrollee ratios and a clear standard for network appointment wait times. To facilitate informed decision-making among consumers

shopping for plans, the Council recommends encouraging the development and promulgation of network adequacy assessment tools that allow patients and employers to compare insurance plans.

Although transparency of health plan network adequacy is addressed in part by Policies H-285.908, D-285.972, and H-330.878, the Council seeks to strengthen AMA policy in this area by recommending that our AMA support requiring health plans to report annually and prominently display important information so it is accessible by enrollees as well as consumers shopping for plans, including the breadth of a plan's provider network; average wait times for primary care appointments and common specialty referrals; numbers of physicians treating mental health and substance use disorders who are accepting new patients; and instructions for enrollees to contact regulators to report access problems and other network adequacy complaints. Even with robust quantitative standards in place, the Council understands that some physicians may be booked or not accepting new patients and that additional tools are needed to measure true patient access to timely and quality in-network care. Accordingly, we recommend encouraging the use of claims data, audits, secret shopper programs, complaints, and enrollee surveys/interviews to monitor and validate in-network provider availability and wait times, network stability, and provider directory accuracy and to identify other access or quality problems.

State and federal regulators have taken a variety of approaches to addressing the role of telehealth in network adequacy, and the policy landscape across many states is evolving. The Council recommends new policy affirming that in-network physicians who provide both in-person and telehealth services may count towards health plan network adequacy requirements on a very limited basis when their physical practice does not meet time and distance standards, such as when there is a shortage of physicians in the needed specialty within the community. The AMA does not support counting physicians who only offer telehealth services towards network adequacy requirements.

It is also important to highlight that even vigorous standards and requirements will fail to strengthen network adequacy unless regulators take a more active role to ensure health plan compliance and patient access to care. Policy H-285.904, which advocates that state regulators should enforce network adequacy standards through active regulation of health plans, is recommended for reaffirmation. The Council further recommends supporting regulation to hold health plans accountable for network inadequacies through the use of corrective action plans and substantial financial penalties.

Several AMA policies (Policies H-285.902, H-285.924, and H-330.878) call for health plans to provide patients with accurate, complete, and up-to-date provider directories and AMA advocacy on this topic has been strong. Because outdated and inaccurate directories are an ongoing pain point that is burdensome for physicians and patients, we recommend reaffirmation of Policy H-285.902, which urges the CMS to take several steps to enhance provider directory accuracy and effectively communicate network information to patients. Similarly, several AMA policies address out-of-network care (Policies H-180.952, H-285.904, and H-285.908); Policy H-285.904, which outlines principles related to coverage and payment for out-of-network care and Policy H-285.908, which addresses out-of-network care as well as other elements of network adequacy, are recommended for reaffirmation. On this topic, the Council notes that the AMA continues its focus on the *No Surprises Act* and remains concerned that implementation of the statute does not support physicians' ability to meaningfully engage in dispute resolution, as Congress intended, because of the Administration's problematic reliance on the qualified payment amount (QPA) in arbitration, among other issues. As a result, health plans may feel emboldened to disengage from fair contract negotiations with physicians and network adequacy may suffer. While there have been successful

legal challenges to the Administration's flawed positions on the QPA among other aspects, the situation continues to be closely monitored.

Policy H-285.911, which advocates that provider networks be sufficient to provide meaningful access to subscribers for all medically necessary and emergency care, at the in-network benefit level, is also recommended for reaffirmation. Additional relevant AMA policies affirm that health plans should be required to inform physicians of criteria used to evaluate a physician for network inclusion (Policy H-285.984), prohibited from forming networks based only on economic criteria (Policy D-285.972), and required to notify providers at least 90 days prior to termination from a network (Policy H-285.908). Among other provisions, Policy H-285.908 directs the AMA to provide assistance (upon request) to state medical associations and disseminate model state legislation; accordingly, the AMA's model state legislation will be updated and made available to the Federation once new network adequacy policy is adopted. The Council also acknowledges that physician shortages across many specialties may impact the adequacy of some networks, especially in, but not limited to, rural areas. As stated previously, although midlevel providers may be in a provider network if permitted under state law, health plans must meet network adequacy requirements for physicians and measurement should be limited to physicians for physician services. Finally, the Council encourages physicians to report network adequacy violations to state departments of insurance, which may track complaints as part of their network adequacy assessments. Contact information for state departments of insurance can be found on the NAIC's website.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) support establishment and enforcement of a minimum federal network adequacy standard requiring health plans to contract with sufficient numbers and types of physicians and other providers, including for mental health and substance use disorder, such that both scheduled and unscheduled care may be provided without unreasonable travel or delay. (New HOD Policy)

2. That our AMA encourage the use of multiple criteria to evaluate the sufficiency of health plan provider networks, including but not limited to:
    a. Minimum physician-to-enrollee ratios across specialties, including mental health and substance use disorder providers who are accepting new patients;
    b. Minimum percentages of non-emergency providers available on nights and weekends;
    c. Maximum time and distance standards, including for enrollees who rely on public transportation;
    d. Clear standard for network appointment wait times across specialties, for both new patients and continuing care, that are appropriate to a patient's urgent and non-urgent health care needs; and
    e. Sufficient providers to meet the care needs of people experiencing economic or social marginalization, chronic or complex health conditions, disability, or limited English proficiency. (New HOD Policy)

3. That our AMA encourage the development and promulgation of network adequacy assessment tools that allow patients and employers to compare insurance plans and make informed decisions when enrolling in a plan. (New HOD Policy)

4. That our AMA support requiring health plans to report to regulators annually and prominently display network adequacy information so that it is available to enrollees and consumers shopping for plans, including:
    a. The breadth of a plan's provider network, by county and geographic region;
    b. Average wait times for primary and behavioral health care appointments as well as common specialty referrals;
    c. The number of in-network physicians treating substance use disorder who are actively accepting new patients, and the type of opioid use disorder medications offered;
    d. The number of in-network mental health physicians actively accepting new patients; and
    e. Instructions for consumers and physicians to easily contact regulators to report complaints about inadequate provider networks and other access problems. (New HOD Policy)

5. That our AMA encourage the use of claims data, audits, secret shopper programs, complaints, and enrollee surveys or interviews to monitor and validate in-network provider availability and wait times, network stability, and provider directory accuracy, and to identify other access or quality problems. (New HOD Policy)

6. That our AMA affirm that in-network physicians who provide both in-person and telehealth services may count towards health plan network adequacy requirements on a very limited basis when their physical practice does not meet time and distance standards, based on regulator discretion, such as when there is a shortage of physicians in the needed specialty within the community served by the health plan. The AMA does not support counting physicians who only offer telehealth services towards network adequacy requirements. (New HOD Policy)

7. That our AMA support regulation to hold health plans accountable for network inadequacies, including through use of corrective action plans and substantial financial penalties. (New HOD Policy)

8. That our AMA reaffirm Policy H-285.908, which supports state regulators as the primary enforcer of network adequacy requirements, sets parameters for out-of-network care and insurer termination of in-network providers, and advocates that plans be required to document to regulators that they have met requisite network adequacy standards including hospital-based physician specialties. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy H-285.904, which supports principles related to unanticipated out-of-network care and advocates that state regulators should enforce network adequacy standards through active regulation of health plans. (Reaffirm HOD Policy)

10. That our AMA reaffirm Policy H-285.902, which urges the Centers for Medicare & Medicaid Services to take several steps to ensure network adequacy, enhance provider directory accuracy, measure network stability, and effectively communicate provider network information to patients. (Reaffirm HOD Policy)

11. That our AMA reaffirm Policy H-285.911, which advocates that health insurance provider networks be sufficient to provide meaningful access to subscribers, for all medically necessary and emergency care, at the preferred, in-network benefit level on a timely and geographically accessible basis. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] Kaiser Family Foundation. KFF Survey of consumer experiences with health insurance. June 15, 2023. Available at: https://www.kff.org/private-insurance/poll-finding/kff-survey-of-consumer-experiences-with-health-insurance/.
[2] *Ibid*.
[3] Hempstead K. Marketplace Pulse: Medicaid and Marketplace Provider Networks. Robert Wood Johnson Foundation Brief, March 8, 2023. Available at: https://www.rwjf.org/en/insights/our-research/2023/03/marketplace-pulse-medicaid-and-marketplace-provider-networks.html
[4] Hall M and Ginsburg PB. A better approach to regulating provider network adequacy. Brookings Center for Health Policy and USC Schaeffer Center for Health Policy & Economics. September 2017. Available at: https://www.brookings.edu/research/a-better-approach-to-regulating-provider-network-adequacy/
[5] Kaiser Family Foundation. Medicare Advantage: How Robust Are Plans' Physician Networks? October 5, 2017. Available at: https://www.kff.org/medicare/report/medicare-advantage-how-robust-are-plans-physician-networks/
[6] Zhu JM, Meiselbach MK, Drake C, and Polsky D. Psychiatrist Networks in Medicare Advantage Plans are Substantially Narrower Than in Medicaid and ACA Markets. Health Affairs Vol. 42, No. 7. July 2023. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.01547?utm_medium=email&utm_source=hat&utm_campaign=journal&vgo_ee=FParS9VfxeoQ7v7N2A78fHeKIiVlV1suvrDGHwTzyVW1%2By8EeyWqcUYA%3ACeriL92AQifNk7Tk%2B%2F7T%2BXh0%2Bsm%2FRjXa
[7] Kaiser Family Foundation. Half of All Eligible Medicare Beneficiaries Are Now Enrolled in Private Medicare Advantage Plans. May 1, 2023. Available at: https://www.kff.org/policy-watch/half-of-all-eligible-medicare-beneficiaries-are-now-enrolled-in-private-medicare-advantage-plans/
[8] Code of Federal Regulations Title 42 Chapter IV Subchapter B Part 422 Subpart C § 422.116. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.116
[9] Centers for Medicare & Medicaid Services. Medicare Advantage Network Adequacy Criteria Guidance. Last Updated: Jan. 10, 2017. Available at: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf
[10] Code of Federal Regulations Title 42 Chapter IV Subchapter B Part 422 Subpart C § 422.116. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.116
[11] Code of Federal Regulations Title 42 Chapter IV Subchapter B Part 422 Subpart C § 422.116. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.116
[12] Kaiser Family Foundation. Medicaid Managed Care Network Adequacy & Access: Current Standards and Proposed Changes. June 15, 2023. Available at: https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-network-adequacy-access-current-standards-and-proposed-changes/
[13] Ludomirsky AB, Schpero WL, Wallace J et al. In Medicaid Managed Care Networks, Care Is Highly Concentrated Among A Small Percentage Of Physicians. *Health Affairs* Vol. 41, No. 5, May 2022. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01747
[14] Hsiang WR, Lukasiewicz A, Gentry M, et al. Medicaid Patients Have Greater Difficulty Scheduling Health Care Appointments Compared With Private Insurance Patients: A Meta-Analysis. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*. 2019;56Available at: https://journals.sagepub.com/doi/full/10.1177/0046958019838118
[15] Code of Federal Regulations Title 42 Chapter IV Subchapter B Part 156 Subpart C § 156.230. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-438.68#p-438.68(b)
[16] U.S. Government Accountability Office. Private Health Insurance: State and Federal Oversight of Provider Networks Varies. December 2022. Available at: https://www.gao.gov/assets/gao-23-105642.pdf
[17] Code of Federal Regulations Title 42 Chapter IV Subchapter B Part 422 Subpart C § 422.116 Available at: https://www.law.cornell.edu/cfr/text/45/156.230
[18] Centers for Medicare & Medicaid Services. Fact Sheet: HHS Notice of Benefit and Payment Parameters for 2024 Final Rule. April 27, 2023. Available at: https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2024-final-rule

[19] Centers for Medicare & Medicaid Services, Center for Consumer Information & Insurance Oversight. 2023 Final Letter to Issuers in the Federally-facilitated Exchanges. April 28, 2022. Available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2023-Letter-to-Issuers.pdf
[20] *Ibid*.
[21] U.S. Government Accountability Office. Private Health Insurance: State and Federal Oversight of Provider Networks Varies. December 2022. Available at: https://www.gao.gov/assets/gao-23-105642.pdf
[22] National Association of Insurance Commissioners. Network Adequacy. Last updated June 1, 2023. Available at: https://content.naic.org/cipr-topics/network-adequacy
[23] The Commonwealth Fund. Ensuring the Adequacy of ACA Marketplace Plan Networks. Feb. 15, 2022. Available at: https://www.commonwealthfund.org/blog/2022/ensuring-adequacy-aca-marketplace-plan-networks
[24] National Conference of State Legislatures. Health Insurance Network Adequacy Requirements. Last updated April 27, 2023. Available at: https://www.ncsl.org/health/health-insurance-network-adequacy-requirements
[25] WCIA. Blue Cross Blue Shield Fined for Lack of Network Adequacy. Posted March 9, 2022. Available at: https://www.wcia.com/news/target3/blue-cross-blue-shield-fined-for-lack-of-network-adequacy/
[26] Kaiser Family Foundation. Network Adequacy Standards and Enforcement. Feb. 4, 2022. Available at: https://www.kff.org/health-reform/issue-brief/network-adequacy-standards-and-enforcement/
[27] Legal Action Center. New Report Reveals Worsening Disparities in Access to Substance Use Disorder and Mental Health Care. Nov. 20, 2019. Available at: https://www.lac.org/news/new-report-reveals-worsening-disparities-in-access-to-substance-use-disorder-and-mental-health-care
[28] Legal Action Center. New Report Reveals Worsening Disparities in Access to Substance Use Disorder and Mental Health Care. Nov. 20, 2019. Available at: https://www.lac.org/news/new-report-reveals-worsening-disparities-in-access-to-substance-use-disorder-and-mental-health-care
[29] Attachment 3 CCR 702-4-2-75-A - Medication-Assisted Treatment (MAT) Reporting Requirements. Available at: https://casetext.com/regulation/colorado-administrative-code/department-700-department-of-regulatory-agencies/division-702-division-of-insurance/rule-3-ccr-702-4-life-accident-and-health/section-3-ccr-702-4-2-life-accident-and-health-series-4-2-accident-and-health-general/regulation-3-ccr-702-4-2-75-concerning-requirements-for-reporting-medication-assisted-treatment-coverage/attachment-3-ccr-702-4-2-75-a-medication-assisted-treatment-mat-reporting-requirements
[30] Goldner EM, Lusted A, Roerecke M, Rehm J, Fischer B. Prevalence of Axis-1 psychiatric (with focus on depression and anxiety) disorder and symptomatology among non-medical prescription opioid users in substance use treatment: systematic review and meta-analyses. *Addict Behav*. 2014;39(3):520-531.
[31] Code of Federal Regulations Title 42 Chapter IV Subchapter B Part 438 Subpart B § 438.68. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-438.68#p-438.68(b)
[32] National Association of Insurance Commissioners. Special (EX) Committee on Race and Insurance. 2023 Adopted Changes. Available at: https://content.naic.org/cmte_ex_race_and_insurance.htm
[33] American Medical Association. Letter to National Association of Insurance Commissioners. Nov. 10, 2021. Available at: https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-11-10-Letter-to-NAIC-FINAL.pdf
[34] NAIC Special Committee on Race and Insurance. Colorado Option Culturally Responsive Provider Networks. Power Point Presentation by Colorado Option Director. Available at: https://content.naic.org/sites/default/files/inline-files/CO%20Presentation%20Culturally%20Competent%20Network.pdf
[35] Colorado Department of Regulatory Agencies, Division of Insurance. 3 CCR 702-4 Amended Regulation 4-2-80 Concerning Network Adequacy Standards and Reporting Requirements for Colorado Option Standardized Health Benefit Plans. Available at: https://drive.google.com/file/d/19pt8youGraXypyj9E3fp_Rytj2-y2mhL/view
[36] Colorado Department of Regulatory Agencies, Division of Insurance. 3 CCR 702-4 Amended Regulation 4-2-80 Concerning Network Adequacy Standards and Reporting Requirements for Colorado Option

Standardized Health Benefit Plans. Available at: https://drive.google.com/file/d/19pt8youGraXypyj9E3fp_Rytj2-y2mhL/view

[37] American Medical Association. Letter to National Association of Insurance Commissioners. Nov. 10, 2021. Available at: https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-11-10-Letter-to-NAIC-FINAL.pdf

APPENDIX

Policies Recommended for Reaffirmation

Network Adequacy H-285.908

1. Our AMA supports state regulators as the primary enforcer of network adequacy requirements.
2. Our AMA supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. Physicians may be added to the network at any time.
3. Our AMA supports requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy, including the number and type of providers that have joined or left the network; the number and type of specialists and subspecialists that have left or joined the network; the number and types of providers who have filed an in network claim within the calendar year; total number of claims by provider type made on an out-of-network basis; data that indicate the provision of Essential Health Benefits; and consumer complaints received.
4. Our AMA supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
5. Our AMA advocates for regulation and legislation to require that out-of-network expenses count toward a participant's annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies.
6. Our AMA supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
7. Our AMA supports health insurers paying out-of-network physicians fairly and equitably for emergency and out-of-network bills in a hospital. AMA policy is that any legislation which addresses this issue should assure that insurer payment for such care be based upon a number of factors, including the physicians' usual charge, the usual and customary charge for such service, the circumstances of the care and the expertise of the particular physician.
8. Our AMA provides assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure physicians and patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks.
9. Our AMA supports the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities.
10. Our AMA advocates for legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited.
11. Our AMA advocates that health plans should be required to document to regulators that they have met requisite standards of network adequacy including hospital-based physician specialties (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible.
12. Our AMA supports requiring that health insurers that terminate in-network providers: (a) notify providers of pending termination at least 90 days prior to removal from network; (b) give to providers, at least 60 days prior to distribution, a copy of the health insurer’s letter notifying patients of the provider’s change in network status; and (c) allow the provider 30 days to respond to

and contest if necessary the letter prior to its distribution. (CMS Rep. 4, I-14; Reaffirmation I-15; Reaffirmed in lieu of Res. 808, I-15; Modified: Sub. Res. 811, I-15; Reaffirmed: CMS Rep. 03, A-17; Reaffirmed: Res. 108, A-17; Appended: Res. 809, I-17; Reaffirmed: Res. 116, A-18; Reaffirmation: A-19)

Out-of-Network Care H-285.904

1. Our AMA adopts the following principles related to unanticipated out-of-network care:
A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
E. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
H. Independent Dispute Resolution (IDR) should be allowed in all circumstances as an option or alternative to come to payment resolution between insurers and physicians.
2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.
3. Our AMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges. (Res. 108, A-17; Reaffirmation: A-18; Appended: Res. 104, A-18; Reaffirmed in lieu of: Res. 225, I-18; Reaffirmation: A-19; Reaffirmed: Res. 210, A-19; Appended: Res. 211, A-19; Reaffirmed: CMS Rep. 5, A-21; Modified: Res. 236, A-22)

Ban on Medicare Advantage "No Cause" Network Terminations H-285.902

1. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) to further enhance the agency's efforts to ensure directory accuracy by: a. Requiring Medicare Advantage (MA) plans to submit accurate provider directories to CMS every year prior to the Medicare open enrollment period and whenever there is a significant change in the physicians included in the network; b. Conducting accuracy reviews on provider directories more frequently for plans that have had deficiencies; c. Publicly reporting the most recent accuracy score for each plan on Medicare Plan Finder; d. Indicating to plans that failure to maintain complete and accurate directories, as well as failure to have a sufficient number of physician practices open and accepting new patients, may

subject the MA plans to one of the following: (i) civil monetary penalties; (ii) enrollment sanctions; or (iii) incorporating the accuracy score into the Stars rating for each plan; e. Requiring MA plans immediately remove from provider directories providers who no longer participate in their network.
2. Our AMA urges CMS to ensure that network adequacy standards provide adequate access for beneficiaries and support coordinated care delivery by: a. Requiring plans to report the percentage of the physicians, broken down by specialty and subspecialty, in the network who actually provided services to plan members during the prior year; b. Publishing the research supporting the adequacy of the ratios and distance requirements CMS currently uses to determine network adequacy; c. Conducting a study of the extent to which networks maintain or disrupt teams of physicians and hospitals that work together; d. Evaluating alternative/additional measures of adequacy.
3. Our AMA urges CMS to ensure lists of contracted physicians are made more easily accessible by: a. Requiring that MA plans submit their contracted provider list to CMS annually and whenever changes occur, and post the lists on the Medicare Plan Finder website in both a web-friendly and downloadable spreadsheet form; b. Linking the provider lists to Physician Compare so that a patient can first find a physician and then find which health plans contract with that physician. Our AMA urges CMS to simplify the process for beneficiaries to compare network size and accessibility by expanding the information for each MA plan on Medicare Plan Finder to include: (i) the number of contracted physicians in each specialty and county; (ii) the extent to which a plan's network exceeds minimum standards in each specialty, subspecialty, and county; and (iii) the percentage of the physicians in each specialty and county participating in Medicare who are included in the plan's network.
4. Our AMA urges CMS to measure the stability of networks by calculating the percentage change in the physicians in each specialty and subspecialty in an MA plan's network compared to the previous year and over several years and post that information on Plan Finder.
5. Our AMA urges CMS to develop a marketing/communication plan to effectively communicate with patients about network access and any changes to the network that may directly or indirectly impact patients; including updating the Medicare Plan Finder website.
6. Our AMA urges CMS to develop process improvements for recurring input from in-network physicians regarding network policies by creating a network adequacy task force that includes multiple stakeholders including patients.
7. Our AMA urges CMS to ban "no cause" terminations of MA network physicians during the initial term or any subsequent renewal term of a physician's participation contract with a MA plan. (BOT Rep. 17, A-19; Reaffirmation: I-19; Modified: Speakers Rep. 1, A-21)

Health Insurance Safeguards H-285.911
Our AMA will advocate that health insurance provider networks should be sufficient to provide meaningful access to subscribers, for all medically necessary and emergency care, at the preferred, in-network benefit level on a timely and geographically accessible basis. (CMS Rep. 8, A-10; Reaffirmed in lieu of Res. 815, I-13; Reaffirmation I-15; Reaffirmed: CMS Rep. 03, A-17; Reaffirmed: Res. 108, A-17)

REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (I-23)
Medicaid Unwinding Update
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the House of Delegates adopted Policy D-440.912, American Medical Association (AMA) Public Health Strategy, which directed the AMA Board of Trustees to provide an update on loss of coverage and uninsurance rates following the return to regular Medicaid redeterminations and the end of the COVID-19 Public Health Emergency (PHE); the ensuing financial and administrative challenges experienced by physicians, physician practices, hospitals, and the health care system; and a report of actions taken by the AMA and recommendations for further action. This report describes Medicaid enrollment changes since the Medicaid continuous enrollment requirement ended, discusses potential impacts of the unwinding on physicians and hospitals, summarizes relevant AMA policy and advocacy, and presents policy recommendations.

The Medicaid unwinding has been described as the most significant nationwide coverage transition since the Affordable Care Act, with major implications for patients, physicians, and health equity. At the time this report was written, the Medicaid unwinding was still in its early stages; many states had been redetermining enrollee eligibility for only a few months; and information on whether individuals disenrolled from Medicaid/Children's Health Insurance Program (CHIP) had transitioned to other sources of coverage—or become uninsured—was limited. Over the coming months, millions of individuals are expected to be disenrolled from Medicaid/CHIP coverage which may in turn decrease patient volume as well as revenue for physicians, clinics, and hospitals treating large numbers of Medicaid/CHIP patients. The Council will continue to monitor unwinding data as it becomes available and recommend new policy and physician resources as needed. At this time, the Council recommends amending Policy H-290.955, which was adopted at the 2022 Annual Meeting via Council Report 3-A-22, Preventing Coverage Losses After the PHE Ends, by the addition of three new clauses that encourage state implementation of strategies to reduce inappropriate terminations from Medicaid/CHIP for procedural reasons; encourage states to provide continuity of care protections to patients transitioning from Medicaid or CHIP to a new health plan; and encourage state Medicaid agencies to make coverage status, including expiration of current coverage and information on pending renewals, accessible to physicians, clinics, and hospitals.

The Council also recommends reaffirmation of Policy H-165.855, which calls for the adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange plans and supports allowing for presumptive eligibility and retroactive coverage to the time at which an eligible person seeks care; and Policy H-165.823, which encourages states to pursue auto-enrollment in health insurance coverage.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-I-23

Subject: Medicaid Unwinding Update

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee J

At the 2023 Annual Meeting, the House of Delegates adopted Policy D-440.912, American Medical Association (AMA) Public Health Strategy, which directed the AMA Board of Trustees to provide an update on loss of coverage and uninsurance rates following the return to regular Medicaid redeterminations and the end of the COVID-19 Public Health Emergency (PHE); the ensuing financial and administrative challenges experienced by physicians, physician practices, hospitals, and the health care system; and a report of actions taken by the AMA and recommendations for further action. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2023 Interim Meeting.

This report provides an overview of Medicaid enrollment changes since the Medicaid continuous enrollment requirement ended, highlights federal policy and guidance, discusses challenges for physicians and other providers, summarizes AMA policy and advocacy, and presents policy recommendations.

BACKGROUND

At the 2022 Annual Meeting, while the Medicaid continuous enrollment requirement was still in effect and many states were planning for the impending onslaught of eligibility redeterminations, the Council on Medical Service presented Report 3-A-22, Preventing Coverage Losses After the PHE Ends, which established new AMA policy encouraging state and federal actions to prepare for and respond to the Medicaid unwinding (Policy H-290.955). Having recognized the potential for widespread coverage disruptions once the continuous enrollment requirement expired, the Council self-initiated Report 3-A-22 to ensure that the AMA had strong policy supportive of key state strategies for preventing coverage losses, including streamlining enrollment/redetermination processes; investing in outreach and enrollment assistance; adopting continuous eligibility policies; encouraging auto-enrollment in health insurance coverage; facilitating coverage transitions, including automatic transitions, to alternate sources of coverage; and federal and state monitoring and oversight. Taken together, these strategies would help ensure that, as states return to normal redeterminations, individuals who continue to be eligible for Medicaid and the Children's Health Insurance Program (CHIP) retain that coverage and those determined no longer eligible can seamlessly transition to other health insurance, such as subsidized Affordable Care Act (ACA) marketplace plans or employer-sponsored insurance (ESI).

During the PHE, the Families First Coronavirus Response Act required states to provide continuous coverage to nearly all Medicaid/CHIP enrollees as a condition of receiving a temporary federal medical assistance percentage (FMAP) increase. With disenrollments frozen, churn out of the program effectively ceased and enrollment increased nationally by 35 percent, from 70,875,069

© 2023 American Medical Association. All rights reserved.

in February 2020 to 93,876,834 in March 2023, after which the continuous enrollment requirement was lifted.[1] Most of this growth was in the Medicaid program, which increased by 22,634,781 individuals (35.3 percent), while CHIP enrollment increased during this period by 366,984 individuals (5.4 percent).[2] The Consolidated Appropriations Act of 2023 (CAA), which was signed into law in December 2022, established March 31, 2023 as the end date for the Medicaid continuous enrollment requirement and phased down the enhanced FMAP amount through December 2023.

Though challenging to quantify the impact on Medicaid enrollment once continuous enrollment was no longer required, the AMA and other interested parties understood that the number of people covered by Medicaid was likely to decrease substantially. The Robert Wood Johnson Foundation estimated that 18 million people would lose coverage during the 14-month unwinding period, including about 3.2 million children expected to transition from Medicaid to CHIP coverage, 9.5 million people who would turn to ESI, 3.8 million who would become uninsured, and one million who would be eligible for subsidized marketplace plans.[3] Estimates from the Kaiser Family Foundation (KFF) ranged from between eight and 24 million people who would be disenrolled from Medicaid during the unwinding period,[4] while the U.S. Department of Health and Human Services (HHS) projected that approximately 15 million Medicaid/CHIP enrollees would lose coverage.[5] According to the HHS analysis, an estimated 2.7 million people disenrolled from Medicaid would qualify for subsidized marketplace plans and 383,000 people would fall into the coverage gap (i.e., below poverty with income too low for ACA marketplace coverage and too high for the state's eligibility limit) in the 10 states that have not expanded Medicaid. HHS also predicted that 8.2 million disenrollments would be due to loss of eligibility while 6.8 million people would lose coverage for procedural reasons, such as the state Medicaid agency being unable to contact an enrollee or not receiving required documentation in time. Children and young adults as well as minoritized groups would be disproportionately impacted by the unwinding, according to the HHS analysis, including those who are African American or Latino.[6] A more recent analysis by the Congressional Budget Office projected that the unwinding would lead to gradual declines in Medicaid enrollment throughout 2023 and 2024, with an estimated 9.3 million people under age 65 transitioning from Medicaid to other sources of coverage, namely ESI and marketplace plans, while approximately 6.2 million people no longer enrolled in Medicaid would become uninsured.[7]

EARLY DATA ON MEDICAID/CHIP RENEWALS AND DISENROLLMENTS

According to the early data that was available at the time this report was written, renewal, disenrollment, and procedural termination rates vary substantially across states. However, a rapid rate of disenrollments in some states, coupled with high proportions of terminations for procedural reasons, is cause for potential concern. Centers for Medicare & Medicaid Services (CMS) data released on July 28, 2023 indicated that more than two million Medicaid/CHIP enrollees went through the renewal process in 18 states that completed renewals during the first month of the unwinding—April 2023.[8] Just over one million (45.5 percent) of these enrollees had their coverage renewed while more than 700,000 (32.2 percent) had their coverage terminated and the status of another 22 percent of enrollees was still pending.[9] Notably, procedural reasons were behind nearly four in five (79 percent) of those whose Medicaid/CHIP coverage was terminated. CMS also reported that 54,000 people previously covered by Medicaid or CHIP had enrolled in a marketplace plan in April 2023 while noting that more complete information on transitions to marketplace coverage is not expected for several months.[10]

Because Medicaid/CHIP enrollment data released from CMS are usually at least three months old, the Council also reviewed data from the KFF, which updates national Medicaid disenrollment numbers based on the most current data from at least 48 states publicly sharing those numbers and

the District of Columbia. According to KFF, as of September 12, 2023—just six months into the unwinding—over six million (6,428,000) Medicaid enrollees had been disenrolled from the program, almost three quarters (72 percent) for procedural reasons and just over a quarter due to an actual determination of ineligibility.[11] Texas had the highest rate of disenrollments, at 69 percent, over 70 percent of which were procedural, while only 9 percent of Michigan's completed renewals led to disenrollments. In the 16 states reporting the ages of those disenrolled from Medicaid, children made up approximately 42 percent of those disenrolled.[12]

Only limited data regarding the ability of individuals disenrolled from Medicaid/CHIP to re-enroll in Medicaid, if eligible, or obtain new coverage through ESI or marketplace plans were available at the time this report was written. Such data are expected to change over time and were not sufficient for the Council to draw meaningful conclusions regarding the impact of the unwinding on loss of coverage, transitions to new coverage, and uninsured rates, beyond the concerns expressed herein and in Council Report 3-A-22. In our review of the data, the Council was mindful that the early numbers are likely impacted by differences between state renewal plans and, most notably, the prioritization by some states to disenroll people already known to be ineligible for Medicaid/CHIP or have other health coverage (some of whom may be categorized as procedural terminations if they did not respond to inquiries from the state Medicaid agency or submit required paperwork). Still, concerns about improper or inappropriate procedural disenrollments are widespread and have led CMS to work with some states to temporarily pause these terminations and address potential problems with their renewal processes.[13]

In its 2022 report, the Council emphasized that the potential for coverage losses and the ability to transition those disenrolled from Medicaid to other affordable coverage would be highly dependent on each state's Medicaid policies and unwinding plans, and whether the state has expanded Medicaid. Though permitted to begin terminating coverage of Medicaid/CHIP enrollees in April 2023, only a handful of states did so, while others began disenrolling individuals in May or June and a dozen states waited until July to do so.[14] Therefore, the data available at the time this report was written were still very much evolving.

FEDERAL POLICY, GUIDANCE, AND RESOURCES

The CAA established new requirements that states must meet to receive the phased-down FMAP increase and gave CMS authority to require states to submit monthly unwinding data, such as the number of people whose coverage was terminated, the number of those terminated based on eligibility criteria versus for procedural reasons, plus call center volume and wait times. The CAA also authorized several enforcement mechanisms including corrective action plans, financial penalties, and requiring states to temporarily pause terminations.[15]

Leading up to the April 1, 2023 unwinding start date, CMS issued numerous fact sheets, guidance, policy and operational resources, best practices and strategies to support specific populations, and Medicaid/Marketplace coordination resources and began offering monthly "all state calls" to support states and territories as well as monthly partner education webinars. CMS also worked with states to assess compliance with Medicaid renewal requirements and adopt mitigation strategies to address areas of non-compliance, summaries of which can be found here. An assortment of outreach resources have been made available, including flyers that physicians can use to inform patients how to prepare for their renewal and direct patients deemed ineligible for Medicaid coverage to explore other coverage options. Notably, many state Medicaid agencies, state medical associations, and national medical specialty societies have also created resources to help physicians help patients retain coverage as the continuous enrollment requirement unwinds (e.g., American Academy of Pediatrics flyer, Michigan State Medical Society media release, and Illinois State

Medical Society event). Such resources are critical since, despite national and state campaigns to inform Medicaid enrollees about steps to take to retain Medicaid/CHIP coverage, consumer awareness and understanding of the unwinding and what it means for one's health coverage has been limited.[16]

In response to early data indicating high rates of procedural disenrollments, in June 2023, CMS announced an "all hands on deck" strategy to address the unwinding along with new flexibilities to help mitigate mass disenrollments. Specifically, the new flexibilities included allowing: 1) managed care plans to assist with completing renewal forms; 2) states to delay termination for one month while additional targeted outreach is performed; and 3) certain frontline entities such as pharmacies and community-based organizations to facilitate reinstatement of coverage based on presumptive eligibility criteria, among other flexibilities. HHS also encouraged states to maximize the use of alternative data sources, such as U.S. Postal Service data, to update enrollee contact information, increase *ex parte* renewal rates (which is when eligibility is confirmed administratively with third-party data), and facilitate reenrollment of people disenrolled for procedural reasons. In an accompanying letter to U.S. governors, the HHS Secretary urged state Medicaid agencies not to rush renewals and to instead take the full 12 months to initiate them, take full advantage of available federal flexibilities and waivers, and get creative in partnering with schools, faith-based organizations, and other community-based groups to perform targeted outreach.[17]

Other relevant federal policies impacting coverage transitions during the unwinding period include:

Mandatory Requirement for Medicaid/CHIP 12-Months Continuous Eligibility for Children: Continuous eligibility policies, which allow enrollees to maintain Medicaid/CHIP coverage for 12 months, have long been supported by the AMA as a strategy to reduce the churn that occurs when people lose coverage and then re-enroll within a short period of time. Although 24 states had adopted continuous Medicaid/CHIP eligibility for children by 2022, the CAA requires all states to implement continuous eligibility in Medicaid/CHIP for all children up to age 19, by January 1, 2024.

Extension of Enhanced Premium Tax Credit Subsidies for ACA Marketplace Plans: The Inflation Reduction Act, signed into law in August 2022, extended through 2025 the enhanced premium tax credits that were made available to eligible consumers under the American Rescue Plan Act of 2021. This advanceable and refundable credit, which the AMA supports, reduces the premium contribution for families with incomes between 100 and 150 percent of the federal poverty level (FPL) to zero and provides subsidies to 90 percent of people selecting marketplace plans.

Special Enrollment Opportunity (SEP) for Consumers Losing Medicaid/CHIP Coverage: CMS established an SEP for consumers losing Medicaid/CHIP coverage due to the unwinding of the continuous enrollment requirement. This SEP, which runs between March 31, 2023 and July 31, 2024, allows individuals and families to enroll in federally facilitated marketplace (HealthCare.gov) plans, if eligible, outside of the annual open enrollment period.[18] CMS, along with the Departments of Labor and Treasury, also sent a letter to employers, plan sponsors, and insurers encouraging them to match the steps taken by HealthCare.gov by allowing employees and their dependents who lose Medicaid/CHIP coverage to enroll anytime through July 31, 2024.

Fixing the "Family Glitch:" The AMA has long supported fixing the "family glitch" which was accomplished this year by regulations allowing family members of workers offered affordable self-only coverage to gain access to subsidized ACA marketplace coverage. Under the new rule, it is anticipated that nearly one million Americans will gain access to more affordable coverage.[19]

CHALLENGES FOR PHYSICIANS, PRACTICES, HOSPITALS AND HEALTH SYSTEMS

Since this report was written only a few months after the continuous enrollment requirement expired, meaningful data regarding the impact of Medicaid/CHIP coverage terminations on physicians, physician practices, hospitals and health systems is limited and still emerging. However, it is generally assumed that the unwinding will increase uninsured rates. The CBO estimates that the number of uninsured will increase from 23 million (uninsured rate of 8.3 percent) in 2023 to 28 million (10.1 percent) in 2027 and remain at that level, which is below the 12 percent uninsured rate in 2019, through 2033.[20]

In turn, physician practices, hospitals and health systems serving large numbers of Medicaid/CHIP patients or located in underserved communities—including rural areas—could disproportionately experience decreased patient volume and revenue losses in the coming months. Such effects may then impact the ability of some practices and facilities to employ staff and continue serving patients, particularly those covered by Medicaid or CHIP, which tend to pay physicians and other providers at rates lower than Medicare and commercial insurance, thus further exacerbating existing access inequities. For example, a January 2023 predictive analysis of the potential effects of the Medicaid unwinding on community health centers, which rely greatly on Medicaid revenue, estimated that the unwinding would decrease health center revenue by $1.5 to $2.5 billion, or four to seven percent, overall. As a result, the analysis posits that between 1.2 and 2.1 million fewer patients will be served and between 10.7 and 18.5 thousand fewer people will be employed by health centers.[21] Kaufman Hall summaries of data from more than 900 hospitals in the first months of the unwinding similarly found increases in both charity care and bad debt, as well as declines in volume, that are attributed by the authors to unwinding-related coverage losses.[22]

Additionally, physicians, hospitals, and other providers will likely see more and more patients who may not realize that they are no longer covered by Medicaid/CHIP, and are therefore uninsured, until they seek care. Most states do not provide renewal information to physicians and other providers or allow them to access such data via the Medicaid agency portal; however, Kentucky is an exception and even explains how providers can find patients' renewal dates online. Having such information in hand before an enrollee is at the practice for an appointment would be helpful to physicians who could then make sure a patient is aware of their Medicaid/CHIP renewal and coverage status.

AMA ACTIVITY

The AMA has consistently worked at both the state and federal levels to improve Medicaid and CHIP programs, expand Medicaid and CHIP coverage options, and generally make it easier for physicians to see Medicaid and CHIP patients. Since the ACA was enacted, AMA advocacy on Medicaid and CHIP has been guided by AMA policy, highlighted in the AMA's Plan to Cover the Uninsured, which seeks to extend the reach of coverage to the remaining uninsured, including individuals eligible for Medicaid/CHIP and adults who fall into the coverage gap. Consistent with AMA policy, the AMA continues to advocate for Medicaid expansion and three years of 100 percent federal funding for states that newly expand.

The AMA regularly comments on federal and state Medicaid proposals related to patient access to care and adequate physician payment, defined in AMA policy as a minimum of 100 percent of Medicare rates. The AMA has advocated that CMS ensure that states are maintaining Medicaid rate structures at levels that ensure sufficient physician participation, so that Medicaid patients can access appropriate, necessary care, including specialty and behavioral health services, in a timely

manner and within a reasonable distance to where they live. Specifically in response to the unwinding of the continuous enrollment requirement, the AMA also:

- Participates in the Connecting to Coverage Coalition, which represents a diverse collection of industry voices partnering to minimize coverage disruptions associated with the resumption of state Medicaid renewals;
- Meets with senior Administration officials to discuss the status of the unwinding and on-the-ground implications, AMA's role in educating physicians on CMS' new guidance and resources, and potential areas for future collaboration;
- Facilitates educational opportunities for the Federation, including a session in August 2023 at the AMA's State Advocacy Roundtable in which resources were shared and unwinding strategies were discussed;
- Shares CMS resources with the Federation and encourages members to participate in CMS' monthly webinars that are part of the agency's "all hands-on deck" strategy;
- Regularly distributes new unwinding information and guidance announcements from CMS and other sources through various AMA platforms and channels, including *AMA Today* and the AMA's biweekly Advocacy Update;
- Creates unwinding-specific resources for physicians, such as AMA issue briefs on Preventing Coverage Losses as the PHE Unwinds and COVID-19 flexibilities that ended when the PHE expired; and
- Submits comments to CMS on relevant notices of proposed rulemaking, such as proposals this year on special enrollment periods and standards for navigators and other consumer assisters; ensuring access to Medicaid services; and managed care access, finance, and quality.

RELEVANT AMA POLICY

Policies H-165.832 and H-165.855 support the adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange plans to limit patient churn and promote the continuity and coordination of patient care. Policy H-165.855 also supports allowing for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care. AMA policy also supports investments in outreach and enrollment assistance activities (Policies H-290.976, H-290.971, H-290.982 and D-290.982). The role of community health workers is addressed under Policy H-440.828, while Policy H-373.994 delineates guidelines for patient navigator programs. Policy D-290.979 directs the AMA to work with state and specialty medical societies to advocate at the state level in support of Medicaid expansion. Policy D-290.974 supports the extension of Medicaid and CHIP coverage to at least 12 months after the end of pregnancy. Policy H-290.958 supports increases in FMAP or other funding during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment.

Policy H-290.955 encourages states to facilitate transitions, including automatic transitions, from health insurance coverage for which an individual is no longer eligible to alternate health insurance coverage for which the individual is eligible; supports coordination between state agencies overseeing Medicaid, ACA marketplaces, and workforce agencies to help facilitate health insurance coverage transitions and maximize coverage; and supports federal and state monitoring of Medicaid retention and disenrollment, successful transitions to quality affordable coverage, and uninsured rates. Policy H-165.839 advocates that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information. Support for fixing the ACA's "family glitch" is addressed by Policy H-165.828, which also supports efforts to ensure clear and meaningful differences between plans offered on

health insurance exchanges. Policy H-165.824 supports increasing the generosity of premium tax credits as well as eliminating ACA's subsidy "cliff." Under Policy H-285.952, patients in an active course of treatment who switch to a new health plan should be able to receive continued transitional care from their treating out-of-network physicians and hospitals at in-network cost-sharing levels.

Policy H-165.823 supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets certain standards related to cost of coverage, individual consent, opportunity to opt-out after being auto-enrolled, and targeted outreach and streamlined enrollment. Under this policy, 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/CHIP or zero-premium marketplace coverage. Policy H-165.823 also outlines standards that any public option to expand health insurance coverage, as well any approach to cover individuals in the coverage gap, must meet.

Under Policy H-165.824, the AMA supports adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits and encourages state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections. Policy H-165.824 further supports: (a) eliminating the subsidy "cliff," thereby expanding eligibility for premium tax credits beyond 400 percent of the FPL; (b) increasing the generosity of premium tax credits; (c) expanding eligibility for cost-sharing reductions; and (d) increasing the size of cost-sharing reductions.

Policy H-165.822 encourages new and continued partnerships to address non-medical, yet critical health needs and the underlying social determinants of health and supports continued efforts by public and private health plans to address social determinants of health. Policy H-180.944 states that health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

DISCUSSION

The Medicaid unwinding has been described as the most significant nationwide coverage transition since the ACA, with major implications for patients, physicians, and health equity. As noted by the Council in Report 3-A-22, eligibility redeterminations and resulting coverage losses may have a disproportionate impact on individuals of color and those with disabilities, and it is critical that states consider how best to avoid exacerbating existing health care inequities. Even if states adopt many of the strategies outlined in Council Report 3-A-22 to help prevent coverage losses (e.g., streamlining redeterminations, adopting continuous eligibility policies, encouraging auto-enrollment, and facilitating coverage transitions, etc.), the unwinding will be painful for many people who have relied on Medicaid/CHIP for their health coverage and may decrease patient volume and revenue for physicians, clinics, and hospitals who regularly provide care to large populations of Medicaid and CHIP patients.

At the time this report was written, the Medicaid unwinding was in its early stages; many states had been conducting renewals for only a few months; and information on transitions from Medicaid/CHIP to other coverage was limited. While state renewal approaches vary and may evolve over time, early data suggesting high rates of procedural terminations in some states are

concerning since an unknown—but potentially substantial—number of individuals (including children) still eligible for Medicaid/CHIP coverage may have been improperly disenrolled. The Council will continue to monitor unwinding data as it becomes available and recommend new AMA policy and physician resources as needed. At this time, the Council has identified three priority areas for new AMA policy development and advocacy: encouraging states to reduce inappropriate terminations from Medicaid/CHIP for procedural reasons; expand continuity of care protections for disenrolled individuals; and enable provider access to Medicaid/CHIP coverage and renewal information.

As the PHE continuous enrollment unwinds over the coming months, disenrollments from Medicaid/CHIP will continue, some based on eligibility and others for procedural reasons, and physicians and hospitals may encounter more patients who do not realize that they have lost Medicaid/CHIP coverage and are therefore uninsured. It is widely understood that even brief gaps in coverage can be costly in terms of interrupting continuity of care and necessary treatments, especially for patients with acute or chronic health conditions. To address concerns regarding procedural terminations of coverage for individuals still eligible for Medicaid, the Council recommends amending Policy H-290.955 to encourage state Medicaid agencies to implement strategies to reduce inappropriate procedural terminations, including automating renewal processes and following up with enrollees who have not responded to a renewal request before terminating coverage.

While many states require insurers to cover services for patients in an active course of treatment at in-network cost-sharing if their provider is terminated from an insurer network, fewer states require similar continuity of care protections for people switching health plans. Because Medicaid patients have higher rates of chronic disease and complex health conditions, the Council recommends encouraging states to provide continuity of care protections for Medicaid/CHIP enrollees transitioning to new health coverage and to recognize prior authorizations completed by the prior Medicaid/CHIP plan. The Council also recommends encouraging states to make Medicaid coverage status, including expiration of current coverage and information on pending renewals, accessible to physicians, clinics, and hospitals through the state Medicaid agency's portal or by other readily accessible means, so that providers can inform patients of upcoming renewals when they come in for appointments.

The Council further recommends reaffirmation of two AMA policies: 1) Policy H-165.855, which calls for the adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange plans and supports allowing for presumptive eligibility and retroactive coverage to the time at which an eligible person seeks care; and 2) Policy H-165.823, which encourages states to pursue auto-enrollment in health insurance coverage as a means of expanding coverage among individuals who may not know that they are eligible for a state's Medicaid or marketplace coverage or what steps to take to enroll.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) amend Policy H-290.955 by addition to read:
   <u>4. Our AMA encourages state Medicaid agencies to implement strategies to reduce inappropriate terminations from Medicaid/CHIP for procedural reasons, including</u>

automating renewal processes and following up with enrollees who have not responded to a renewal request, using multiple modalities, before terminating coverage.
5. Our AMA encourages states to provide continuity of care protections to patients transitioning from Medicaid or CHIP to a new health plan that does not include their treating physicians and other providers in network, and to recognize prior authorizations completed under the prior Medicaid/CHIP plan.
6. Our AMA encourages state Medicaid agencies to make Medicaid coverage status, including expiration of current coverage and information on pending renewals, accessible to physicians, clinics, and hospitals through the state's portal or by other readily accessible means. (Modify HOD Policy)

2. That our AMA reaffirm Policy H-165.855, which calls for adoption of 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans and supports allowing for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-165.823, which supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets certain standards related to consent, cost, ability to opt out, and other guardrails. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] Centers for Medicare & Medicaid Services. March 2023 Medicaid and CHIP Enrollment Trends Snapshot. Available at: https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/march-2023-medicaid-chip-enrollment-trend-snapshot.pdf
[2] *Ibid*.
[3] Buettgens Matthew and Green Andrew. The Impact of the COVID-19 Public Health Emergency Expiration on All Types of Health Coverage. Urban Institute and Robert Wood Johnson Foundation Research Report. December 2022. Available at: https://www.urban.org/sites/default/files/2022-12/The%20Impact%20of%20the%20COVID-19%20Public%20Health%20Emergency%20Expiration%20on%20All%20Types%20of%20Health%20Coverage_0.pdf
[4] Kaiser Family Foundation. 10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision. June 9, 2023. Available at: https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/
[5] U.S Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (ASPE). Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches, August 19, 2022. Available at: https://aspe.hhs.gov/sites/default/files/documents/404a7572048090ec1259d216f3fd617e/aspe-end-mcaid-continuous-coverage_IB.pdf
[6] *Ibid*.
[7] Hanson, C, Hou, C, Percy A et al. Health Insurance for People Younger Than Age 65: Expiration of Temporary Policies Projected to Reshuffle Coverage, 2023-2033. *Health Affairs* Vol. 42, No. 6, June 2023.
[8] Centers for Medicare & Medicaid Services. Medicaid and CHIP Renewals: Returning to Regular Operations. Downloaded July 31, 2023. Available at: https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-data-reporting/index.html
[9] *Ibid*.

[10] *Ibid*.
[11] Kaiser Family Foundation. Medicaid Enrollment and Unwinding Tracker. Updated daily. Available at: https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-and-unwinding-tracker/
[12] Kaiser Family Foundation. Medicaid Enrollment and Unwinding Tracker. Updated daily. Available at: https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-and-unwinding-tracker/
[13] Ibid.
[14] Centers for Medicare & Medicaid Services. 2023 State Timelines for Initiating Unwinding-Related Renewals As of June 29, 2023Available at: https://www.medicaid.gov/resources-for-states/downloads/ant-2023-time-init-unwin-reltd-ren-06292023.pdf
[15] U.S. Department of Health and Human Services. Fact Sheet: Returning to Regular Medicaid Renewals: Monitoring, Oversight, and Requiring States to Meet Federal Requirements. July 2023. Available at: https://www.medicaid.gov/resources-for-states/downloads/renewals-for-monitoring-state-systems.pdf
[16] Kaiser Family Foundation. The Unwinding of Medicaid Continuous Enrollment: Knowledge and Experiences of Enrollees, May 24, 2023. Available at: https://www.kff.org/medicaid/poll-finding/the-unwinding-of-medicaid-continuous-enrollment-knowledge-and-experiences-of-enrollees/?utm_campaign=KFF-2023-Medicaid&utm_medium=email&_hsmi=2&_hsenc=p2ANqtz-_PkdkT3cI-XhADnQIFKJcM2zm-s33yNCZWhDAoOuc9Dy2pfo9i0M_usPll5HmuuQU0I5k8LLdKm5F6kkQq1pGf43D34g&utm_content=2&utm_source=hs_email
[17] U.S. Department of Health and Human Services. Letter to U.S. Governors from HHS Secretary Xavier Becerra on Medicaid Redeterminations, June 12, 2023. Available at: https://www.hhs.gov/about/news/2023/06/12/letter-us-governors-from-hhs-secretary-xavier-becerra-medicaid-redeterminations.html
[18] Centers for Medicare & Medicaid Services. Center for Consumer Information & Insurance Oversight. FAQ: Temporary Special Enrollment Period (SEP) for Consumers Losing Medicaid or the Children's Health Insurance Program (CHIP) Coverage Due to Unwinding of the Medicaid Continuous Enrollment Condition. January 27, 2023. Available at: https://www.cms.gov/technical-assistance-resources/temp-sep-unwinding-faq.pdf
[19] American Medical Association. Advocacy Update: Proposed fix to ACA family glitch follows AMA advocacy, April 15, 2022. Available at: https://www.ama-assn.org/health-care-advocacy/advocacy-update/april-15-2022-national-advocacy-update
[20] Hanson, C, Hou, C, Percy A et al. Health Insurance for People Younger Than Age 65: Expiration of Temporary Policies Projected to Reshuffle Coverage, 2023-2033. *Health Affairs* Vol. 42, No. 6, June 2023.
[21] Ku, L, Sharac, J, Shin, P, Rosenbaum, S and Jacobs F. Data Note: The Potential Effects of Medicaid Unwinding on Community Health Centers. George Washington University Geiger Gibson Program in Community Health. January 2023. Available at: https://geigergibson.publichealth.gwu.edu/potential-effect-medicaid-unwinding-community-health-centers#:~:text=The%20unwinding%20is%20estimated%20to,to%2018.5%20thousand%20staff%20members.
[22] Kaufman Hall. National Hospital Flash Report, August 2023. Available at: https://www.kaufmanhall.com/sites/default/files/2023-08/KH-NHFR_2023-08.pdf.

APPENDIX

Policies Recommended for Amendment and Reaffirmation

Preventing Coverage Losses After the Public Health Emergency Ends H-290.955
1. AMA encourages states to facilitate transitions, including automatic transitions, from health insurance coverage for which an individual is no longer eligible to alternate health insurance coverage for which the individual is eligible, and that auto-transitions meet the following standards:
a. Individuals must provide consent to the applicable state and/or federal entities to share information with the entity authorized to make coverage determinations. b. Individuals should only be auto-transitioned 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. c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-transitioned.
d. Individuals should not be penalized if they are auto-transitioned into coverage for which they are not eligible. e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values. f. 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 special enrollment periods. g. Auto-transitions should preserve existing medical home and patient-physician relationships whenever possible. h. Individuals auto-transitioned into a plan that does not include their physicians in-network should be able to receive transitional continuity of care from those physicians, consistent with Policy H-285.952.
2. Our AMA supports coordination between state agencies overseeing Medicaid, Affordable Care Act marketplaces, and workforce agencies that will help facilitate health insurance coverage transitions and maximize coverage.
3. Our AMA supports federal and state monitoring of Medicaid retention and disenrollment, successful transitions to quality affordable coverage, and uninsured rates. (CMS Rep. 3, A-22)

Medical Care for Patients with Low Incomes H-165.855
It is the policy of our AMA that: (1) states be allowed the option to provide coverage to their Medicaid beneficiaries who are nonelderly and nondisabled adults and children with the current Medicaid program or with premium tax credits that are refundable, advanceable, inversely related to income, and administratively simple for patients, exclusively to allow patients and their families to purchase coverage through programs modeled after the state employee purchasing pool or the Federal Employee Health Benefits Program (FEHBP) with minimal or no cost-sharing obligations based on income. Children qualified for Medicaid must also receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program benefits and have no cost-sharing obligations. (2) in order to limit patient churn and assure continuity and coordination of care, there should be adoption of 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans. (3) to support the development of a safety net mechanism, allow for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care. (4) tax credit beneficiaries should be given a choice of coverage, and that a mechanism be developed to administer a process by which those who do not choose a health plan will be assigned a plan in their geographic area through auto-enrollment until the next enrollment opportunity. Patients who have been auto-enrolled should be permitted to change plans any time within 90 days of their original enrollment. (5) state public health or social service programs should cover, at least for a transitional period, those benefits that would otherwise be available under Medicaid, but are not medical benefits per se. (6) as the nonelderly and nondisabled

populations transition into needing chronic care, they should be eligible for sufficient additional subsidization based on health status to allow them to maintain their current coverage. (7) our AMA encourages the development of pilot projects or state demonstrations, including for children, incorporating the above recommendations. (8) our AMA should encourage states to support a Medicaid Physician Advisory Commission to evaluate and monitor access to care in the state Medicaid program and related pilot projects. (CMS Rep. 1, I-03; Reaffirmed in lieu of Res. 105, A-06; Reaffirmation I-07; Modified: CMS Rep. 1, A-12; Reaffirmed in lieu of Res. 101, A-13; Reaffirmed: CMS Rep. 02, A-16; Reaffirmation: A-18; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21; Reaffirmed: CMS Rep. 3, A-22)

Options to Maximize Coverage under the AMA Proposal for Reform H-165.823

1. 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.
2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards: a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition. b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits. c. Physician payments under the 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. 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. e. The public option is financially self-sustaining and has uniform solvency requirements. f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans. 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.
3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards: 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. 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. c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled. 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. e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values. 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. 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. h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the

availability of premium tax credits and cost-sharing reductions and establishing a special enrollment period.
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. (CMS Rep. 1, I-20Appended: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22; Reaffirmed: Res. 122, A-22; Modified: Res. 813, I-22)

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-I-23

Subject: Rural Hospital Payment Models

Presented by: Sheila Rege, MD Chair

Referred to: Reference Committee J

At the June 2023 Annual Meeting the House of Delegates adopted Policy D-465.996. The second resolve of the adopted policy asks that the American Medical Association (AMA) study alternative payment models for rural hospitals to examine their feasibility, and that the study include a discussion as to the feasibility of the patient-centered payment and standby capacity payments models. Consistent with Policy D-465.996, this report examines alternative payment models, including patient-centered payment and standby capacity payment models, that could assist in efforts to ensure that rural hospitals remain financially viable and able to provide care to rural patients.

BACKGROUND

Nearly one-fifth of the U.S. population, about 60 million people, live in rural areas. Individuals living in these areas are more likely to be sicker, older, and underinsured than their urban and suburban dwelling counterparts. They also have higher rates of smoking, hypertension, and obesity. These factors along with higher poverty rates, lead to health disparities for rural Americans. Additionally, rural populations are more likely to be beneficiaries of Medicare or Medicaid with nearly half of rural hospital revenue coming from these sources. A more in-depth look at the state of health care for rural populations can be found in CMS Report 09-A-21, Addressing Payment and Delivery in Rural Hospitals, and CMS Report 09-A-23, Federally Qualified Health Centers and Rural Health.

RURAL HOSPITALS

Rural hospitals are those that exist and serve communities outside metropolitan areas and make up about a quarter of all American hospitals.[1] These hospitals are geographically isolated, often making them one of the only, if not the only, source of health care in the community. These hospitals are a vital point of access to communities that are often older, sicker, and less insured than urban and suburban communities.

Rural hospitals are incredibly vulnerable not only to many of the issues facing health care generally but often face additional unique challenges like low patient volumes and higher fixed costs. As a result of lower patient volumes many rural hospitals face challenges in both reporting and being assessed by quality metrics. A full discussion of the complications faced by rural hospitals in relation to quality metrics can be found in CMS Report 09-A-21. Additionally, nearly a third of all rural hospitals in the U.S. are at risk of closing and a third of those hospitals are in jeopardy of immediate closure.[2] An estimated 136 rural hospitals closed completely between 2005 and 2021

© 2023 American Medical Association. All rights reserved.

with 19 closing in 2020 alone.[3] Nearly 100 additional facilities no longer provide inpatient services and have either converted to a Rural Emergency Hospital or provide limited outpatient services.[4]

These closures are often a result of payment rates that do not cover costs. Rural hospitals face a unique financial situation as many insurers do not pay them enough to cover the cost of providing services in low-population and rural communities.[5] Specifically, many private payers and Medicare Advantage plans pay rural hospitals less than the actual cost to deliver services.[6] While rural hospitals can sometimes also lose money when providing services to Medicaid beneficiaries, 19 states offset these losses with additional payments to hospitals via bolstered reimbursement rates.[7] Traditional Medicare, not Medicare Advantage, beneficiaries are the most financially beneficial patients for many rural hospitals. This is because Medicare explicitly pays more to cover the higher costs to deliver health services in these rural settings for hospitals classified as Critical Access Hospitals (CAHs). Of note, while all CAHs are rural hospitals, not all rural hospitals qualify as CAHs. For a hospital to qualify as a CAH it must go through a specific certification process and meet criteria related to its size, location, services provided, and average patient length of stay.[8] In addition to the payment shortfalls facing rural hospitals, they are also more susceptible to the workforce challenges that many hospitals and medical practices are facing.[2]

Another important factor impacting the financial viability of rural hospitals is the Affordable Care Act's (ACA) Medicaid expansion. Starting in 2014 states were able to opt into an expanded Medicaid coverage for nearly all adults with an income level up to 138 percent of the Federal Poverty Level along with enhanced federal matching for these extended populations. Currently, 40 states and the District of Columbia have implemented this expansion and are often referred to as "expansion states."[9] This is essential to understanding the full state of rural hospitals as research has demonstrated that rural hospitals fare financially better in expansion states compared to non-expansion states. This improvement is thought to stem from a lessening in uncompensated care as more patients are insured. Specifically, rural hospitals in Medicaid expansion states were shown to have increased operating margins and were less likely to face full or partial closures.[8] While many rural hospitals still struggle in expansion states, the situation is grimmer for the 34 percent of rural hospitals in non-expansion states.[8]

PATIENT-CENTERED PAYMENT MODEL

Research demonstrates that patient-centered payment and care models tend to yield positive impacts for patients and providers. Improved patient outcomes in these models include improved health and well-being.[10] Physicians and health care teams also report improved patient interactions, cost-effectiveness, and work environments. However, some studies have found patient drawbacks like an increase in personal and financial costs to patients.[7] Many of the studies done on this type of model focus on the broader patient-centered care models, not specifically on patient-centered payment models. Additionally, these studies are focused on outpatient instead of hospital inpatient settings. Accordingly, these studies need to be taken with some caution regarding their applicability to rural hospitals. A joint report from the AMA and the Center for Healthcare Quality and Payment Reform (CHQPR) has shown promise for this payment model but was not specific to rural health. Specifically, the report demonstrated that the patient-centered payment model yields higher-quality and lower-cost care through increased flexibility for physicians to deliver care and increases in physician payments.[11]

STANDBY CAPACITY PAYMENTS MODEL

Generally, standby capacity payments for hospitals would provide hospitals with advance payment for the populations of their respective communities regardless of how many health care services are

actually rendered.[9] Advocates of this type of payment system suggest that all health insurance plans, both public and private, should provide participating hospitals with a standby capacity payment for their community populations.[12] Though payment could hypothetically come from any payer, it seems most likely that the funding would, at least initially, come from local, state, and/or federal government entities to prevent critical rural hospitals from closing. For rural hospitals, standby payment would combat the issue of fixed costs that are often overwhelming for these hospitals. All hospitals are required to always maintain an emergency standby capability[13] to ensure that hospitals are ready if and/or when an emergency occurs. Larger hospitals are more likely to be able to incorporate this into their cost structure, but many rural hospitals are unable to cover the cost of emergency standby capability due to lower payments and smaller patient volumes. The struggle for many rural hospitals to absorb these costs means that standby capacity could be particularly advantageous. The amount of the standby capacity payment would be dependent on the population of the community, services provided by the hospital, and the hospital's operating costs. The AMA[5] and CHQPR[9] have supported standby payment for rural hospitals.

Much of the research on standby payment does not focus specifically on rural hospitals. The research does yield a number of distinct advantages to the patient and physician, such as an increase in quality of care, a decrease in costs, and the potential to aid in the mitigation of unsustainable cost trends. However, experts suggest that these payments alone would not be sufficient to address health care value generally or in rural hospitals particularly.[14] Experts suggest that standby payment models should be paired with incentives to improve care outcomes and that the Centers for Medicare & Medicaid Services (CMS) lead the payment reform. As low payment rates from Medicare Advantage plans are a key contributor to the problems facing rural hospitals the government would need to require that these plans provide more financially sustainable compensation.[12]

GLOBAL BUDGETS/PAYMENTS MODEL

Global budgets or global payments are similar to standby capacity payments in that they are a predictable and reliable payment to the hospital. However, this type of payment is constructed on fixed payments to hospitals or other providers that are based on the range of services that would be billed for individually in a traditional fee-for-service (FFS) arrangement during a specific time period, rather than the size of the community.[15] Generally, global payments are made at a predetermined point, which could be incremental or after a set of services are provided by a hospital. An important aspect of global payment systems is that they are made on behalf of a group of patients, like Medicaid beneficiaries, instead of individual patients. For global payments to be successful, contracts delineate specific standards and outcomes for the range of services included in the contract. Commonly, covered services are broad and include physician services, hospital services, diagnostic testing, prescription drugs, and may include expanded services like home health or hospice care.[12] The global payment system aims to improve patient outcomes and increase access to preventative services. It may include bonuses to physicians or hospitals if quality benchmarks are reached, which aims to promote high-value care.

The use of global payments or budgets has grown, as the model is used by some private payers as well as some Medicare Advantage plans and Medicaid managed care plans. A particularly relevant and promising implementation of this model was launched by the state of Pennsylvania with the support of CMS in 2019. The Pennsylvania Rural Health Model (PARHM) was created to allow rural hospitals in Pennsylvania to stay open and provide high-quality health care services that improve the health of the communities they serve.[16] PARHM was implemented as a CMS innovation model and is in an ongoing evaluation stage through 2024. As with many rural

communities, rural populations in Pennsylvania have poorer health outcomes than their urban counterparts.

The PARHM model is a potential answer to issues facing rural hospitals. In this model, payment is based on historical net patient revenue for both inpatient and outpatient services adjusted for factors like inflation and service line changes.[13] Participating hospitals are also able to access supports in identifying and implementing areas of transformation focused on prevention services, quality improvement, and community-based services, as well as advancing both community health goals and health equity. This model currently includes 18 rural hospitals, Medicare, Pennsylvania Medical Assistance (Medicaid), and five private payers; Geisinger Health Plan, Highmark Blue Cross Blue Shield, UPMC Health Plan, Gateway, and Aetna.[17]

Each participating PARHM hospital receives regular and consistent payments from participating payers based on the FFS portion of the budget. These consistent payments have shown promising results in the initial years of evaluation. Importantly, hospitals who participate have expressed strong commitment to the model and indicated that participation has allowed the hospitals to attain greater financial stability and remain open.[15] Although some participating commercial payers have expressed concern over the sustainability of this type of model, the model is continuing to be evaluated and will remain under a trial/evaluation period through 2024. Evaluators have indicated that future reports will assess the sustainability and impact of the model on health outcomes in the communities served. However, one main outcome is clear—rural hospitals at risk of closing are able to not only remain open but improve their financial stability.[15] In an era where many rural hospitals are closing or struggling to stay open, this is a potentially promising outcome to ensure that rural communities have access to health care services.

RELEVANT AMA POLICY

The AMA has extensive policy on both rural hospitals and rural health generally. Policy D-465.998 outlines the AMA's support to ensure that payments to rural hospitals from both public and private payers are adequate to cover services rendered. Additionally, this policy works to ensure that coordination of care and transparency are encouraged in rural hospitals. Finally, the policy encourages rural residents to select health insurance plans that pay rural hospitals equitably. Notably, this policy specifically calls for supporting the development of capacity payment models for rural hospitals.

In addition to the aforementioned policy, the AMA has multiple policies that outline the importance of economically supporting rural hospitals and advocating for their financial stability. Policy H-465.979 recognizes the importance of rural hospitals and supports organizations that are advocating for their sustainability. Policy H-465.990 addresses the concerning trend of rural hospital closures by encouraging legislation that reduces financial constraints on these hospitals. Policy H-420.971 supports eliminating the payment differentials that are seen between urban and rural medical care, and Policy H-240.970 advocates for reimbursement to rural hospitals for patients returning from tertiary care centers.

In addition to payment and reimbursement related policies, the AMA has policies that support reasonable designation and certification processes for rural hospitals. Policy D-465.999 focuses on encouraging CMS to support state development of rural health networks, oppose the elimination of CAH necessary provider designations, and to pursue steps to ensure that the federal government fully funds its obligations in the Medicare Rural Hospital Flexibility Program. Policy H-465.999 urges Health and Human Services to take a realistic approach to the

certification of rural hospitals and recommends that state licensing and certifying agencies surveil the process for issues with the certification and accreditation process.

The AMA also has a number of policies related to improving the health of rural Americans. Policy H-465.994 supports the development and implementation of programs that improve rural health, urges rural physicians to be involved in community health, and calls for the AMA to disseminate its efforts related to rural health improvement. Policies H-465.982 and H-465.997 focus on efforts to support and encourage the study and development of proposals to solve access issues in rural communities. Policy H-465.978 encourages the recognition of payment bias as a factor in rural health disparities and advocates for the resolution of these biases. Policy H-465.989 focuses on the monitoring and defense against adverse impacts of the Budget Reconciliation legislation along with AHA. Finally, Policy H-465.986 encourages the study and dissemination of results on the Rural Health Clinics Program and its certification and how to best incorporate mid-level practitioners with physician supervision.

DISCUSSION

The AMA is committed to improving the health of rural communities through maintaining and expanding access to care in those settings. AMA policy and advocacy have focused on ensuring that rural hospitals remain open and able to serve their communities. One potential method of ensuring the maintenance of rural hospitals is to focus on transforming payment models. Patient-centered payment, standby capacity payment, and global budgets/payment models all provide potential alternatives to the traditional FFS payment models that are generally used in American health care settings. In its study, the Council is encouraged that each of these models has some distinct advantages that indicate they could be leveraged to ease the burden many rural hospitals are facing.

In order to support rural hospitals with adequate payment to stay open and to encourage additional innovative strategies to address the payment issues facing rural hospitals, the Council recommends new policy that encourages the AMA to support efforts to create and implement proposals to transform the payment models utilized in rural hospitals. This policy would support such proposals from any entity including CMS and interested state medical associations.

Finally, the Council recommends that Policies H-465.978, Recognizing and Remedying Payment System Bias as a Factor in Rural Health Disparities, and D-465.998, Addressing Payment and Delivery in Rural Hospitals, be reaffirmed. Each of these policies works to both acknowledge and encourage action to remedy payment disparities and issues facing rural hospitals.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) support and encourage efforts to develop and implement proposals for improving payment models to rural hospitals. (New HOD Policy)

2. That our AMA reaffirm Policy H-465.978, which recognizes the payment bias toward rural hospitals as a factor in rural health disparities and encourages solutions to help solve this bias. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy D-465.998, which advocates for improvements to the payment and health care service delivery in rural hospitals. (Reaffirm HOD Policy)

4. That our AMA rescind Policy D-465.996 as having been accomplished with this report. (Rescind HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] Importance of Rural Hospitals. *Center for Healthcare Quality and Payment Reform.* 2021. https://ruralhospitals.chqpr.org/Importance.html
[2] Rural Hospitals at Risk of Closing. *Center for Healthcare Quality and Payment Reform*. 2023. https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf
[3] Rural Hospital Closures Threaten Access: Solutions to Preserve Care in Local Communities. *American Hospital Association.* 2022. https://www.aha.org/2022-09-07-rural-hospital-closures-threaten-access
[4] Rural Hospital Closures. *University of North Carolina: The Cecil G. Sheps Center for Health Services Research.* 2023. https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/
[5] Payment and Delivery in Rural Hospitals. *American Medical Association.* 2021. https://www.ama-assn.org/system/files/issue-brief-rural-hospital.pdf
[6] Rural Healthcare Payment and Reimbursement. *Rural Health Information.* 2022. https://www.ruralhealthinfo.org/topics/healthcare-payment
[7] Rural Hospitals and Medicaid Payment Policy. *Medicaid and CHIP Payment and Access Commission (MACPAC).* 2018. https://www.macpac.gov/publication/rural-hospitals-and-medicaid-payment-policy/
[8] Critical Access Hospitals. *Rural Health Information Hub.* 2021. https://www.ruralhealthinfo.org/topics/critical-access-hospitals
[9] Status of State Medicaid Expansion Decisions: Interactive Map. *Kaiser Family Foundation.* 2023. https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/
[10] Summer Meranius M, Holmström IK, Håkansson J, et al. Paradoxes of person-centred care: A discussion paper. Nurs Open. 2020;7(5):1321-1329. Published 2020 Jun 10. doi:10.1002/nop2.520
[11] A Guide to Physician-Focused Alternative Payment Models. *American Medical Association* and *Center for Healthcare Quality and Payment Reform.* 2021. https://pubmed.ncbi.nlm.nih.gov/32802352/
[12] A Better Way to Pay Rural Hospitals. Center for Healthcare Quality and Payment Reform. 2022. https://chqpr.org/downloads/Better_Way_to_Pay_Hospitals.pdf
[13] Fact Sheet: Site-neutral Payment Provisions. *American Hospital Association.* 2019. https://www.aha.org/system/files/media/file/2019/09/fact-sheet-site-neutral-0919.pdf
[14] The Potential of Global Payment: Insight from the Field. *The Commonwealth Fund.* 2010. https://www.commonwealthfund.org/publications/fund-reports/2010/feb/potential-global-payment-insights-field#:~:text=Global%20payment%20can%20address%20concerns,addressed%20by%20using%20this%20model.
[15] Payment Model Primer: Global Payments. *Center for Evidence-Based Policy.* 2022. https://centerforevidencebasedpolicy.org/CEbP_PaymentModelPrimer_GlobalPayments.pdf
[16] Pennsylvania Rural Health Model. *Center for Medicare and Medicaid Services.* 2023. https://innovation.cms.gov/innovation-models/pa-rural-health-model
[17] Pennsylvania Rural Health Model (PARHM) Evaluation of Performance Years 1-2 (2019-2020). Findings at a Glance. *CMS: Center for Medicare and Medicaid Innovation.* 2022. https://innovation.cms.gov/data-and-reports/2021/parhm-ar1-full-report

REPORT 7 OF THE COUNCIL ON MEDICAL SERVICE (I-23)
Sustainable Payment for Community Practices
(Resolution 108-A-23)
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the House of Delegates referred Resolution 108-A-23, which asked the American Medical Association (AMA) to assess the prevalence of insurance payments to small medical practices that are below Medicare rates and the impact of these payment levels on the ability of practices to provide care. The AMA was also asked to consider the impact on small and medium-sized practices of being excluded from population health management, outcome evidence-based care, and value-based purchasing arrangements, as well as to consider model legislation to address payment rates below the cost of practicing.

Despite the current trend toward larger practices, as of 2022, more than half of physicians still work in small private practices of ten or fewer physicians, a percentage that has fallen continuously since 2012. While small practices have some advantages that cannot be matched by larger practices, they are not necessarily well equipped to succeed in value-based purchasing given the financial investment and regulatory, technological, and analytic expertise necessary to enter these arrangements. However, small practices can collaborate to form alliances, which provide the scale needed to negotiate value-based contracts and to spread the risk across multiple practices. Such collaboration allows each practice access to the necessary technologies to draw actionable insights from data and regulatory and coding expertise to maximize revenue, while laying the groundwork for future savings.

Given their relative lack of market leverage, small practices are at a disadvantage when it comes to negotiating payment schedules. However, research shows that private insurance payment rates are, on average, higher than Medicare payment rates for the same medical services. This may benefit small practices, which have more private health insurance patients than Medicare patients and a higher percentage of private health insurance patients than larger practices. While AMA policy does not endorse a specific payment mechanism such as the Medicare Resource-Based Relative Value Scale (RBRVS), it does support use of RBRVS relative values as one option that could provide the basis for both public and private physician payment systems.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7-I-23

Subject: Sustainable Payment for Community Practices (Resolution 108-A-23)

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee J

At the 2023 Annual Meeting, the House of Delegates referred Resolution 108, which was sponsored by the District of Columbia Delegation. Resolution 108-A-23 asked for the American Medical Association (AMA) to:

> "(1) study small medical practices to assess the prevalence of insurance payments to these practices that are below Medicare rates and to assess the effects of these payment levels on practices' ability to provide care, and report back by the 2024 Annual Meeting; (2) study and report back on remedies for such reimbursement rates for physician practices; (3) study the impact on small and medium-sized physician practices of being excluded from population health management, outcome evidence-based care, and value-based purchasing arrangements; and study and report back to the House of Delegates options for model legislation for states and municipalities seeking to correct reimbursement rates for medical practices that are below those required to meet fixed costs."

This report focuses on non-hospital owned small practices, which are typically not eligible for facility fees nor possess the market power inherent in larger, hospital-owned practices. We compare Medicare and private insurance payment rates, outline collaborative and negotiating resources available to small practices, highlight essential AMA policy and resources, and present new policy recommendations.

BACKGROUND

Despite the current trend toward larger practices, more than half of physicians (51.8 percent) still work in small private practices of ten or fewer physicians, a percentage that has fallen continuously from 61.4 percent in 2012.[1] Contributing factors to the shift include mergers and acquisitions, practice closures, physician job changes, and the different practice settings chosen by younger physicians compared to those of retiring physicians. The "cohort effect"[2] demonstrates that younger physicians appear to prefer larger practices for the more predictable income and work-life balance they can offer.[3] They also may be hesitant to assume the business and entrepreneurial responsibilities demanded by smaller practices.[4]

However, small practices have some advantages that cannot be matched by larger practices, most notably patients with lower rates of preventable readmissions than those in larger practices.[5] The autonomy of small practices and preservation of the traditional patient-physician relationship provide reassurance to patients that the physician is acting in their best interests. It is thought that

© 2023 American Medical Association. All rights reserved.

the patient-physician bond generates trust, which leads to better adherence to a treatment plan.[6] As physicians become patient-centered medical homes, their decisions can control downstream costs, highlighting the importance of trusted, engaged, and financially aligned physicians in value-based payment systems. Although the medical home model suggests that physicians in small practices are uniquely positioned to succeed in value-based purchasing arrangements, they are not necessarily well equipped to do so given the financial investment and regulatory, technological, and analytic expertise necessary to enter these arrangements. In addition to these inherent limitations of small practices, extrinsic factors can play a role in creating an uneven playing field, including the fact that independent primary care physicians often fill gaps in care in low-income, rural, and other underserved communities.[7]

Assessing the current level of sustainability for small community practices requires appreciating the limitations of governmental authority, understanding the relationship between Medicare and private insurance payment rates, acknowledging relevant AMA policy and advocacy, and exploring the resources available for small practices that want to engage more fully in an evolving value-based health care system.

FAIR LABOR STANDARDS ACT OF 1938

The Fair Labor Standards Act of 1938 (FLSA) protects workers against unfair employment practices. FLSA rules specify when workers are considered "on the clock" and when they should be paid overtime, along with a minimum wage. Employees are deemed either exempt or nonexempt under the FLSA.

Resolution 108-A-23 postulates that the FLSA confers governmental authority to establish minimum levels of payment for medical practices. However, Section 13(a)(1) of the FLSA provides an exemption from both minimum wage and overtime pay for employees employed as "bona fide executive, administrative, professional, and outside sales employees." Physicians are exempted from FLSA protection since they are considered "Learned Professionals," as their primary duty requires advanced knowledge, defined as work that is predominantly intellectual in character and that includes work requiring the consistent exercise of discretion and judgment, in a field of science or learning; and customarily acquired by a prolonged course of specialized intellectual instruction.[8] As such, the FLSA cannot provide protection for small medical practices regarding minimum levels of payment.

MEDICARE PHYSICIAN PAYMENT SCHEDULE

In 1992, the federal government established a standardized Medicare Physician Payment Schedule (MPPS) based on a resource-based relative value scale (RBRVS). Prior to that, the federal government paid physicians using a system of "customary, prevailing, and reasonable" (CPR) charges, which was based on the "usual, customary, and reasonable" system used by many private insurers. The Medicare CPR system allowed for wide variation in the amount paid for the same service, resulting in unfounded discrepancies in Medicare payment levels among geographic service areas and physician specialties.

In an RBRVS system, payments for services are determined by the standardized resource costs needed to provide them, which are then adjusted to account for differences in work, practice expense, and professional liability insurance costs across national geographic service areas. The MPPS publishes relative value units (RVUs) for each service, which are then converted to a payment amount using geographical practice cost indices and an annually-updated MPPS Conversion Factor (CF). The MPPS is required to make budget neutrality adjustments to ensure

payment rates for individual services do not result in changes to estimated Medicare spending. Since any MPPS changes cannot increase or decrease Medicare expenditures by more than $20 million in a year, the Centers for Medicare & Medicaid Services (CMS) typically maintains budget neutrality through annual adjustment of the MPPS CF.

The AMA/Specialty Society Relative Value Scale Update Committee (RUC) identifies the resources required to provide physician services, which CMS then considers in developing MPPS RVUs. The RUC represents the entire medical profession, with 22 of its 32 members appointed by major national medical specialty societies including those with a large percentage of physicians in patient care and those that account for high percentages of Medicare expenditures. While, historically, 90 percent or more of RUC recommendations have been accepted,[9] CMS makes all final Medicare payment decisions.

The RUC process allows the federal government to consider input from physicians about the medical services they perform in their daily patient care so that the government can adopt payment policies that reflect current medical practice. The RUC process produces a balanced system where physicians volunteer their highly technical and unique hands-on expertise regarding complex medical procedures, while the government retains oversight and final decision-making authority. Each step of the process is made accessible and transparent, as the RUC publishes meeting dates, meeting minutes, and vote totals for each service evaluated.

The transparency inherent in the RUC process results in an MPPS built on RVUs that accurately reflect the resources required to provide services. As such, 77 percent of public and private payers, including Medicaid programs, have adopted components of the MPPS to pay physicians.[10] Even in the current era of evolving models of physician payment, the MPPS, the coding principles on which it is built, and the code sets that foster standardized communication remain the most effective systems to ensure transparency, relativity, and representative fairness in physician service valuation.

PRIVATE INSURANCE PAYMENT SCHEDULES

For small community practices, payment schedules are typically negotiated between the payer and the practice as part of a network of preferred physicians. Practices agree to these payment schedules to permit inclusion in the network, since being in-network is generally more appealing to patients, allows access to in-network referrals, and reduces the chance of unexpectedly low payment to the practice.

When negotiating payment schedules, it is important that the practice is aware of its fixed and variable costs for a given service so that the long-term break-even point can be determined. The smaller the practice, the more important it is to negotiate with as much data and defined value proposition as possible, because a smaller practice has less leverage. Given that private insurance payment schedules are negotiated between two parties, they can vary by state, region, payer, specialty, and/or practice. Thus, it is likely that most small practices accept multiple different payment schedules from different payers.

A general measurement of a private insurance payment schedule is its relative payment rate compared to the MPPS, or “benchmarking” to Medicare. Payment schedules that are less than the MPPS are considered beneficial for the payer, whereas payment schedules that match or are greater than the MPPS are considered beneficial for the practice. The percentage of MPPS rates is one of the most widely accepted commercial payment benchmarks when evaluating physician payment level and comparing contracts in the health care industry. It can reflect the mix of services across

physicians and plans while removing impacts from billed charges that can vary widely across providers and regions.

Private insurance payments are variable across physician specialties. The Urban Institute conducted an analysis of FAIR Health professional claims from March 2019 to February 2020, comparing them to the MPPS for the same time period. The analysis included 17 physician specialties and approximately 20 services per specialty, which represented about 40 percent of total professional spending. The specialties considered "primary care" (i.e., family medicine, internal medicine, obstetrics/gynecology) had among the lowest commercial markups relative to Medicare prices, averaging approximately 110 percent of Medicare rates or less."[11] Since the majority of primary care offices are physician-owned and almost half of primary care physicians are full or partial owners of their practices,[12] it follows that lower relative payments to primary care physicians place small practices at an additional relative disadvantage. This is further supported by the 2022 AMA Physician Benchmark Study, which found that "primary care in private practice is typically provided in the solo or single specialty setting, with 30.9 percent of private practice physicians working in a solo or single specialty primary care practice."[13]

Areas where there is greater market concentration among physicians tend to have lower payment amounts from private insurance. The Health Care Cost Institute's Health Care Cost and Utilization Report found that there was substantial variation in private insurance payments across states, with average commercial prices ranging from 98 percent to 188 percent of Medicare rates. Seven states had payments that were, on average, higher than 150 percent of Medicare rates while eleven states had average payments within 10 percent of Medicare. The states with the highest private insurance payments relative to Medicare tended to be in the northwest of the country and along the Great Plains.[14]

MEDICARE VERSUS PRIVATE INSURANCE PAYMENT RATES

A 2020 Kaiser Family Foundation literature review discovered that private insurance paid 143 percent of Medicare rates for physician services, on average, ranging from 118 percent to 179 percent of Medicare rates across studies.[15] Estimates from a more recent Milliman white paper closely align, finding that 2022 commercial payment for professional medical services to be approximately 141 percent of Medicare fee-for-service rates.[16] A 2022 Congressional Budget Office report identified "rapid increases in the prices that commercial insurers pay for hospitals' and physicians' services,"[17] leading to further divergence between private and public insurance payment rates, a trend that has proven consistent over time. A 2003 Office of the Inspector General review determined that of 217 procedures, 119 were valued lower by Medicare than by private insurers[18] and a 2017 Health Care Cost Institute report found that commercial payments for the average professional service were 122 percent of what would have been paid under Medicare.[19] The 2022 AMA Physician Practice Benchmark Survey found that small practices of 1 to 15 physicians have a greater percentage of private health insurance patients than Medicare patients (45.9 percent vs 28.4 percent) and a higher percentage of private health insurance patients than larger practices (45.9 percent vs 40.9 percent).[20] Since research shows that private insurance payment rates are, on average, higher than Medicare payment rates for the same health services, this may benefit small practices.

While the Council was unable to identify a survey focused on small practice Medicare to private insurance rate ratios, anecdotal reports indicate that some small practices are seeing private insurers offer payment below 100 percent of Medicare, which may be further depressed when insurers utilize a prior year Medicare rate. A Washington, D.C. two-physician clinic reported receiving private insurance payment rates ranging from 16-43 percent lower than Medicare, despite

becoming a Patient-Centered Medical Home and entering into a local accountable care organization (ACO). Similarly, a solo endocrinologist who left a university-affiliated practice reported being disadvantaged by no longer being able to collect facility fees to generate higher billing, forcing him to opt out of all insurance plans due to inadequate payment.

SMALL PRACTICES AND VALUE-BASED PAYMENT SYSTEMS

Physicians have been moving to larger group practices in order to gain access to more resources to effectively implement value-based care and risk-based payment models.[21] In this era of consolidation, there is an expectation of progression from solo or small physician practices to groups and multispecialty practices and, finally, to fully integrated delivery systems that employ the physicians, own the hospitals, and use a single information system. In this limited view, the earlier forms of practice organization are assumed to be incapable of implementing the supporting systems needed for population health (e.g., registries, electronic medical records, care management, team-based care) and are therefore unable to compete in value-based payment systems. A 2011 report of the Massachusetts Attorney General concluded that while bearing financial risk through value-based payments encourages coordinated care, it also requires significant investment to develop the capacity to effectively manage risk, which is more difficult for most physicians who practice in small groups and have historically been paid less than larger practices.[22] The report also found that physicians who transitioned to larger groups received professional payment that was approximately 30 percent higher, which accelerated the number of physicians leaving small practices and joining larger groups.

However, small practices are able to compete if they join forces to create profitable economies of scale without forfeiting the advantages of being small.[23] When small practices collaborate, they form a network of peers to learn from and to glean deeper insights from population health models. Alliances can provide the scale needed to negotiate value-based contracts and to spread the risk across multiple practices, so that a handful of unavoidable hospitalizations does not destroy a single practice. Collaboration allows each practice access to the necessary technologies to draw actionable insights from data and regulatory and coding expertise to maximize revenue, while laying the groundwork for future savings.

Independent practice associations (IPAs), if structured in compliance with antitrust laws, allow contracting between independent physicians and payers and can succeed in value-based purchasing arrangements if they are able to achieve results equal to more highly capitalized and tightly structured large medical groups and hospital-owned practices. Traditionally, most IPAs have been networks of small practices organized for the purpose of negotiating fee-for-service contracts with health insurers. While small practices considering participating in an IPA should be aware of the potential risks, such as underfunded capitation revenue, IPAs can act as a platform for sharing resources and negotiating risk-bearing medical services agreements on behalf of participating practices. Many IPAs, especially those that are clinically integrated, have already converted to an ACO, or provide the infrastructure for their members to organize as one. Because many of these organizations have already operated as risk-bearing provider networks, IPAs are well positioned to take leading roles in developing ACOs or acting as sustaining member organizations. Even if the physician organization has operated in a fee-for-service environment, an IPA can bring expertise regarding contracting, analytics, and management. For example, the Greater Rochester IPA (GRIPA) has over 1,500 physician members who benefit from data analytics services to stratify and manage patients, as well as care management support, pharmacists, visiting home nurses, and diabetes educators. GRIPA has its own ACO, which distributed 83 percent of its 2020 shared savings to participants. ACOs can also benefit from participation by small practices. A 2022 study

found that small practices in ACOs controlled costs better than larger practices, thereby generating higher savings for ACOs.[24]

CMS structures several of its initiatives in an effort to support small practices in value-based participation, such as the Small, Underserved, and Rural Support initiative, which provides free, customized technical assistance to practices with 15 or fewer physicians. Small practices can contact selected organizations in their state to receive help with choosing quality measures, strategic planning, education and outreach, and health information technology optimization. CMS also includes several reporting flexibilities and rewards, specifically targeting solo and small practices under the Quality Payment Program's Merit-Based Incentive Payment System, most notably by varying submission methods and allowing special scoring consideration. The CMS ACO Investment Model built on the experience with the Advance Payment Model to test the use of pre-paid shared savings to encourage new ACOs to form in rural and underserved areas and to encourage current Medicare Shared Savings Program ACOs to transition to arrangements with greater financial risk. It resulted in more physicians in rural and underserved communities signing on to participate in ACOs. These new ACOs invested in better care coordination, and savings have been attributed to fewer unnecessary acute hospitalizations, fewer emergency department visits, and fewer days in skilled nursing facilities among beneficiaries. The ACO Investment Model generated $381.5 million in net Medicare savings between 2016 and 2018.[25] In June 2024, CMS will launch the Making Care Primary program to allow practices to build a value-based infrastructure by "improving care management and care coordination, equipping primary care clinicians with tools to form partnerships with health care specialists, and leveraging community-based connections to address patients' health needs as well as their health-related social needs such as housing and nutrition." The program will offer three progressive tracks to recognize participants' varying experience in value-based care, including one reserved for practices with no prior value-based care experience.

There has been a recent emergence of payer-sponsored arrangements, such as the one sponsored by Acuitas Health. It is a partnership between a nonprofit health plan and a large multispecialty group that offers a range of services to small practices, including billing and coding assistance, practice transformation consulting, and patient aggregation, thereby allowing practices to achieve the scale needed for value-based contracts. Through its work with Acuitas, the NYC Population Health Improvement Program was able to "answer important questions about what skills small practices need in order to succeed in the new environment and how small practices might work together to share the services necessary to develop those skills…(as well as) break new ground by presenting a financial model for the cost of shared services and probing the legal and regulatory issues raised by such arrangements."[26] Other private companies have created shared service infrastructures to allow small, independent practices to participate in APMs, offering low-cost shared resources in return for a portion of downstream savings.

RESOURCES FOR SMALL PRACTICES

Regardless of the payment rates, small practices can increase profit margins if they are able to keep their costs down. Group purchasing organizations (GPOs) and physician buying groups (PBGs) can offer independent practices a chance to access lower costs by using the power of many practices to benefit all. Some GPOs do not require purchases from a given supplier yet still offer leverage with other suppliers to grant small practices reduced rates. As most community-based practices offer vaccines, PBGs can play an important role in keeping costs down. Vaccines are one of the most costly and important investments a practice makes, and PBGs can offer practices lower contract pricing and rebates from the vaccine manufacturer. Practices can save five to 25 percent on the cost

of supplies by joining a GPO or PBG, most of which have no fee and often allow practices to join several organizations.[27]

Small practices typically sign "evergreen" contracts with payers, which continuously renew automatically until one party terminates the agreement. A payment schedule is part of the contract and will not be updated unless one party opens the contract for negotiation. In most cases, this must be the practice since it is not usually in the payer's best financial interest to negotiate a new contract. As such, practices need to be prepared to contact the payer multiple times in order to actually get a contract negotiated – and then come to the table with as much data and population health metrics (e.g., A1C numbers for patients with diabetes) as possible. A practice able to successfully manage complex patients will have costs within a relatively narrow range without many outliers, thereby increasing negotiating leverage. Small practices can also gain a negotiating advantage if they have extended office hours, are considered the "only show in town," provide specialized care for an underserved patient population, have obtained quality accreditation recognition (e.g., National Committee for Quality Assurance), or can share positive patient testimonials.

The AMA has several resources dedicated to support physicians in private practice, such as the AMA Private Practice Simple Solutions series, which are "free, open access rapid learning cycles designed to provide opportunities to implement actionable changes that can immediately increase efficiency in private practices." Session topics range from marketing to recruitment to reducing administrative burden. The AMA Practice Management Center developed the Evaluating and Negotiating Emerging Payment Options manual to assist members who are considering transitioning to risk-based payment, while the AMA Value Based Care Toolkit is being updated for 2023 to provide a step-by-step guide to designing, adopting, and optimizing the value-based care model. The 2016 adoption of AMA Policy D-160.926, which calls for the development of a guide to provide information to physicians in or considering solo and small practice on how they can align through Independent Practice Associations, Accountable Care Organizations, Physician Hospital Organizations, and other models to help them with the imminent movement to risk-based contracting and value-based care, resulted in the development of the Joining or Aligning with a Physician-Led Integrated Health System guide, which was updated in June 2020. The AMA also offers a Private Practice Group Membership Program to drive sustainability and accelerate innovation for members in private practice, as well as a Voluntary Best Practices to Advance Data Sharing Playbook to address the future of sustainable value-based payment.

AMA POLICY

The AMA's longstanding goal to promote the sustainability of solo, small, and primary care practices is reflected in numerous AMA policies, including those that:

- Call for the development of a guide to provide information to physicians in or considering solo and small practice on how they can align through IPAs, ACOs, Physician Hospital Organizations, and other models to help them with the imminent movement to risk-based contracting and value-based care (Policy D-160.926);
- Advocate in Congress to ensure adequate payment for services rendered by private practicing physicians, create and maintain a reference document establishing principles for entering into and sustaining a private practice, and issue a report in collaboration with the Private Practice Physicians Section at least every two years communicating efforts to support independent medical practices (Policy D-405.988);
- Support development of administrative mechanisms to assist primary care physicians in the logistics of their practices to help ensure professional satisfaction and practice

sustainability, support increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, and advocate for public and private payers to develop physician payment systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes (Policy H-200.949);

- Reinforce the freedom of physicians to choose their method of earning a living and 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 (Policy H-385.926);
- Support insurance payment rates that are established through meaningful negotiations and contracts (Policy H-165.838);
- Call for a formal, legal review of ongoing grievous behaviors of the health insurance industry (Policy D-385.949);
- Advocate for payment rates that are sufficient to cover the full cost of sustainable medical practice, continue to monitor health care delivery and physician payment reform activities, and provide resources to help physicians understand and participate in payment reform initiatives (Policy H-390.849); and
- Seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs to ensure payment rates cover the full cost of sustainable medical practice (D-390.946).

The AMA has policy that addresses the challenges presented by the evolving value-based health care system, such as those that:

- Provide guidance and support infrastructure that allows independent physicians to join with other physicians in clinically integrated networks independent of any hospital system, 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);
- Support a pluralistic approach to third-party payment methodology, promoting flexibility in payment arrangements (Policy H-385.989);
- Reaffirm the AMA's support for a neutral public policy and fair market competition among alternative health care delivery and financing systems (Policy H-385.990); and
- Emphasize the AMA's dedication to seeking payment reform, supporting independent physicians in joining clinically integrated networks, and refining relative values for services based on valid and reliable data (Policy H-400.972).

AMA policy does not endorse a specific payment mechanism such as the MPPS RBRVS, but instead, states that use of RBRVS relative values is one option that could provide the basis for both public and private physician payment systems. Among the most relevant policies are those that:

- Oppose any type of national mandatory fee schedule (Policy H-385.986);
- Seek legislation and/or regulation to prevent insurance companies from utilizing a physician payment schedule below the updated Medicare professional fee schedule (Policy D-400.990);
- Advocate that annually updated and rigorously validated RBRVS relative values could provide a basis for non-Medicare physician payment schedules, ensure that any potential non-Medicare use of an RBRVS reflects the most current and accurate data and implementation methods, and identify the extent to which third party payers and other

public programs modify, adopt, and implement Medicare RBRVS payment policies (Policy D-400.999);

- Support a pluralistic approach to third-party payment methodology under fee-for-service, and do not support a preference for usual and customary or reasonable or any other specific payment methodology (Policy H-385.989); and
- Reinforce that there is no relationship between the Medicare fee schedule and Usual, Customary, and Reasonable Fees (Policy H-385.923).

Finally, AMA policies establish a minimum physician payment of 100 percent of the RBRVS Medicare allowable for the Children's Health Insurance Program and Medicaid (Policy H-290.976) as well as for TRICARE and any other publicly funded insurance plan (Policy H-385.921).

DISCUSSION

Research has found that small community practices are able to deliver more personalized patient care and have lower rates of preventable hospital admissions. They are able to detect potential conditions before they result in hospital admissions and accordingly play a vital role in keeping patients healthier. However, small community practices may be challenged in implementing the support systems needed for participation in population health management and value-based purchasing arrangements. Small physician-owned practices are typically not eligible to collect facility fees or utilize various addresses or facility types to generate higher billing for similar procedures depending on contracts and incentives, thereby creating a revenue differential with larger practices. There are resources available to help small practices succeed, most notably in underserved markets where average private professional service payments tend to be higher than those in more competitive physician markets.[28]

Resolution 108-A-23 presumes that small practices experience private insurance payment rates well below Medicare payment rates. However, research shows that private insurance payment rates are, on average, higher than Medicare payment rates for the same health care services.[29] While there are limitations in the available data due to inclusion of larger practices and hospital-employed physicians, variability in private insurance payment schedules means that most small practices accept multiple different payment schedules from different payers, making it difficult for them to respond to questions about payment rates with accuracy. Accordingly, a physician survey is not likely to illuminate payment variations in small practices between private insurance and Medicare payment rates.

AMA policy does not endorse a specific payment mechanism such as the MPPS RBRVS and opposes any type of mandatory payment schedule. However, it does support the use of RBRVS relative values as one option that could provide the basis for both public and private physician payment systems – independent of Medicare's conversion factor and inappropriate payment policies. Amending existing Policies H-290.976 and H-385.921, including revising their titles, will corroborate consistency across all payer types.

The Council believes that current policy supporting the RVU methodology as one option in a pluralistic payment system, remains the best position for the AMA. An RBRVS that is annually updated and rigorously validated could be a basis for non-Medicare physician payment schedules. It is important to reiterate that this policy pertains to the RBRVS relative values only. It does not apply to Medicare's conversion factor, balance billing limits, geographical practice cost indices, and inappropriate payment policies.

In addition to recognizing appropriate payment policies, the Council believes it is imperative that private payers update their payment schedule on an annual basis to reflect coding changes and revisions to relative values. Each year, new services are assigned relative values and existing codes receive revised relative values. Therefore, payers must continually update their fee schedule, so physicians are paid according to the most recent relative values and payment policies.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 108-A-23, and the remainder of the report be filed:

1. That our American Medical Association (AMA) amend Policy H-290.976[2] by addition and deletion, and modify the title by deletion, as follows:

Enhanced ~~SCHIP~~ Enrollment, Outreach, and ~~Reimbursement~~ Payment H-290.976

1. It is the policy of our AMA that prior to or concomitant with states' expansion of State Children's Health Insurance Programs (SCHIP) to adult coverage, our AMA urge all states to maximize their efforts at outreach and enrollment of SCHIP eligible children, using all available state and federal funds.

2. Our AMA affirms its commitment to advocating for reasonable SCHIP, ~~and~~ Medicaid, and private insurance payment ~~reimbursement~~ for its medical providers, defined as at minimum 100 percent of RBRVS Medicare allowable. (Modify Current HOD Policy)

2. That our AMA amend Policy H-385.921 by addition and deletion, and modify the title by deletion, as follows:

Health Care Access ~~for Medicaid Patients~~ H-385.921

It is AMA policy that to increase and maintain access to health care for all, payment for physician providers for Medicaid, TRICARE, ~~and~~ any other publicly funded insurance plan, and private insurance must be at minimum 100 percent of the RBRVS Medicare allowable. (Modify Current HOD Policy)

3. That our AMA reaffirm Policy D-400.990, which seeks legislation and/or regulation to prevent insurance companies from utilizing a physician payment schedule below the updated Medicare professional fee schedule. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-385.986, which opposes any type of national mandatory fee schedule. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-200.949, which supports development of administrative mechanisms to assist primary care physicians in the logistics of their practices to help ensure professional satisfaction and practice sustainability, support increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, and advocate for public and private payers to develop physician payment systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy D-405.988, which calls for advocacy in Congress to ensure adequate payment for services rendered by private practicing physicians, creating and maintaining a reference document establishing principles for entering into and sustaining a

private practice, and issuing a report in collaboration with the Private Practice Physicians Section at least every two years to communicate efforts to support independent medical practices. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] Kane, Carol, American Medical Association Policy Research Perspectives, "Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022;" Available at: https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf
[2] Simply Psychology, "What Is A Cohort Effect? Definitions and Examples;" Available at: https://www.simplypsychology.org/cohort-effect-definition.html
[3] Dorsey ER, Jarjoura D, Rutecki GW. The influence of controllable lifestyle and sex on the specialty choices of graduating U.S. medical students, 1996-2003. Acad Med. 2005 Sep;80(9):791-6. doi: 10.1097/00001888-200509000-00002. PMID: 16123455. Available at: https://pubmed.ncbi.nlm.nih.gov/16123455/
[4] Lin KY. Physicians' perceptions of autonomy across practice types: Is autonomy in solo practice a myth? Soc Sci Med. 2014 Jan;100:21-9. doi: 10.1016/j.socscimed.2013.10.033. Epub 2013 Nov 5. PMID: 24444835; PMCID: PMC3898537. Available at: https://pubmed.ncbi.nlm.nih.gov/24444835/
[5] Casalino LP, Pesko MF, Ryan AM, Mendelsohn JL, Copeland KR, Ramsay PP, Sun X, Rittenhouse DR, Shortell SM. Small primary care physician practices have low rates of preventable hospital admissions. Health Aff (Millwood). 2014 Sep;33(9):1680-8. doi: 10.1377/hlthaff.2014.0434. Epub 2014 Aug 13. PMID: 25122562. Available at: https://pubmed.ncbi.nlm.nih.gov/25122562/
[6] Piette JD, Heisler M, Krein S, Kerr EA. The role of patient-physician trust in moderating medication nonadherence due to cost pressures. Arch Intern Med. 2005;165(15):1749–1755. Available at: https://pubmed.ncbi.nlm.nih.gov/16087823/
[7] Hostetter M, Klein S. The Commonwealth Fund Case Study, "How Independent Primary Care Clinicians Leverage Trust to Help Vulnerable Populations;" September 2020. Available at: https://www.commonwealthfund.org/publications/case-study/2020/sep/how-independent-primary-care-clinicians-leverage-trust-help
[8] United States, Department of Labor, "Fact Sheet #17D: Exemption for Professional Employees Under the Fair Labor Standards Act (FLSA);" Available at: https://www.dol.gov/agencies/whd/fact-sheets/17d-overtime-professional
[9] American Medical Association, "AMA/Specialty Society RVS Update Committee: An Overview of the RUC Process," 2023. Available at: https://amatoday.sharepoint.com/sites/teamwork/RUC/doc/ruc-update-booklet.pdf?csf=1&e=jvcBH9&cid=63350f70-c0a0-4e39-adfb-5715cde71f57
[10] American Academy of Pediatrics, "2022 RBRVS: What Is It And How Does It Affect Pediatrics," 2022. Available at: https://downloads.aap.org/AAP/PDF/2022%20RBRVS.pdf
[11] McMorrow, S, et al., The Urban Institute, "Commercial Health Insurance Markups over Medicare Prices for Physician Services Vary Widely by Specialty," October 2021. Available at: https://www.urban.org/sites/default/files/publication/104945/commercial-health-insurance-markups-over-medicare-prices-for-physician-services-vary-widely-by-specialty.pdf
[12] Robert Graham Center, "Primary Care in the United States: A Chartbook of Facts and Statistics," February 2021. Available at: https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/PrimaryCareChartbook2021.pdf
[13] Kane, Carol, American Medical Association Policy Research Perspectives, "Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022;" Available at: https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf
[14] Johnson, B, et al., Health Care Cost Institute, "Comparing Commercial and Medicare Professional Service Prices," August 2020. Available at: https://healthcostinstitute.org/all-hcci-reports/comparing-commercial-and-medicare-professional-service-prices
[15] Lopez, E, et al., Kaiser Family Foundation, "How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature;" Available at: https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/

[16] McBeth, A, et al., Milliman white paper, "Commercial Reimbursement Benchmarking," November 2022. Available at: https://www.milliman.com/en/insight/commercial-reimbursement-benchmarking#2
[17] Congressional Budget Office, "The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services," January 2022. Available at: https://www.cbo.gov/system/files/2022-01/57422-medical-prices.pdf
[18] Office of Inspector General, "Comparing Medicare Physician Payments to Private Payers," January 2003. Available at: https://oig.hhs.gov/oei/reports/oei-06-00-00570.pdf
[19] Johnson, B, et al., Health Care Cost Institute, "Comparing Commercial and Medicare Professional Service Prices," August 2020. Available at: https://healthcostinstitute.org/all-hcci-reports/comparing-commercial-and-medicare-professional-service-prices
[20] Rama, Apoorva, American Medical Association, 2022 AMA Physician Practice Benchmark Survey, July 2023. Available at: https://www.ama-assn.org/about/research/physician-practice-benchmark-survey#:~:text=2022%20Benchmark%20Survey,-Recent%20Changes%20in&text=There%20has%20been%20a%20redistribution,from%2012.2%25%20to%2018.3%25
[21] Muhlestein DB, Smith NJ. Physician Consolidation: Rapid Movement From Small To Large Group Practices, Health Affairs, September 2016. Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0130
[22] Coakley, Martha, Office of the Massachusetts Attorney General, Examination of Health Care Cost Trends and Cost Drivers, June 2011. Available at: https://www.mass.gov/doc/2011-examination-of-health-care-cost-trends-and-cost-drivers-with-appendix/download
[23] Liaw WR, Jetty A, Petterson SM, Peterson LE, Bazemore AW. Solo and Small Practices: A Vital, Diverse Part of Primary Care. Ann Fam Med. 2016 Jan-Feb;14(1):8-15. doi: 10.1370/afm.1839. PMID: 26755778; PMCID: PMC4709150. Available at: https://pubmed.ncbi.nlm.nih.gov/26755778/
[24] Gibbons, JB, et al., The American Journal of Managed Care, "Small Practice Participation and Performance in Medicare Accountable Care Organizations," Vol 8, Issue 3, March 2022; Available at: https://www.ajmc.com/view/small-practice-participation-and-performance-in-medicare-accountable-care-organizations
[25] Jacobs, D, et al, New England Journal of Medicine, "Expanding Accountable Care's Reach among Medicare Beneficiaries," July 14, 2022. Available at: https://www.nejm.org/doi/full/10.1056/NEJMp2202991
[26] New York City Health Department, "The PHIP Small Practice Project Final Report," June 2018. Available at: https://www.nyc.gov/assets/doh/downloads/pdf/public/phip-report2018.pdf
[27] Kaplan, DA, Medical Economics Journal, "Group purchasing: Save money by aligning with other physicians," Vol 95, Issue 21, November 2018; Available at: https://www.medicaleconomics.com/view/group-purchasing-save-money-aligning-other-physicians
[28] Baker LC, Bundorf MK, Royalty AB, Levin Z. Physician Practice Competition and Prices Paid by Private Insurers for Office Visits. JAMA. 2014;312(16):1653–1662. doi:10.1001/jama.2014.10921. Available at: https://jamanetwork.com/journals/jama/fullarticle/1917436
[29] Lopez, E, et al., Kaiser Family Foundation, "How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature;" Available at: https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 801
(I-23)

Introduced by: Medical Student Section

Subject: Improving Pharmaceutical Access and Affordability

Referred to: Reference Committee J

Whereas, the US spends nearly $600 billion on pharmaceuticals annually, with prices rising at an average of 10% and some exceeding 500%, doubling the increases seen in comparable countries after adjusting for rebates and discounts[1-2]; and

Whereas, over 3 million Americans use biologics, which comprise 40% of US drug spending with annual costs of $10,000 to $40,000 per patient and in some cases, $500,000[3-7]; and

Whereas, medication cost is a major barrier for 13 million Americans and often leads patients using biologics to switch to less expensive alternative treatments[7-12]; and

Whereas, the lack of biosimilar penetration in US markets due to preferential patent exclusivity for originator biologics further exacerbates the problem of medication costs[13-14]; and

Whereas, direct member reimbursement policies in some private insurance plans require patients to pay full medication costs out-of-pocket upfront and then submit a claim for reimbursement later, with biologics often requiring initial payments over $20,000[15-19;] and

Whereas, patients with direct member reimbursement plans are considered to have comprehensive coverage for medication costs due to eventual reimbursement and are ineligible for many patient assistance and discount programs for initial out-of-pocket payments[20-23]; and

Whereas, patient assistance programs often have yearly maximums and still exclude patients on publicly funded insurance[20-23]; therefore be it

RESOLVED, that our American Medical Association supports lowering out-of-pocket maximums in insurance plans including but not limited to ERISA plans, other forms of employer-sponsored insurance, plans offered on the ACA marketplace, TRICARE, and any other public or private payers (New HOD Policy); and be it further

RESOLVED, that our AMA oppose Direct Member Reimbursement plans, where patients pay the full retail costs of a prescription drug that they may then be reimbursed for, due to their potential to expose patients to significant out-of-pocket costs. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 09/11/2023

REFERENCES

1. Tichy EM, Hoffman JM, Suda KJ, et al. National trends in prescription drug expenditures and projections for 2022. Am J Health Syst Pharm. 2022;79(14):1158-1172. doi:10.1093/ajhp/zxac102
2. Bosworth A. Price increases for prescription drugs, 2016-2022. ASPE. https://aspe.hhs.gov/reports/prescription-drug-price-increases#:~:text=There%20were%201%2C216%20products%20whose,more%20than%20%2420%2C000%20or%20500%25. Published September 30, 2022. Accessed March 8, 2023.
3. Zhai M, Sarpatwari A, Kesselheim, AS. Why Are Biosimilars Not Living Up to Their Promise in the US? AMA J Ethics. 2019;21(8):E668-678. doi: 10.1001/amajethics.2019.668
4. Keller GS, Park AM. Introduction: An Overview. Facial Plast Surg Clin North Am. 2018;26(4):403-405. doi:10.1016/j.fsc.2018.06.001
5. Keller GS, Park AM. Introduction: An Overview. Facial Plast Surg Clin North Am. 2018;26(4):403-405. doi:10.1016/j.fsc.2018.06.001
6. Chen BK, Yang YT, Bennett CL. Why Biologics and Biosimilars Remain So Expensive: Despite Two Wins for Biosimilars, the Supreme Court's Recent Rulings do not Solve Fundamental Barriers to Competition. *Drugs*. 2018;78(17):1777-1781. doi:10.1007/s40265-018-1009-0
7. Morgan SG, Lee A. Cost-related non-adherence to prescribed medicines among older adults: a cross-sectional analysis of a survey in 11 developed countries. *BMJ Open*. 2017;7(1):e014287. doi:10.1136/bmjopen-2016-014287
8. Karpman M, Blavin F, McMorrow S, O'Brien C. In the Years before the COVID-19 Pandemic, Nearly 13 Million Adults Delayed or Did Not Get Needed Prescription Drugs because of Costs.; 2021. Accessed April 9, 2023. https://www.urban.org/sites/default/files/publication/105184/millio1.pdf
9. Osborn CY, Kripalani S, Goggins KM, Wallston KA. Financial strain is associated with medication nonadherence and worse self-rated health among cardiovascular patients. J Health Care Poor Underserved. 2017;28(1):499-513. doi:10.1353/hpu.2017.0036
10. Braverman G, Bridges SL, Moreland LW. Tapering biologic dmards in rheumatoid arthritis. Current Opinion in Pharmacology. 2022;67:102308. doi:10.1016/j.coph.2022.102308
11. Silver J, Bogart M, Molfino NA, et al. Factors leading to discontinuation of biologic therapy in patients with severe asthma. *J Asthma*. 2022;59(9):1839-1849. doi:10.1080/02770903.2021.1971700
12. Steve Tsang CC, Browning J, Todor L, Dougherty S, Hohmeier KC, Sam Li M, Borja-Hart N, Hines LE, Wang J. Factors associated with medication nonadherence among Medicare low-income subsidy beneficiaries with diabetes, hypertension, and/or heart failure. J Manag Care Spec Pharm. 2021 Aug;27(8):971-981. doi: 10.18553/jmcp.2021.27.8.971. PMID: 34337985.
13. Cross RK, Stewart AL, Edgerton CC, Shah B, Welz JA, Kay J. Implementation Strategies of Biosimilars in Healthcare Systems: The Path Forward. American Health & Drug Benefits. 2022;15(2):45-53. https://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=157435150&site=eds-live. Accessed April 10, 2023.
14. Socal M, Ballreich J, Chyr L, Anderson G. Biosimilar Medications - Savings Opportunities for Large Employers.; 2020. https://www.eric.org/wp-content/uploads/2020/03/JHU-Savings-Opportunities-for-Large-Employers.pdf Accessed April 8, 2023.
15. Humana. 2023 Direct Member Reimbursement Policy. Published November 10, 2022. https://docushare-web.apps.external.pioneer.humana.com/Marketing/docushare-app?file=3523546. Accessed April 9, 2023.
16. Direct Member Reimbursement (DMR) Frequently Asked Questions. https://www.modahealth.com/pdfs/oebb/oebb_dmr_faq.pdf. Accessed April 9, 2023.
17. Center for Medicaid and Medicare Services. How Medicare Covers Self-Administered Drugs Given in Outpatient Hospital Settings. *Medicare*, https://www.medicare.gov/Pubs/pdf/11333-Outpatient-Self-Administered-Drugs.pdf, Revised June 2020, Accessed August 28, 2022.
18. STELARA® (ustekinumab). STELARA® (ustekinumab). Published May 14, 2019. https://www.stelarainfo.com/crohns-disease/cost-support-and-more. Accessed April 8, 2023.
19. Yazdany J, Dudley RA, Chen R, Lin GA, Tseng CW. Coverage for high-cost specialty drugs for rheumatoid arthritis in Medicare Part D. *Arthritis Rheumatol*. 2015;67(6):1474-1480. doi:10.1002/art.39079
20. Stelara Savings Program. https://www.stelarawithme.com/sites/www.stelarawithme.com/files/stelara-savings-program-overview.pdf. Published May 2022. Accessed April 7, 2023.
21. Janssen Biotech. Stelara® (USTEKINUMAB) cost support. STELARA® (ustekinumab).https://www.janssencarepath.com/patient/stelara/cost-support. Accessed April 7, 2023.
22. Paying for remicade® - Cost Support. Janssen CarePath. https://www.janssencarepath.com/patient/remicade/cost-support. Published August 19, 2022. Accessed August 31, 2022.
23. Find out if you may be eligible. Find Out If You May Be Eligible | Johnson & Johnson Patient Assistance Foundation, Inc. https://www.jjpaf.org/eligibility/. Accessed August 31, 2022.

RELEVANT AMA POLICY

H-110.987 Pharmaceutical Costs

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.

4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation.
[CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21; Reaffirmed in lieu of: Res. 810, I-22]

H-110.998 Cost of New Prescription Drugs
Our AMA urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs. [Res. 112, I-89; Reaffirmed: Res. 520, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed in lieu of Res. 229, I-14]

H-120.975 Certifying Indigent Patients for Pharmaceutical Manufacturers' Free Drug Programs
Our AMA: (1) supports Pharmaceutical Research and Manufacturers of America (PhRMA) programs for indigent patients and the development of a universal application process, eligibility criteria and form for all prescription drug patient-assistance programs to facilitate enrollment of patients and physicians; (2) encourages PhRMA to provide information to physicians and hospital medical staffs about member programs that provide pharmaceuticals to indigent patients; (3) urges drug companies to develop user-friendly and culturally sensitive uniform centralized policies and procedures for certifying indigent patients for free or discounted medications; and (4) opposes the practice of charging patients to apply for or gain access to pharmaceutical assistance programs. [Sub. Res. 105, I-92; Sub. Res. 507, A-96; Appended: Sub. Res. 513, I-97; Reaffirmation I-98; Reaffirmation I-00; Reaffirmation A-01; Amended: Res. 513, A-02; Reaffirmed and Appended: Sub. Res. 705, I-03; Reaffimed and Modified: BOT Rep. 13, A-04; Reaffirmation I-04; Modified: CSAPH Rep. 1, A-14]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 802
(I-23)

Introduced by: Medical Student Section

Subject: Improving Nonprofit Hospital Charity Care Policies

Referred to: Reference Committee J

Whereas, nonprofit hospitals comprise over half of all US hospitals nationwide and receive a total in $28 billion in federal tax exemptions[1-2]; and

Whereas, nonprofit hospitals must fulfill community benefit requirements, including charity care, but they spend half as much on charity care as public and for-profit hospitals[3-5]; and

Whereas, nonprofit hospitals decide their own criteria for charity care eligibility, and only 10 states require that these are communicated to patients[6-8]; and

Whereas, the New York Times reported that a large nonprofit hospital system trained administrative employees to intentionally avoid screening patients for charity care eligibility or provide financial assistance information when asking patients for payment[1]; and

Whereas, in 2019, nonprofit hospitals billed patients who qualified for charity care for nearly $3 billion, and a study found that nonprofits comprised 70% of hospitals suing patients for medical debt, despite the IRS banning “extraordinary collections actions” by nonprofits[9-10]; and

Whereas, although nonprofit hospitals are supposed to widely publicize their charity care policies and notify and screen community members, they charge patients who meet eligibility criteria in over 50% of cases[8-9,11]; and

Whereas, health economists propose that increasing nonprofit hospital transparency by disclosing charity-care-to-expense and -benefit ratios would increase compliance with charity care and community benefit obligations[5]; therefore be it

RESOLVED, that our American Medical Association advocate for legislation and regulations that require nonprofit hospitals to notify and screen all patients for financial assistance according to their own eligibility criteria prior to billing (Directive to Take Action); and be it further

RESOLVED, that our AMA support efforts to establish regulatory standards for nonprofit hospital financial assistance eligibility (New HOD Policy); and be it further

RESOLVED, that our AMA encourages the Centers for Medicare and Medicaid Services (CMS) to publish the charity-care-to-expense ratio and the charity-care-to-benefit ratio for hospitals listed in Medicare Cost Reports to improve transparency and compliance of charitable care and community benefit activities. (New HOD Policy)

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

Received: 09/11/2023

REFERENCES

1. Jessica Silver-Greenberg KT. They Were Entitled to Free Care. Hospitals Hounded Them to Pay. *The New York Times*. Sept. 24, 2022. https://www.nytimes.com/2022/09/24/business/nonprofit-hospitals-poor-patients.html?searchResultPosition=1
2. Jamie Godwin ZL and Scott Hulver. The Estimated Value of Tax Exemption for Nonprofit Hospitals Was About $28 Billion in 2020. *Kaise Family Foundation*. Mar 14 , 2023. https://www.kff.org/health-costs/issue-brief/the-estimated-value-of-tax-exemption-for-nonprofit-hospitals-was-about-28-billion-in-2020/
3. Charitable Hospitals - General Requirements for Tax-Exemption Under Section 501(c)(3). *IRS*. Jul 15, 2022. https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3
4. James J. Nonprofit Hospitals' Community Benefit Requirements. *Health Affairs*. February 25, 2016; doi:10.1377/hpb20160225.954803
5. Ge Bai HZ, Matthew D. Eisenberg, Daniel Polsky, Gerard F. Anderson. Analysis Suggests Government And Nonprofit Hospitals' Charity Care Is Not Aligned With Their Favorable Tax Treatment *Health Affairs*. April 2021;40(4)https://doi.org/10.1377/hlthaff.2020.01627
6. Andrea Bopp Stark JB. An Ounce of Prevention: A Review of Hospital Financial Assistance Policies in the States. *National Consumer Law Center* November 2021. https://www.nclc.org/wp-content/uploads/2022/09/Rpt_Ounce_of_Prevention.pdf
7. State Community Benefit Requirements and Tax Exemptions for Nonprofit Hospitals. *The Hilltop Institue UMBC*. https://hilltopinstitute.org/our-work/hospital-community-benefit/hcbp-state-comparison/
8. Levey NN. Hundreds of Hospitals Sue Patients or Threaten Their Credit, a KHN Investigation Finds. Does Yours? *Kaiser Health News*. December 21, 2022.
9. Rau J. Patients Eligible For Charity Care Instead Get Big Bills. *Kaiser Health News*. October 14, 2019. https://khn.org/news/patients-eligible-for-charity-care-instead-get-big-bills/
10. Giuseppe RJ, Paturzo FH, Chen Dun, et al. Trends in Hospital Lawsuits Filed Against Patients for Unpaid Bills Following Published Research About This Activity. *JAMA Netw Open*. 2021;4(8). doi:doi:10.1001/jamanetworkopen.2021.21926
11. Financial Assistance Policy and Emergency Medical Care Policy – Section 501(r)(4). *IRS*. Jul 15, 2022. https://www.irs.gov/charities-non-profits/financial-assistance-policy-and-emergency-medical-care-policy-section-501r4

RELEVANT AMA POLICY

H-160.923 Offsetting the Costs of Providing Uncompensated Care

Our AMA: (1) supports the transitional redistribution of disproportionate share hospital (DSH) payments for use in subsidizing private health insurance coverage for the uninsured;(2) supports the use of innovative federal- or state-based projects that are not budget neutral for the purpose of supporting physicians that treat large numbers of uninsured patients, as well as EMTALA-directed care; and (3) encourages public and private sector researchers to utilize data collection methodologies that accurately reflect the amount of uncompensated care (including both bad debt and charity care) provided by physicians. [CMS Rep. 8, A-05; Reaffirmation A-07; Modified: CMS Rep. 01, A-17]

H-155.958 Appropriate Hospital Charges

Our AMA encourages hospitals to adopt, implement, monitor and publicize policies on patient discounts, charity care, and fair billing and collection practices, and make access to those programs readily available to eligible patients. [CMS Rep. 4, A-09; Reaffirmed in lieu of: Res. 213, I-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 803
(I-23)

Introduced by: Medical Student Section

Subject: Improving Medicaid and CHIP Access and Affordability

Referred to: Reference Committee J

Whereas, states may implement premiums and cost-sharing, including copays, coinsurance, deductibles, and other charges, for Medicaid and CHIP patients, which limits enrollment efforts, removes coverage from patients who cannot afford costs, and raises rates of uninsured patients, uncompensated care, and expensive emergency care[1-5]; and

Whereas, 8 states use CMS Section 1115 waivers to charge Medicaid premiums, 26 states charge CHIP premiums, and 21 states use other cost-sharing in CHIP[6-7]; and

Whereas, the RAND Health Insurance Experiment found that increased cost-sharing reduces use of both necessary and unnecessary services at similar rates and worsens health for patients from the most low-income households and patients with the most severe illness[8]; and

Whereas, in Indiana, 13,600 patients lost Medicaid, 46,200 patients lost eligibility, and 289,000 patients were restricted benefits due to inability to pay in 2015 and 2016[6,9-11;] and

Whereas, in Arkansas, only 14% of Medicaid patients paid at least one premium in 2015, and in Michigan, only 47% of those owing premiums paid at least one from 2014 to 2021[12–13]; and

Whereas, in Indiana and Wisconsin, inability to pay locks patients out of Medicaid for 6 months, while in Montana patients are locked out until all premium debt is paid[6]; and

Whereas, in Wisconsin, even an increase of up to $10 in monthly Medicaid premiums resulted in a 12% decrease in probability of remaining enrolled[14]; and

Whereas, in Alabama, CHIP premium and copay increases decreased renewal by 8%, especially among Black children, low-income children, and children with chronic illness[15]; and

Whereas, Medicaid copays affect preventive and chronic care, reducing vaccination rates and increasing rates of uncontrolled hypertension[16-17]; and

Whereas, state collections from premiums and cost-sharing are extremely limited and do not significantly finance care, comprising less than 0.02% of Michigan's Medicaid budget[6,13]; and

Whereas, state premiums and cost-sharing may even increase administrative costs, with Arkansas premiums increasing costs by nearly 30% compared to standard Medicaid[12]; and

Whereas, with the end of the COVID public health emergency, states that previously could not disenroll patients from Medicaid due to unaffordable costs may now reimpose those measures, leading to even greater expected coverage losses[1]; therefore be it

RESOLVED, that our American Medical Association oppose premiums, copayments, and other cost-sharing methods for Medicaid and the Children's Health Insurance Program, including Section 1115 waiver applications that would allow states to charge premiums or copayments to Medicaid beneficiaries (New HOD Policy); and be it further

RESOLVED, that our AMA amend policy H-290.982 "Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured" by deletion as follows;

> Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982
> AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients;
> (2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.
> (3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;
> (4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs;
> (5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;
> (6) urges states to administer their Medicaid and SCHIP programs through a single state agency;
> (7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs;
> (8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health

insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children;

(9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services;

(~~10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals;~~ (Modify Current HOD Policy)

and be it further

RESOLVED, that our AMA encourage the Centers for Medicare & Medicaid Services to amend existing Section 1115 waivers to disallow states the ability to charge premiums to Medicaid beneficiaries. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 09/19/2023

REFERENCES

1. Samantha Artiga PU, Julia Zur. The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings. *Kaiser Family Foundation* Jun 01, 2017. https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings
2. Cost Sharing. *Medicaidgov*. https://www.medicaid.gov/medicaid/cost-sharing/index.html
3. Genevieve Kenney JH, Fredric Blavin. Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003. *Inquiry* 2003;43(Winter 2006/2007):345-361.
4. Stephen Zuckerman DMM, Emily Shelton Pape. Missouri's 2005 Medicaid Cuts: How Did They Affect Enrollees And Providers? *Health Affairs*. 2009;28doi:https://doi.org/10.1377/hlthaff.28.2.w335
5. Subramanian S. Impact of Medicaid copayments on patients with cancer: lessons for Medicaid expansion under health reform. *Med Care*. 2011;49(9):842-7. doi:doi: 10.1097/MLR.0b013e31821b34db
6. Madeline Guth MA, Elizabeth Hinton. Understanding the Impact of Medicaid Premiums & Cost-Sharing: Updated Evidence from the Literature and Section 1115 Waivers. *Kaiser Family Foundation*. Sep 09, 2021. https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers
7. Premiums, Enrollment Fees, and Cost-Sharing Requirements for Children. *Kaiser Family Foundation*. 2020. https://www.kff.org/medicaid/state-indicator/premiums-enrollment-fees-and-cost-sharing-requirements-for-children/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
8. 40 Years of the RAND Health Insurance Experiment. *RAND Corporation*. https://www.rand.org/health-care/projects/HIE-40.html
9. Federal Evaluation of Montana Health and Economic Livelihood Partnership (HELP): Draft Interim Evaluation Report. *Social & Scientific Systems*. July 22, 2019. https://www.medicaid.gov/medicaid/downloads/mt-fed-eval-draft-interim-eval-rpt.pdf
10. Iowa Wellness Plan. *Medicaidgov*. https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81706
11. Robin Rudowitz MBM, Elizabeth Hinton. Digging Into the Data: What Can We Learn from the State Evaluation of Healthy Indiana (HIP 2.0) Premiums. *Kaiser Family Foundation*. Mar 08, 2018. https://www.kff.org/medicaid/issue-brief/digging-into-the-data-what-can-we-learn-from-the-state-evaluation-of-healthy-indiana-hip-2-0-premiums
12. Arkansas Health Care Independent Program ('Private Option') Section 1115 Demonstration Waiver Final Report *Arkansas Center for Health Improvement* June 30, 2018. https://humanservices.arkansas.gov/wp-content/uploads/Final-Report-with-Appendices.pdf
13. MI Health Account Executive Summary Report. *Maximus* August 2022. https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder2/Folder83/Folder1/Folder183/MIHA_Monthly_Exec_Summary_Report.pdf?rev=cb3e2e9645ee41e6a7ca3f53947fa557
14. Dague L. The effect of Medicaid premiums on enrollment: a regression discontinuity approach. *J Health Econ*. May 17, 2014;(37):1-12. doi:10.1016/j.jhealeco.2014.05.001
15. Michael A. Morrisey JB, Bisakha Sen, David Becker, Meredith L. Kilgore, Cathy Caldwell, Nir Menachemi. The Effects of Premium Changes on ALL Kids, Alabama's CHIP Program. *Medicare Medicaid Res Rev*. 2012;2(3)doi:10.5600/mmrr.002.03.a01

16. Deliana Kostova JF. Chronic Health Outcomes and Prescription Drug Copayments in Medicaid. *Med Care*. May 2017;55(5):520-527. doi:10.1097/MLR.0000000000000700
17. Charles Stoecker AMS, Megan C. Lindley. The Cost of Cost-Sharing: The Impact of Medicaid Benefit Design on Influenza Vaccination Uptake. *Vaccines (Basel)*. Mar 6 2017;5(1):8. doi:10.3390/vaccines5010008

RELEVANT AMA POLICY

D-290.979 Medicaid Expansion
1. 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% (138% 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.
2. Our AMA will: (a) continue to advocate strongly for expansion of the Medicaid program to all states and reaffirm existing policies D-290.979, H 290.965 and H-165.823; and (b) work with interested state medical associations and national medical specialty societies to provide AMA resources on Medicaid expansion and covering the uninsured to health care professionals to inform the public of the importance of expanded health insurance coverage to all. [Res. 809, I-12; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: CMS Rep. 9, A-21; Reaffirmed: CMS Rep. 3, I-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21; Appended: Res. 122, A-22]

H-290.965 Affordable Care Act Medicaid Expansion
1. Our AMA encourages state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.
2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.
3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries.
4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents.
5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.
6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs.
7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care.
8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.
9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS.
10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.
11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.
12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches.
13. Our AMA supports the use of emergency department (ED) best practices that are evidenced-based to reduce avoidable ED visits.
[CMS Rep. 02, A-16; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 807, I-18; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 3, I-21; Reaffirmed: Res. 122, A-22]

H-290.960 Oppose Medicaid Eligibility Lockout
Our AMA will oppose ‘lock-out’ provisions that exclude Medicaid eligible persons for lengthy periods, and support provisions that permit them to reapply immediately for redetermination. [Res. 103, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 804
(I-23)

Introduced by: AMDA – The Society for Post-Acute and Long-Term Care Medicine

Subject: Required Clinical Qualifications in Determining Medical Diagnoses and Medical Necessity

Referred to: Reference Committee J

Whereas, governmental regulatory bodies and commercial payors audit and survey the clinical practice of medicine routinely and regularly to authorize payments made for medical care and services provided to patients in all care settings, including verifying and validating the accuracy of medical diagnoses made and used in determining medical necessity of such care and services, under the nomenclature of Utilization Management (UM), Medicare/Medicaid audits and regulatory surveys; and

Whereas, the survey and audit teams determining the accuracy of medical diagnoses and medical necessity are often clinicians who are not licensed, trained or qualified in making such diagnoses or determining medical necessity - which are the prerogative and privilege of trained and licensed Physicians, Nurse Practitioners, Physician Assistants and Clinical Psychologists; and

Whereas, the use of clinicians who are not trained, licensed and qualified to diagnose medical conditions or determine medical necessity in UM, audit and survey processes creates unnecessary hurdles to safe, timely, and equitable practice of clinical medicine and can create unnecessary additional physician work and contribute to burnout of healthcare professionals; therefore be it

RESOLVED, that our American Medical Association advocate for a change to existing public and private processes including Utilization Management, Prior Authorization, Medicare and Medicaid audits, Medicare and State Public Health surveys of clinical care settings, to only allow clinicians with adequate and commensurate training, scope of practice, and licensure to determine accuracy of medical diagnoses and assess medical necessity. (Directive to Take Action)

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

Received: 9/26/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 805
(I-23)

Introduced by: Michigan

Subject: Medication Reconciliation Education

Referred to: Reference Committee J

Whereas, increasingly medical documentation is housed in electronic health records (EHR); and

Whereas, the lack of interoperability between dissimilar EHRs remains problematic related to the sharing of information throughout the continuum of care; and

Whereas, skilled nursing facilities (SNF) and other patient care settings and primary providers in these facilities often do not have access to the same EHR as acute care facilities, primary care physicians, and specialty physicians within their geographic domain; and

Whereas, many older patients have complex care needs that may result in transitions for care with documentation for their health care in multiple care settings with dissimilar EHRs; and

Whereas, the medication list within one EHR may not be accurate in any care setting due to these transitions and dissimilar EHRs; and

Whereas, the “source of truth” for the medication list may be fragmented and difficult to determine, especially if the patient has a degree of cognitive impairment; and

Whereas, medication errors have been shown to result in severe illness, hospitalization, and death for 1.5 million patients annually in the United States with an estimated cost of $77 billion (with the majority of health care dollars spent on patients over the age of 65; and

Whereas, careful medication reconciliation utilizing all relevant EHR resources and patient input in each care setting and at each visit is imperative to ascertain and maintain accuracy of the medication list; and

Whereas, many physicians rely on other health care professionals, such as licensed pharmacists, to perform medication reconciliation, although thorough reconciliation including diagnostic indications for each medication and consideration of overlapping side effects may exceed their scope of practice; therefore be it

RESOLVED, that our American Medical Association work with Centers for Medicare and Medicaid Services and other appropriate organizations to study current medication-reconciliation practices across transitions of care with dissimilar electronic health records to evaluate the impact on patient safety and quality of care, and to determine the potential need for additional training to reduce medical errors and ensure patient safety and quality of care (Directive to Take Action); and be it further

RESOLVED, that our American Medical Association work with other appropriate organizations to determine whether education for physicians-in-training is sufficient to attain the medication

reconciliation core competencies necessary to reduce medical errors and ensure patient safety and quality of care and provide recommendations for action as applicable. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 9/26/23

REFERENCES
1. Hughes RB, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr, Chapter 38: Medication Reconciliation, p. 7.
2. Institute of Medicine, Committee on Identifying and Preventing Medication Errors, Preventing Medication Errors. National Academies Press; 2007:124-25.
3. Grissinger MC, et al. "The Role of Managed Care Pharmacy in Reducing Medication Errors." Journal of Managed Care Pharmacy 9, no. 1 (2003):62-65.

RELEVANT AMA POLICY

Pharmacy Review of First Dose Medication D-120.965
1. Our AMA supports medication reconciliation as a means to improve patient safety.
2. It is AMA policy that (a) systems be established to support physicians in medication reconciliation, and (b) medication reconciliation requirements should be at a level appropriate for a particular episode of care and setting. [BOT Action in response to referred for decision Res. 808, I-06; Reaffirmation A-10; Reaffirmation A-15]

Hospital Discharge Communications H-160.902
1. Our AMA encourages the initiation of the discharge planning process, whenever possible, at the time patients are admitted for inpatient or observation services and, for surgical patients, prior to hospitalization.
2. Our AMA encourages the development of discharge summaries that are presented to physicians in a meaningful format that prominently highlight salient patient information, such as the discharging physician's narrative and recommendations for ongoing care.
3. Our AMA encourages hospital engagement of patients and their families/caregivers in the discharge process, using the following guidelines:
    a. Information from patients and families/caregivers is solicited during discharge planning, so that discharge plans are tailored to each patient's needs, goals of care and treatment preferences.
    b. Patient language proficiency, literacy levels, cognitive abilities and communication impairments (e.g., hearing loss) are assessed during discharge planning. Particular attention is paid to the abilities and limitations of patients and their families/caregivers.
    c. Specific discharge instructions are provided to patients and families or others responsible for providing continuing care both verbally and in writing. Instructions are provided to patients in layman's terms, and whenever possible, using the patient's preferred language.
    d. Key discharge instructions are highlighted for patients to maximize compliance with the most critical orders.
    e. Understanding of discharge instructions and post-discharge care, including warning signs and symptoms to look for and when to seek follow-up care, is confirmed with patients and their families/caregiver(s) prior to discharge from the hospital.
4. Our AMA supports making hospital discharge instructions available to patients in both printed and electronic form, and specifically via online portals accessible to patients and their designated caregivers.
5. Our AMA supports implementation of medication reconciliation as part of the hospital discharge process. The following strategies are suggested to optimize medication reconciliation and help ensure that patients take medications correctly after they are discharged:
    a. All discharge medications, including prescribed and over-the-counter medications, should be reconciled with medications taken pre-hospitalization.

b. An accurate list of medications, including those to be discontinued as well as medications to be taken after hospital discharge, and the dosage and duration of each drug, should be communicated to patients.
c. Medication instructions should be communicated to patients and their families/caregivers verbally and in writing.
d. For patients with complex medication schedules, the involvement of physician-led multidisciplinary teams in medication reconciliation including, where feasible, pharmacists should be encouraged.

6. Our AMA encourages patient follow-up in the early time period after discharge as part of the hospital discharge process, particularly for medically complex patients who are at high-risk of re-hospitalization.
7. Our AMA encourages hospitals to review early readmissions and modify their discharge processes accordingly. [CMS Rep. 07, I-16]

Reducing Polypharmacy as a Significant Contributor to Senior Morbidity D-120.928
1. Our AMA will work with other organizations e.g., AARP, other medical specialty societies, PhRMA, and pharmacists to educate patients about the significant effects of all medications and most supplements, and to encourage physicians to teach patients to bring all medications and supplements or accurate, updated lists including current dosage to each encounter.
2. Our AMA along with other appropriate organizations encourages physicians and ancillary staff if available to initiate discussions with patients on improving their medical care through the use of only the minimal number of medications (including prescribed or over-the-counter, including vitamins and supplements) needed to optimize their health.
3. Our AMA will work with other stakeholders and EHR vendors to address the continuing problem of inaccuracies in medication reconciliation and propagation of such inaccuracies in electronic health records.
4. Our AMA will work with other stakeholders and EHR vendors to include non-prescription medicines and supplements in medication lists and compatibility screens. [Res. 515, A-22]

Continuity of Care for Patients Discharged from Hospital Settings H-125.974
Our AMA:
(1) will advocate for protections of continuity of care for medical services and medications that are prescribed during patient hospitalizations, including when there are formulary or treatment coverage changes that have the potential to disrupt therapy following discharge;
(2) supports medication reconciliation processes that include confirmation that prescribed discharge medications will be covered by a patient's health plan and resolution of potential coverage and/or prior authorization (PA) issues prior to hospital discharge;
(3) supports strategies that address coverage barriers and facilitate patient access to prescribed discharge medications, such as hospital bedside medication delivery services and the provision of transitional supplies of discharge medications to patients;
(4) will advocate to the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and hospital organizations, and health information technology developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and electronic health record (EHR) vendors;
(5) will advocate to the ONC to include proven and established real-time pharmacy benefit criteria within its certification program;
(6) will advocate to the ONC and the CMS that any policies requiring health information technology developers to integrate real-time pharmacy benefit systems (RTPB) within their products do so without disruption to EHR usability and minimal to no cost to physicians and hospitals, providing financial support if necessary; and
(7) supports alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTPB tools. [CMS Rep. 2, A-21; Modified: CMS Rep. 2, I-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 806
(I-23)

Introduced by: Michigan

Subject: Evidence-Based Anti-Obesity Medication as a Covered Benefit

Referred to: Reference Committee J

Whereas, obesity is a complex, multifactorial, common, serious, relapsing, and costly chronic disease that serves as a major risk factor for developing conditions such as heart disease, stroke, type 2 diabetes, renal disease, non-alcoholic steatohepatitis, and certain types of cancer; and

Whereas, health care costs are 34 percent higher for people with obesity, with the total cost of obesity in the U.S. being $1.7 trillion; and

Whereas, weight bias negatively impacts those affected financially, mentally, socially, and physically; and

Whereas, the National Health and Nutrition Examination Survey data shows that from 1999–2000 through 2017–March 2020, U.S. obesity prevalence increased from 30.5% to 41.9%. During the same time, the prevalence of severe obesity increased from 4.7% to 9.2%; and

Whereas, health care coverage for obesity and weight management is inadequate and insufficient, and varies significantly by each health plan, with millions of Americans being denied access to evidence-based treatments to help them address this disease and the numerous comorbidities that accompany obesity; for example, a majority of state employee health plans fail to cover FDA-approved obesity drugs and 27 state health exchanges exclude coverage for metabolic and bariatric surgery; and

Whereas, people who are affected by obesity deserve access to affordable, individualized medical coverage for science-based treatments in the same way as other chronic diseases are managed; therefore be it

RESOLVED, that our American Medical Association amend Policy H-150.953, “Obesity as a Major Public Health Problem,” by addition as follows:

9. Urge national payors to ensure coverage parity for FDA-approved anti-obesity medications without exclusions or additional carve-outs. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 9/27/23

RELEVANT AMA POLICY

Obesity as a Major Public Health Problem H-150.953
Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions;
(2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs;
(3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians;
(4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight;
(5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity;
(6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain;
(7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and
(8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.
[CSA Rep. 6, A-99; Reaffirmation A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 3, A-13; Reaffirmation: A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 807
(I-23)

Introduced by: Young Physicians Section

Subject: Any Willing Provider

Referred to: Reference Committee J

Whereas, access to quality healthcare is a fundamental right for all Americans; and

Whereas, the ability of physicians to establish and maintain a successful practice is critical to the provision of quality healthcare; and

Whereas, many insurance companies limit access to their networks for new physicians, thereby limiting a physician's ability to establish a practice and provide care to patients; and

Whereas, a few states have adopted "Any Willing Provider" laws, which allow physicians to contract with insurance companies to participate as in-network providers without discrimination; and

Whereas, the American Medical Association believes that access to quality healthcare should not be restricted by insurance company practices that limit the ability of physicians to establish a successful practice; therefore be it

RESOLVED, that our American Medical Association shall develop and advocate for model "Any Willing Provider" legislation nationwide, enabling all physicians to build successful practices and deliver quality patient care (Directive to Take Action); and be it further

RESOLVED, that our AMA shall lobby for federal regulations or legislation mandating insurers to implement "Any Willing Provider" policies as a prerequisite for participating in federally-supported programs (Directive to Take Action); and be it further

RESOLVED, that our AMA will work with state and national organizations, including insurance companies, to promote and support the adoption of "Any Willing Provider" laws, and will monitor the implementation of these laws to ensure that they are having a positive impact on access to quality healthcare. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 9/26/23

RELEVANT AMA POLICY

Any Willing Provider Provisions and Laws H-285.984
Our AMA: (1) acknowledges that health care plans or networks may develop and use criteria to determine the number, geographic distribution, and specialties of physicians needed;

(2) will advocate strongly that managed care organizations and third party payers be required to disclose to physicians applying to the plan the selection criteria used to select, retain, or exclude a physician from a managed care plan, including the criteria used to determine the number, geographic distribution, and specialties of physicians needed;

(3) will advocate strongly that those health care plans or networks that use criteria to determine the number, geographic distribution, and specialties of physicians needed be required to report to the public, on a regular basis, the impact that the use of such criteria has on the quality, access, cost, and choice of health care services provided to patients enrolled in such plans or networks;

(4) will advocate in those cases in which economic issues may be used for consideration of sanction or dismissal, the physician participating in the plan should have the right to receive profile information and education, in a due process manner, before action of any kind is taken;

(5) opposes any federal effort to preempt state "any willing provider" laws; and

(6) will continue to advocate its "Legislative Specifications for Federal Regulation of Managed Care Plans." [BOT Rep. I-93-25; Reaffirmed: Sub. Res. 110 and 702, A-94; Reaffirmed: CMS Rep. 3, I-97; Reaffirmed: Sub. Res. 704, A-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmation: A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 808
(I-23)

Introduced by: Young Physicians Section

Subject: Prosthodontic Coverage after Oncologic Reconstruction

Referred to: Reference Committee J

Whereas, head and neck cancer and trauma that requires resection often times leaves patients with incomplete or completely absent dentition; and

Whereas, prosthodontic reconstruction can broaden the opportunities for nutritional supplementation after treatment of head and neck cancers; and

Whereas, prosthodontic reconstruction allows for improved psychosocial outcomes after treatment of head and neck cancers; and

Whereas, prosthodontic reconstruction done at the time of orofacial reconstruction is more frequently covered by insurers while delayed prosthodontic reconstruction is significantly less likely to be covered; and

Whereas, same day reconstruction is not an option for all patients but does not negate the potential benefits for eventual prosthodontic reconstruction; and

Whereas, the American Medical Association has long standing policy advocating for coverage of dental implants for persons with congenital orofacial clefting; therefore be it

RESOLVED, that our American Medical Association with appropriate stakeholders to advocate: (a) that prosthodontic reconstruction (including dental implants) after orofacial reconstruction secondary to oncologic resection be covered by all insurers, (b) that such coverage, shall include treatment which, in the opinion of the treating physician is medically necessary to optimize the patient's appearance and function to their original form as much as possible, and (c) that such insurability be portable, i.e. not denied as a pre-existing condition if the patients insurance coverage changes before treatment has been initiated or completed. (Directive to Take Action)

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

Received: 9/26/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 809
(I-23)

Introduced by: New York

Subject: Outsourcing of Administrative and Clinical Work to Different Time Zones – An Issue of Equity, Diversity, and Inclusion

Referred to: Reference Committee J

Whereas, our American Medical Association (AMA) has previously affirmed its strategic plan to embed equity, diversity, and inclusion as its guiding principles; and

Whereas, many healthcare tasks are outsourced by health plans to lower-cost countries in vastly different time zones, including India, Pakistan, Philippines, among others; likewise, many revenue cycle management (RCM) duties, >70% are outsourced to the same countries by medical practices, including hospitals and physician practices. Surveys suggest that 85-90% of calls are answered by insurance representatives in non-US time zones, and

Whereas, studies have shown that night shift work has adverse health effects; and

Whereas, provider outsourced RCM staff and health plan outsourced staff work in the same time zone, separated from the US by around 12 hours. Both provider RCM outsourced staff and health plan outsourced staff work night shifts during US business hours while mostly interacting with each other; and

Whereas, common sense suggests that it would be advantageous for outsourced staff to work in their local time zone as much as possible, and that would be the preferred option for most; and

Whereas, outsourced workers in low-cost outsourced countries are relatively under-privileged; therefore it be

RESOLVED, that our American Medical Association advocate that health plans that outsource their customer service facing operations to foreign countries in time zones separated by more than 4 hours from the US should implement 16 or 24-hour availability for their support services staffed by outsourced employees to allow local day shift work schedules for their own outsourced employees in different time zones and provider employees located in similar time zones (Directive to Take Action); and be it further

RESOLVED, that our AMA support national legislation that calls on health plans that outsource their customer service facing operations to foreign countries in time zones separated by more than 4 hours from the US to implement 16 or 24-hour availability for their support services staffed by outsourced employees to allow local day shift work schedules for their own outsourced employees in different time zones and provider employees located in similar time zones (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for fair treatment of outsourced employees in vastly different time zones by health plans. (Directive to Take Action)

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

Received: 9/26/23

RELEVANT AMA POLICY

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.
Policy Timeline: 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

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.
Policy Timeline: 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

Plan for Continued Progress Toward Health Equity H-180.944
Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.
Policy Timeline: BOT Rep. 33, A-18; Reaffirmed: CMS Rep. 5, I-21

Prior Authorization Reform D-320.982
Our AMA will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.
Policy Timeline: Res. 704, A-19; Reaffirmation: A-22

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 811
(I-23)

Introduced by: Medical Student Section

Subject: Expanding the Use of Medical Interpreters

Referred to: Reference Committee J

Whereas, over 25 million people in the US have limited English proficiency (LEP), and interpreter use for these patients is associated improved morbidity and mortality, provider communication, discharge education, and health literacy and fewer medical errors[1-8]; and

Whereas, a study of increased interpreter use showed decreased readmission rates with monthly hospital savings of $160,000, after accounting for interpreter costs[9]; and

Whereas, multiple analyses, including a systematic review, find that reminders by text and phone provided in a patient's preferred language can increase appointment attendance that reminders by text reminders by text or phone improve patient adherence and appointment attendance when delivered in the patient's preferred language[10-13]; and

Whereas, bilingual physicians are not officially certified and may still be required to use an interpreter for liability[14]; and

Whereas, in one study, 84% of bilingual medical students reported being asked to interpret for patients, of whom 53% reported feeling uncomfortable with interpretation[15]; and

Whereas, some institutions offer interpretation courses (with advanced skills beyond introductory language electives) for already bilingual trainees to increase comfort with interpretation, improve patient interactions, and even save costs[16-22]; therefore be it

RESOLVED, that our American Medical Association amend H-160.924, "Use of Language Interpreters in the Context of the Patient-Physician Relationship," by addition as follows:

> Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924
> 1. AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care; (b) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (c) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid Limited English Proficiency (LEP) patients' involvement in meaningful decisions about their care; <u>d) patients have expanded access to documentation and</u>

communications available in their preferred language, including appointment reminder calls/messages, post-appointment summaries, and electronic medical records, through access to trained interpreter and translator services; and (~~d~~e) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements.

2. Our AMA recognizes the importance of using medical interpreters as a means of improving quality of care provided to patients with LEP including patients with sensory impairments.

3. Our AMA encourage hospital systems, clinics, residency programs, and medical schools to promote and incentivize opportunities for physicians, staff, and trainees to receive medical interpreter training and certification.

(Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 09/27/2023

REFERENCES

1. State Demographics Data | migrationpolicy.org. Accessed March 9, 2023. https://www.migrationpolicy.org/data/state-profiles/state/language/US#
2. Pippins JR, Alegría M, Haas JS. Association between language proficiency and the quality of primary care among a national sample of insured Latinos. Med Care. 2007 Nov;45(11):1020-5. doi: 10.1097/MLR.0b013e31814847be. PMID: 18049341; PMCID: PMC2836911.
3. Diamond, L, Izquierdo, K, Canfield, D et al. A Systematic Review of the Impact of Patient–Physician Non-English Language Concordance on Quality of Care and Outcomes. Journal of General Internal Medicine. 2019;34:1591–1606. https://doi.org/10.1007/s11606-019-04847-5.
4. Parker MM, Fernández A, Moffet HH, et al. Association of Patient-Physician Language Concordance and Glycemic Control for Limited-English Proficiency Latinos With Type 2 Diabetes. JAMA Intern Med. 2017;177(3):449. doi:10.1001/jamainternmed.2016.8648
5. Schwebel F, Larimer ME.. Using text message reminders in health care services: A narrative literature review. Internet Interventions. 2018;13:82-104. https://doi.org/10.1016/j.invent.2018.06.002.
6. Schiaffino MK, Nara A, Mao L. Language Services In Hospitals Vary By Ownership And Location. Health Aff (Millwood). 2016;35(8):1399-1403. doi:10.1377/hlthaff.2015.0955
7. Tan-McGrory A., Schwamm L.H., Kirwan C., et al. Addressing Virtual Care Disparities for Patients With Limited English Proficiency. American Journal of Managed Care. 2022;28(1):36-40. https://doi.org/10.37765/ajmc.2022.88814.
8. Lee, JS, Pérez-Stable, EJ, Gregorich, SE. et al. Increased Access to Professional Interpreters in the Hospital Improves Informed Consent for Patients with Limited English Proficiency. J GEN INTERN MED 2017;32(8):863–870. https://doi.org/10.1007/s11606-017-3983-4
9. Karliner LS, Pérez-Stable EJ, Gregorich SE. Convenient Access to Professional Interpreters in the Hospital Decreases Readmission Rates and Estimated Hospital Expenditures for Patients With Limited English Proficiency. Med Care. 2017;55(3):199-206. doi:10.1097/MLR.0000000000000643
10. Schwebel F, Larimer ME.. Using text message reminders in health care services: A narrative literature review. Internet Interventions. 2018;13:82-104. https://doi.org/10.1016/j.invent.2018.06.002.
11. Mehranbod C, Genter P, Serpas L, et al. Automated Reminders Improve Retinal Screening Rates in Low Income, Minority Patients with Diabetes and Correct the African American Disparity. Journal of Medical Systems. 2020;44(1):1-7. doi:10.1007/s10916-019-1510-3
12. Flower KB, Wurzelmann S, Rojas C, et al. Improving satisfaction and appointment attendance through navigation for spanish-speaking families. J Health Care Poor Underserved. 2020;31(2):810-826. doi: https://doi.org/10.1353/hpu.2020.0062.
13. NYC Health + Hospitals expands access to text message appointment reminders. NYC Health + Hospitals. https://www.nychealthandhospitals.org/pressrelease/nyc-health-hospitals-expands-access-to-text-message-appointment-reminders/. Published May 26, 2022. Accessed April 2, 2023.
14. Duma N, Velazquez AI, Franco I, et al. Dónde están? latinx/hispanic representation in the oncology workforce: present and future. JCO Oncol Pract. 2022;18(5):388-395. doi:10.1200/OP.22.00153
15. Vela MB, Fritz C, Press VG, Girotti J. Medical students' experiences and perspectives on interpreting for LEP patients at two US medical schools. J Racial Ethn Health Disparities. 2016;3(2):245-249. doi:10.1007/s40615-015-0134-7

16. Diaz JEL, Ekasumara N, Menon NR, et al. Interpreter training for medical students: pilot implementation and assessment in a student-run clinic. BMC Med Educ. 2016;16(1):256. doi:10.1186/s12909-016-0760-8
17. Hernandez RG, Tanaka K, McPeak K, Thompson DA. Resident Training Experiences Providing Spanish-Language Concordant Care: Implications for Growing Health Equity Efforts Within Graduate Medical Education. Clin Pediatr (Phila). 2022;61(4):352-361. doi:10.1177/00099228221074776
18. Himmelstein J, Wright WS, Wiederman MW. U.S. medical school curricula on working with medical interpreters and/or patients with limited English proficiency. Adv Med Educ Pract. 2018;9:729-733. doi:10.2147/AMEP.S176028
19. Cowden JD, Martinez FJ, Dickmeyer JJ, Bratcher D. Culture and language coaching for bilingual residents: the first 10 years of the CHiCoS model. Teach Learn Med. June 30, 2022:1-12. doi:10.1080/10401334.2022.2092113
20. Barr WB, Valdini A, Louis JS, Weida N, Marshall C. Sí, tu puedes: an integrated spanish language acquisition in residency utilizing personal instruction. J Grad Med Educ. 2018;10(3):343-344. doi:10.4300/JGME-D-17-00919.1
21. ASL Medical School Elective | Family Medicine | Michigan Medicine | University of Michigan. Accessed April 10, 2023. https://medicine.umich.edu/dept/family-medicine/programs/mdisability/education/asl-medical-school-elective
22. Pre-Clerkship Electives | Medical Education | Medical School | Brown University. Accessed April 10, 2023. https://education.med.brown.edu/md-curriculum/pre-clerkship/pre-clerkship-electives

RELEVANT AMA POLICY

H-295.870 Medical School Language Electives in Medical School Curriculum
Our AMA strongly encourages all Liaison Committee on Medical Education- and American Osteopathic Association-accredited US medical schools to offer medical second languages to their students as electives. [Res. 304, A-07; Reaffirmed: CME Rep. 01, A-17]

H-160.931 Health Literacy
Our AMA:
(1) recognizes that limited patient literacy is a barrier to effective medical diagnosis and treatment;
(2) encourages the development of literacy appropriate, culturally diverse health-related patient education materials for distribution in the outpatient and inpatient setting;
(3) will work with members of the Federation and other relevant medical and nonmedical organizations to make the health care community aware that approximately one fourth of the adult population has limited literacy and difficulty understanding both oral and written health care information;
(4) encourages the development of undergraduate, graduate, and continuing medical education programs that train physicians to communicate with patients who have limited literacy skills;
(5) encourages all third party payers to compensate physicians for formal patient education programs directed at individuals with limited literacy skills;
(6) encourages the US Department of Education to include questions regarding health status, health behaviors, and difficulties communicating with health care professionals in all future National Assessment of Adult Literacy studies;
(7) encourages the allocation of federal and private funds for research on health literacy;
(8) recommends all healthcare institutions adopt a health literacy policy with the primary goal of enhancing provider communication and educational approaches to the patient visit;
(9) recommends all healthcare and pharmaceutical institutions adopt the USP prescription standards and provide prescription instructions in the patient's preferred language when available and appropriate; and
(10) encourages the development of low-cost community- and health system resources, support state legislation and consider annual initiatives focused on improving health literacy. [CSA Rep. 1, A-98; Appended: Res. 415, I-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Appended: Res. 718, A-13; Reaffirmed: BOT Rep. 09, A-23]

H-385.917 Interpreter Services and Payment Responsibilities
Our AMA supports efforts that encourage hospitals to provide and pay for interpreter services for the follow-up care of patients that physicians are required to accept as a result of that patient's emergency room visit and Emergency Medical Treatment and Active Labor Act (EMTALA)-related services. [CMS Rep. 5, A-11; Reaffirmed: CMS Rep. 1, A-21; Reaffirmed in lieu of: Res. 231, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 812
(I-23)

Introduced by: Medical Student Section

Subject: Indian Health Service Improvements

Referred to: Reference Committee J

Whereas, the Indian Health Service (IHS) serves 2.6 million American Indian and Alaska Native (AI/AN) patients in facilities operated by the federal government, tribes, and Urban Indian organizations (UIO)[1-2]; and

Whereas, unlike Medicaid, Medicare, and the VA, the IHS is not an insurance or entitlement program with an established benefits package[3-5]; and

Whereas, the IHS is a payer of last resort, thus their patients must exhaust all other public or private coverage for which they are eligible before receiving IHS payment, including the 36% of AI/AN adults under 65 who are on Medicaid[6-8]; and

Whereas, since 1976, all state Medicaid programs have been fully reimbursed at 100% Federal Medical Assistance Percentage (FMAP) for services at IHS/Tribal facilities[9-10]; and

Whereas, the 1976 100% FMAP legislation specifically excluded UIOs, even though 70% of AI/AN adults live in areas served by these facilities[8,10]; and

Whereas, in 2016, CMS expanded 100% FMAP to services from non-IHS/Tribal physicians if first requested by an IHS/Tribal physician with a care coordination agreement[10-11]; and

Whereas, the American Rescue Plan temporarily extended 100% FMAP to UIOs for 2 years, with the federal government saving 22 states an estimated $70 million[10,12]; and

Whereas, Congress is considering permanently extending 100% FMAP for UIOs, which is estimated to save states $547 million over 10 years[10]; and

Whereas, Washington State currently reinvests their $16 million in annual savings from 100% FMAP into into a tribally-driven health improvement fund[13-14]; and

Whereas, 100% FMAP expansion for UIOs will not negatively impact appropriations and services at Indian Health Service and Tribal Health Programs[13]; and

Whereas, pharmacoequity is also a serious concern for many Tribal leaders and advocates for AI/AN health[15]; and

Whereas, the IHS National Pharmacy and Therapeutics Committee (NPTC) sets the IHS National Core Formulary (NCF) for baseline pharmaceutical coverage at federal IHS facilities, but does not maintain parity with other federal health programs[16]; and

Whereas, the IHS NPTC added emergency contraception to the NCF 4 years after reports of complete lack availability at over half of all IHS facilities and 2 years after over-the-counter approval without age limits by the Food and Drug Administration[17-19]; and

Whereas, the IHS NPTC added testosterone and estradiol to the NCF 5 years after the release of consensus specialty clinical guidelines on gender-affirming medication[20-21]; and

Whereas, our American Medical Association supports "enforc[ing] the Medicare Part D Prescription Drug Program statutory requirement that all Part D plans include at least two drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients"; and

Whereas, in 1997, Congress created the IHS Special Diabetes Program for Indians (SDPI), an $150 million annual program funding diabetes prevention and treatment, which now comprises 301 community programs serving 780,000 adults and children in 35 states[22]; and

Whereas, in the 20 years since SDPI implementation, diabetes prevalence in AI/AN adults has consistently declined, diabetes-related mortality decreased 37%, diabetes-related hospitalizations decreased 84%, diabetic eye disease decreased 50%, and specifically diabetes-related kidney failure decreased 54% (the greatest reduction for any racial or ethnic group), which alone saved Medicare $520 million over 10 years[22-23]; and

Whereas, SDPI is subject to reauthorization every 2 years, affecting continuity of care during prolonged Congressional negotiations and exacerbating existing staffing issues because IHS is the only federal health program without advance appropriations[24]; and

Whereas, SDPI funds have stagnated at $150 million since 2004 without inflation-based adjustments, limiting program expansion, decreasing grant value, and forcing grantees and IHS programs to unsustainably absorb 20 years of inflationary cost increases[25-26]; and

Whereas, similar to SDPI, other IHS grants, such as the 5-year health professions grant Indians Into Medicine, are discretionary (not mandatory) and are also subject to repeated Congressional reauthorization, lack of funding increases, and struggles with inflation[27]; therefore be it

RESOLVED, that our American Medical Association advocate to permanently increase the Federal Medical Assistance Percentage (FMAP) to 100% for medical services which are received at or through an Urban Indian Organization that has a grant or contract with the Indian Health Service (IHS) (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage state and federal governments to reinvest Medicaid savings from 100% FMAP into tribally-driven health improvement programs (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for greater physician and federal oversight of the IHS National Core Formulary, ensuring that the pharmacy benefit for American Indian and Alaska Native patients represents the standard-of-care for prevalent diseases and medical conditions in this population (Directive to Take Action); and be it further

RESOLVED, that our AMA work with IHS and appropriate agencies and organizations to ensure that their National Core Formulary includes at least two standard-of-care drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients (Directive to Take Action); and be it further

RESOLVED, that our AMA support permanent reauthorization of the Special Diabetes Program for Indians (New HOD Policy); and be it further

RESOLVED, that our AMA support biannual inflationary increases for public health and health profession grants sponsored by IHS. (New HOD Policy)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 09/27/23

REFERENCES

1. Indian Health Service: Information on Third-Party Collections and Processes to Procure Supplies and Services. U.S. Government Accountability Office. Published online 2022. https://www.gao.gov/assets/gao-22-104742.pdf
2. Federal Register Volume 87, Issue 19 (January 28, 2022). Office of the Federal Register, National Archives and Records Administration. Published online 2022. https://www.govinfo.gov/app/details/FR-2022-01-28/2022-01789
3. Patient Resources. Indian Health Service. Accessed 2023. https://www.ihs.gov/forpatients/faq
4. Purchase/Referred Care (PRC): Requirements: Eligibility. Indian Health Services. Published online 2022. https://www.ihs.gov/prc/eligibility/requirements-eligibility
5. Indian Health Service (IHS) FY2022 Budget: Request and Funding History: In Brief. Congressional Research Service. Published online 2022. https://crsreports.congress.gov/product/pdf/R/R47004
6. Purchase/Referred Care (PRC). Indian Health Services. Published online 2022. https://www.ihs.gov/prc/
7. Requirements: Alternate Resources | Eligibility. Purchased/Referred Care (PRC). Accessed March 2023 https://www.ihs.gov/prc/eligibility/requirements-alternate-resources
8. Health Insurance Coverage and Access to Care for American Indians and Alaska Natives: Current Trends and Key Challenges. ASPE Office of the Assistant Secretary for Planning and Evaluation. Published online July 22, 2021. https://aspe.hhs.gov/sites/default/files/2021-07/aspe-aian-health-insurance-coverage-ib.pdf
9. 100% FMAP for LTSS — Educate Your State. Centers for Medicare and Medicaid Services. Published online November 15, 2022. https://www.cms.gov/outreach-and-education/american-indian-alaska-native/aian/ltss-ta-center/info/100-percent-fmap-educate-your-state#:~:text=CMS%20reimburses%20each%20state%20for,typically%20have%20a%20higher%20FMAP
10. Kalweit, Andrew, Chandos Culleen, and Isaiah O'Rear. Recent Trends in Third-Party Billing at Urban Indian Organizations: Impact of the American Rescue Plan Act and 100% FMAP Provisions. National Council for Urban Indian Health. Washington DC, 2022.
11. Urban Indian Organizations. Indian Health Service. https://www.ihs.gov/Urban/urban-indian-organizations
12. H.Res.1319 American Rescue Plan Act of 2021. US House. March 11, 2021. https://www.congress.gov/bill/117th-congress/house-bill/1319
13. Seattle Indian Health Board. Payment Parity for Indian Health Care Providers. Published online April 16, 2020. https://www.sihb.org/wp-content/uploads/SIHB-FMAP_FAQ_20200416_2.pdf
14. Lundberg, Laura, Sara Gentzler. Washington's Indian Health Improvement Act, explained. Washington State Wire. Published online June 5, 2019. https://washingtonstatewire.com/washington-state-passes-indian-health-improvement-bill
15. Calac A, Gasca L, Calac D. Reducing Health Disparities Through Achieving Pharmacoequity. JAMA. 2022;327(6):588-589. doi:10.1001/jama.2021.24516
16. Indian Health Service: About. National Pharmacy & Therapeutics Committee. Accessed March 2023. https://www.ihs.gov/nptc/about
17. Indian Health Services Releases Long-Awaited Update to Policy on Emergency Contraception. American Civil Liberties Union. Accessed March 2023. https://www.aclu.org/press-releases/indian-health-services-releases-long-awaited-update-policy-emergency-contraception
18. Indian Health Service: Chapter 15 - Emergency Contraception | Part 1. The Indian Health Manual (IHM). Published 2015. https://www.ihs.gov/IHM/pc/part-1/p1c15
19. Kingfisher P, The Native American Women's Health Education Resource Center. Indigenous Women' S Dialogue: Roundtable Report on the Accessibility of Plan B® as an over the Counter (OTC) within Indian Health Service.; 2012. http://www.nativeshop.org/images/stories/media/pdfs/Plan-B-Report.pdf
20. Indian Health Service. National Pharmacy and Therapeutics Committee Formulary Brief: Gender-Affirming Medications. Published February 2022. https://www.ihs.gov/sites/nptc/themes/responsive2017/display_objects/documents/guidance/NPTC-Formulary-Brief-Gender-Affirming-Medications.pdf
21. Wylie C Hembree, Peggy T Cohen-Kettenis, Louis Gooren, Sabine E Hannema, Walter J Meyer, M Hassan Murad, Stephen M Rosenthal, Joshua D Safer, Vin Tangpricha, Guy G T'Sjoen, Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, The Journal of Clinical Endocrinology & Metabolism, Volume 102, Issue 11, 1 November 2017, Pages 3869–3903, https://doi.org/10.1210/jc.2017-01658
22. Special Diabetes Program for Indians 2020 Report to Congress: Changing the Course of Diabetes: Charting Remarkable Progress [Internet]. Rockville (MD): Indian Health Service (US); 2020.

23. Bullock, A. et al. “Prevalence of diagnosed diabetes in American Indian and Alaska Native adults, 2006-2017.” BMJ open diabetes research & care vol. 8,1 (2020): e001218.
24. Advance Appropriations. National Indian Health Board. Accessed September 22, 2022. https://www.nihb.org/legislative/advance_appropriations.php
25. National Clinical Care Commission. Report to Congress on Leveraging Federal Programs to Prevent and Control Diabetes and Its Complications. Department of Health and Human Services. Published 2021. Accessed August 31, 2022. https://health.gov/sites/default/files/2022-01/NCCC%20Report%20to%20Congress.pdf
26. FY 2023 National Tribal Budget Formulation Workgroup. Indian Health Service. Published February 12, 2021. Accessed September 22, 2022. https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2023NationalTribalBudgetFormulationWorkSessionMaterials.pdf
27. National Indian Health Board. Increasing Funding for the Indians Into Medicine (INMED) Program. Resolution 22-05. Published 2022. Accessed August 31, 2022. https://www.nihb.org/docs/02252022/22-05%20NIHB%20Resolution%20on%20Increasing%20Funding%20for%20the%20Indians%20Into%20Medicine%20(INMED)%20Program.pdf

RELEVANT AMA POLICY

D-350.992 Medicaid Coverage for American Indian and Alaska Native Children
Our AMA will advocate for immediate changes in Medicaid regulations to allow American Indian/Alaska Native (AI/AN) children who are eligible for Medicaid in their home state to be automatically eligible for Medicaid in the state in which the Bureau of Indian Affairs boarding school is located. [BOT Action in response to referred for decision Res. 102, A-06; Reaffirmed: Res. 221, A-07; Reaffirmed: CMS Rep. 01, A-17]

H-350.948 Purchased and Referred Care Expansion
Our AMA will advocate for increased funding to the Indian Health Service Purchased/Referred Care Program and to the Urban Indian Health Program to enable the programs to fully meet the healthcare needs of American Indian/Alaska Native (AI/AN) patients. [Res. 209, A-23]

D-330.933 Restoring High Quality Care to the Medicare Part D Prescription Drug Program
Our AMA will:
a. work to eliminate prior authorizations under the Medicare Part D Prescription Drug Program which undermine a physician's best medical judgment;
b. work with the Centers for Medicare and Medicaid Services (CMS) to enforce the Medicare Part D Prescription Drug Program statutory requirement that all Part D plans include at least two drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients;
c. work with CMS to place reasonable copays in the Medicare Part D Prescription Drug Program;
d. work with other interested parties to simplify the CMS prior authorization process such that a diagnosis or reason written on the prescription should be accepted as documentation for non formulary request; and
e. work with CMS to develop a one-page form for physicians and patients to utilize in appealing a prescription coverage denial. [Res. 106, A-07; Reaffirmation A-08; Reaffirmation A-14]

D-350.987 Strong Opposition to Cuts in Federal Funding for the Indian Health Service
1. Our AMA will strongly advocate that all of the facilities that serve Native Americans under the Indian Health Service be adequately funded to fulfill their mission and their obligations to patients and providers.
2. Our AMA will ask Congress to take all necessary action to immediately restore full and adequate funding to the Indian Health Service.
3. Our AMA adopts as new policy that the Indian Health Service not be treated more adversely than other health plans in the application of any across the board federal funding reduction.
4. In the event of federal inaction to restore full and adequate funding to the Indian Health Service, our AMA will consider the option of joining in legal action seeking to require the federal government to honor existing treaties, obligations, and previously established laws regarding funding of the Indian Health Service.
5. Our AMA will request that Congress: (A) amend the Indian Health Care Improvement Act to authorize Advanced Appropriations; (B) include our recommendation for the Indian Health Service (HIS) Advanced

Appropriations in the Budget Resolution; and (C) include in the enacted appropriations bill IHS Advanced Appropriations. [Res. 233, A-13; Appended: Res. 229, A-14]

H-440.844 Expansion of National Diabetes Prevention Program
Our AMA: (1) supports evidence-based, physician-prescribed diabetes prevention programs, (2) supports the expansion of the NDPP to more CDC-certified sites across the country; and (3) will support coverage of the NDPP by Medicare and all private insurers. [Sub. Res. 911, I-12; Reaffirmed: CSAPH Rep. 1, A-22]

H-350.976 Improving Health Care of American Indians
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. [CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Reaffirmed: BOT Rep. 09, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 813
(I-23)

Introduced by: Medical Student Section

Subject: Strengthening Efforts Against Horizontal & Vertical Consolidation

Referred to: Reference Committee J

Whereas, despite robust evidence for the effects of both horizontal and vertical consolidation on patient outcomes, physician pay and work conditions, and market performance, FTC and DOJ are hesitant to try cases due to inadequate finances and a history of losses, including several in the early 2000s and recent cases only won after appeals requiring major funds[1-41]; and

Whereas, while healthcare merger activity rose 50% from 2010-2020, Federal Trade Commission (FTC) and Department of Justice (DOJ) budgets declined, and the amount of resources needed per antitrust lawsuit increased[37-40]; and

Whereas, nonprofit hospitals account for the majority of US hospitals but are immune from antitrust enforcement, despite also being impacted by the harms of consolidation[37-40]; and

Whereas, most vertical healthcare mergers are not reported because they fall beneath the $50 million threshold for mandatory reporting, even though they account for $30 to 40 billion in total value, making FTC and DOJ ineffective in preventing vertical consolidation[37-40]; and

Whereas, FTC and DOJ struggle in cases due to the extremely high evidentiary burdens placed on plaintiffs, such as proof that a merger will lead to “likely harm to competition,” which requires additional funds to effectively demonstrate and exacerbates budgetary concerns[37-41]; and

Whereas, while most healthcare mergers are challenged preemptively, FTC has previously challenged mergers retroactively, and given the inadequacies of existing enforcement, retroactive challenges will likely be necessary to restore effective markets[37-40]; therefore be it

RESOLVED, that our American Medical Association advocate to adequately resource competition policy authorities such as the Federal Trade Commission (FTC) and Department of Justice Antitrust Division to perform oversight of healthcare markets (Directive to Take Action); and be it further

RESOLVED, that our AMA oppose not-for-profit firm immunity from FTC competition policy enforcement in the healthcare sector, which represent the majority of U.S. hospitals (New HOD Policy); and be it further

RESOLVED, that our AMA support lowering the transaction value threshold for merger reporting in healthcare sectors to ensure that vertical acquisitions in healthcare do not evade antitrust scrutiny (New HOD Policy); and be it further

RESOLVED, that our AMA support healthcare-specific advocacy efforts which will strengthen antitrust enforcement in the healthcare sector through multiple mechanisms, including but not

limited to a) simplifying the evidentiary burden on plaintiffs and shifting the evidentiary burden to defendants and b) encouraging the FTC to leverage its authority to increase the frequency of challenges in consolidated healthcare markets. (New HOD Policy)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 09/27/2023

REFERENCES

1. Martin, Anne B., Micah Hartman, Benjamin Washington, Aaron Catlin, and the National Health Expenditures Team. 2019. “National Health Care Spending in 2017: Growth Slows to Post Great Recession Rates; Share of GDP Stabilizes.” Health Affairs 38 (1): 96–106.
2. Jean Tirole, 1988. "The Theory of Industrial Organization," MIT Press Books, The MIT Press, edition 1, volume 1, number
3. Fulton, Brent D. 2017. “Health Care Market Concentration Trends in the United States: Evidence and Policy Responses.”Health Affairs 36 (9): 1530–38.
4. Singh, Anu. 2019. “2018 Healthcare M&A in Review: A NewLandscape Takes Shape.” KaufmanHall, Chicago, IL.
5. American Hospital Association. 2018. “Trendwatch Chartbook 2018: Organizational Trends, Chart 2.9: Announced Hospital Mergers and Acquisitions, 2005–2017.” American Hospital Association, Chicago, IL
6. Cutler, David M., and Fiona Scott Morton. 2013. “Hospitals, Market Share, and Consolidation.” Journal of the American Medical Association 310 (18): 1964.
7. Capps, Cory S., David Dranove, and Christopher Ody. 2017. “Physician Practice Consolidation Driven by Small Acquisitions, So Antitrust Agencies Have Few Tools to Intervene.” Health Affairs 36 (9): 1556–63.
8. Muhlestein, David B., and Nathan J. Smith. 2016. “Physician Consolidation: Rapid Movement from Small to Large Group Practices.” Health Affairs 35 (9): 1638–42.
9. Capps, Cory S., and David Dranove. 2004. “Hospital Consolidation and Negotiated PPO Prices.” Health Affairs 23 (2): 175–81.
10. Cooper, Zack, Stuart V. Craig, Martin Gaynor, and John Van Reenen. 2019. “The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured.” Quarterly Journal of Economics 134 (1): 51–107.
11. Capps, Cory S., David Dranove, and Mark Satterthwaite. 2003. “Competition and Market Power in Option Demand Markets.” RAND Journal of Economics 34 (4): 737–63
12. Dafny, Leemore. 2009. “Estimation and Identification of Merger Effects: An Application to Hospital Mergers.” Journal of Law and Economics 52 (3): 523–50.
13. Gowrisankaran, Gautam, Aviv Nevo, and Robert Town. 2015. “Mergers When Prices Are Negotiated: Evidence from the Hospital Industry.” American Economic Review 105 (1): 172–203.
14. Haas-Wilson, Deborah, and Christopher Garmon. 2011. “Hospital Mergers and Competitive Effects: Two Retrospective Analyses.” International Journal of the Economics of Business 18 (1): 17–32.
15. Tenn, Steven. 2011. “The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction.” International Journal of the Economics of Business 18 (1): 65–82
16. Thompson, Aileen. 2011. “The Effect of Hospital Mergers on Inpatient Prices: A Case Study of the New Hanover-Cape Fear Transaction.” International Journal of the Economics of Business 18 (1): 91–101
17. Koch, Thomas, and Shawn W. Ulrick. 2017. “Price Effects of A Merger: Evidence from A Physicians’ Market.” Working Paper 333, Bureau of Economics, Federal Trade Commission, Washington, DC.
18. Anand, Priyanka. 2017. “Health Insurance Costs and Employee Compensation: Evidence from the National Compensation Survey.” Health Economics 26 (12): 1601–16
19. Baicker, Katherine and Amitabh Chandra. 2006. “The Labor Market Effects of Rising Health Insurance Premiums.” Journal of Labor Economics 24 (3): 609–34.
20. Cooper, Zack, Stephen Gibbons, Simon Jones, and Alistair McGuire. 2011. “Does Hospital Competition Save Lives? Evidence from the English NHS Patient Choice Reforms.” Economic Journal 121 (554): F228–F260.
21. Gaynor, Martin, Rodrigo Moreno-Serra, and Carol Propper. 2013.“Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service.” American Economic Journal: Economic Policy 5 (4): 134–66
22. Romano, Patrick, and David Balan. 2011. “A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare.” International Journal of the Economics of Business 18 (1): 45–64.
23. Cutler, David M., Robert S. Huckman, and Jonathan T. Kolstad. 2010. “Input Constraints and the Efficiency of Entry: Lessons from Cardiac Surgery.” American Economic Journal: Economic Policy 2 (1): 51–76.
24. Hayford, Tamara B. 2012. “The Impact of Hospital Mergers on Treatment Intensity and Health Outcomes.” Health Services Research 47 (3pt1): 1008–29.
25. Haas, Susan, Atul A. Gawande, and Mark E. Reynolds. 2018. “The Risks to Patient Safety from Health System Expansions.” Journal of the American Medical Association 319 (17): 1765–66.
26. Prager, Elena, and Matt Schmitt. 2019. “Employer Consolidation and Wages: Evidence from Hospitals.” Unpublished manuscript, Northwestern University, Chicago, IL.
27. Kane, Carol K. 2017. “Updated Data on Physician Practice Arrangements: Physician Ownership Drops Below 50 Percent.” Policy Research Perspectives, American Medical Association, Chicago, IL.
28. Baker, Lawrence, M. Kate Bundorf, and Daniel Kessler. 2014. Vertical integration: Hospital ownership of physician practices is associated with higher prices and spending. Health Affairs 33 (5): 756–63.
29. Capps, Cory S., David Dranove, and Christopher Ody. 2016. “The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending.” Unpublished manuscript, Northwestern University, Evanston, IL

30. Neprash, Hannah T., Michael E. Chernew, Andrew L. Hicks, Teresa Gibson, and Michael McWilliams. 2015. “Association of Financial Integration Between Physicians and Hospitals with Commercial Health Care Prices.” Journal of the American Medical Association Internal Medicine 175 (12): 1932–39.
31. Robinson, James C., and Kelly Miller. 2014. “Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California.” Journal of the American Medical Association 312 (6): 1663–69.
32. Brot-Goldberg, Zarek, and Mathijs de Vaan. 2018. “Intermediation and Vertical Integration in the Market for Surgeons.” Unpublished manuscript, University of California, Berkeley, CA.
33. Venkatesh, Shruthi. 2019. “The Impact of Hospital Acquisition on Physician Referrals.” Unpublished manuscript, Carnegie Mellon University, Pittsburgh, PA.
34. United States and the State of North Carolina v. The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas Healthcare System. 2019
35. People of the State of California Ex Rel. Xavier Becerra v. Sutter Health. (2018).
36. Abelson, Reed. 2019, October 16. “Sutter Health to Settle Antitrust Lawsuit.” New York Times.
37. Slaughter, Rebecca-Kelley. “Remarks of Commissioner Rebecca Kelly Slaughter As Prepared for Delivery: Antitrust and Health Care Providers Policies to Promote Competition and Protect Patients”. Federal Trade Commission. 2019.
38. Gaynor, Martin. 2020. “What to Do about Health-Care Markets? Policies to Make Health-Care Markets Work.” Brookings Institution.
39. Gaynor, Martin. “Statement before the U.S. Senate Subcommittee on Competition Policy, Antitrust, and Consumer Rights: Antitrust Applied: Hospital Consolidation Concerns and Solutions”. 2021.
40. Cooper, Zach and Gaynor, Martin. Addressing Hospital Concentration and Rising Consolidation in the United States. 1% Steps for Health Care Reform Project.
41. Cory Capps et al., The Continuing Saga of Hospital Merger Enforcement, 82 Antitrust Law Journal. 441, 485 (2019).

RELEVANT AMA POLICY

D-160.907 Health System Consolidation
1. Our American Medical Association will assess and report annually on nationwide health system and hospital consolidation, as well as payer consolidation, to assist policymakers and the federal government.
2. Our AMA annual report on nationwide hospital consolidation will be modeled after the “Competition in health insurance: A comprehensive study of U.S. Markets” in its comprehensiveness to include for example data an analyses as:
A) A review of the current level of hospital and/or health system consolidation at the level of all metropolitan statistical areas, state, and national markets;
B) A list of all mergers and acquisition transactions valued above a set threshold amount resulting in hospital and/or health system consolidation;
C) Analyses of how each transaction has changed or is expected to change the level of competition in the affected service and geographic markets;
D) Analyses of healthcare costs and prices have changes in affected markets after a large consolidation transaction has taken place.
3. Our AMA will report the initial findings of this study to the House of Delegates by Annual 2024.
4. Our AMA will report the findings of this study to its members and stakeholders, including policymakers and legislators, to inform future healthcare policy. [Res. 727, A-23]

D-160.908 Vertical Consolidation in Health Care – Markets or Monopolies
Our American Medical Association: (1) advocates against anticompetitive business practices that have the potential to adversely affect the physician patient relationship, to result in higher costs or decreased quality of care, or are not in the best interest of patients, the public and/or physicians; (2) supports efforts to increase transparency, review, and enforcement of laws with respect to vertical mergers that have the potential to negatively impact the health care industry; and (3) will work with all appropriate stakeholders to create model legislation to prohibit anticompetitive business practices within the health care sector. [Res. 723, A-23]

H-160.885 Impact of Integration and Consolidation on Patients and Physicians
Our AMA will:
1.Continue to monitor the impact of hospital-physician practice and hospital-hospital mergers and acquisitions on health care prices and spending, patient access to care, potential changes in patient quality outcomes, and physician wages and labor.
2.Continue to monitor how provider mix may change following mergers and acquisitions and how non-compete clauses may impact patients and physicians.

3.Support efforts to collect relevant information regarding hospital-physician practice and hospital-hospital mergers and acquisitions in states or regions that may fall below the Federal Trade Commission (FTC)/Department of Justice review threshold.
4.Encourage state and local medical associations, state specialty societies, and physicians to contact their state attorney general with concerns of anticompetitive behavior.
5.Encourage physicians to share their experiences with mergers and acquisitions, such as those between hospitals and/or those between hospitals and physician practices, with the FTC via their online submission form. [CMS Rep. 08, A-23]

D-215.984 Health System Consolidation
Our AMA will: (1) study nationwide health system and hospital consolidation in order to assist policymakers and the federal government in assessing healthcare consolidation for the benefit of patients and physicians who face an existential threat from healthcare consolidation; and (2) regularly review and report back on these issues to keep the House of Delegates apprised on relevant changes that may impact the practice of medicine, with the first report no later than the 2023 Annual Meeting. [Res. 702, A-22]

H-215.960 Hospital Consolidation
Our AMA: (1) affirms that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) the AMA strongly supports and encourages competition in all health care markets; (c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and (d) antitrust relief for physicians remains a top AMA priority; (2) will continue to support actions that promote competition and choice, including: (a) eliminating state certificate of need laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency; and (3) will work with interested state medical associations to monitor hospital markets, including rural, state, and regional markets, and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices. [CMS Rep. 07, A-19; Reaffirmation I-22]

D-383.980 Health Care Entity Consolidation
Our AMA will (1) 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 (2) develop an action plan for legislative and regulatory advocacy to achieve more vigorous application of antitrust laws to protect physician practices which are confronted with potentially monopolistic activity by health care entities. [BOT Rep. 8, I-15]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 814
(I-23)

Introduced by: Senior Physicians Section

Subject: Providing Parity for Medicare Facility Fees

Referred to: Reference Committee J

Whereas, Payment rates for outpatient services provided in hospital facilities are higher than rates paid to physician offices that provide the same service; and

Whereas, Facility fees help hospitals to cover resources, such as staff, space, equipment and overhead; and

Whereas, This current site-of-service differential incentivizes payments based on the location of where a service is provided; and

Whereas, Many patients are unaware of Medicare payments paid to hospital outpatient settings or to private physicians; and

Whereas, Medicare, for example, pays $116 for a clinic visit to a doctor in an outpatient hospital clinic, and only $46 for the same level visit to an independent doctor[1]; and

Whereas, These payment cuts can ultimately effect where physicians choose to practice, and can contribute to physician shortages and payment disparities for those in rural and underserved areas; and

Whereas, Several states have recently passed laws that support site-neutral payment policies in some form that require reporting facility fee revenues in annual financial filings to the state[2]; and

Whereas, The financial viability of rural and underserved areas for office space procedures and care depends on the payment for healthcare services provided; therefore be it

RESOLVED, That our American Medical Association promote awareness that the 'site of service' payment differential does not reflect quality of care (Directive to Take Action); and be it further

RESOLVED, That our AMA seek legislative action or relief for independent physician practices, including rural and underserved practices, to be paid equally for office-based procedures whether or not they practice in offices, facilities or hospitals (Directive to Take Action); and be it further

RESOLVED, That our AMA amend policy D-330.902, The Site-of-Service Differential, by addition to read as follows:

Our AMA will produce a graphic report <u>yearly</u> illustrating the fiscal losses and inequities that practices without facility fees have endured for decades as a result of the site of service differential factoring in inflation. (Modify Current HOD Policy)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 09/27/23

REFERENCES

1. Carey, M. J. (2018). Facility fees: the farce everyone pays for. *Medical Economics*. August, 16.
2. Emerson, J. (2023, July 25) 14 recent state legislative actions supporting site-neutral payments. *Becker's Hospital Review*. Retrieved August 29 from https://www.beckershospitalreview.com/finance/14-recent-state-legislative-actions-supporting-site-neutral-payments.html

RELEVANT AMA POLICY

The Site-of-Service Differential D-330.902
1. Our AMA supports Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments.
2. Our AMA supports Medicare payments for the same service routinely and safely provided in multiple outpatient settings (e.g., physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting.
3. Our AMA will urge CMS to update the data used to calculate the practice expense component of the Medicare physician fee schedule by administering a physician practice survey (similar to the Physician Practice Information Survey administered in 2007-2008) every five years, and that this survey collect data to ensure that all physician practice costs are captured.
4. Our AMA encourages CMS to both: a) base disproportionate share hospital payments and uncompensated care payments to hospitals on actual uncompensated care data; and b) study the costs to independent physician practices of providing uncompensated care.
5. Our AMA will collect data and conduct research both: a) to document the role that physicians have played in reducing Medicare spending; and b) to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery.
6. Our AMA will produce a graphic report illustrating the fiscal losses and inequities that practices without facility fees have endured for decades as a result of the site of service differential factoring in inflation.
7. Our AMA will consider disseminating the resulting educational materials and graphics.
Citation: CMS Rep.04, I-18; Reaffirmed: BOT Action in response to referred for decision; Res.111, A-19; Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19; Appended: Res.826, I-22

Reimbursement for Office-Based Surgery Facility Fees H-385.916
Our AMA urges third party payers to include facility fee payments for procedures using more than local anesthesia in accredited office-based surgical facilities.
Citation: Res. 716, A-11; Reaffirmed: CMS Rep. 1, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 815
(I-23)

Introduced by: Senior Physicians Section

Subject: Long-Term Care and Support Services for Seniors

Referred to: Reference Committee J

Whereas, The current U.S. population is rapidly aging such that by 2030 those 65 years of age and above will total 73 million, accounting for approximately 20% of the population[1]; and

Whereas, The risk for disability increases with age and it is expected that at least half of the U.S. population will require long-term care and support services[2]; and

Whereas, Access to quality long-term care and support services can significantly improve the quality of life for older adults and people with disabilities[3]; and

Whereas, Long-term care insurance has become unaffordable or unobtainable increasing the likelihood of catastrophic financial consequences[4]; and

Whereas, Under Medicaid all states are required to provide institutional care, but home or community-based services are optional, left to the discretion of individual states; and

Whereas, The overall corporatization of medical care, has increased investment by venture capital firms in the long-term care marketplace, resulting in both increased costs and decreased quality[5]; and

Whereas, Optimizing long-term care and support services can reduce healthcare costs, improve patient outcomes, and alleviate caregiver burden; therefore be it

RESOLVED, That our American Medical Association advocate that private payors offer an affordable insurance product[s] to address long-term care needs (Directive to Take Action); and be it further

RESOLVED, That our AMA with other interested organizations, including the insurance industry, explore ways to ensure the viability of long-term care insurance by a mix of mandates and/or incentives that can be advocated for (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for equity in the financing of long-term care in order to assure affordable care of long-term care for all Americans (Directive To Take Action); and be it further

RESOLVED, That our AMA reaffirm Policy H-25.991, to continue to advocate for fiscal support for “aging in place” by promoting state and federal policy to expand home and community-based services (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA promote research regarding evidence-based interventions to assure the quality of long-term care for seniors both in the home and institutional settings. (Directive to Take Action)

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

Received: 09/27/23

REFERENCES

1. Federal Interagency Forum on Aging. (2004). Older Americans 2020-key indicators of well-being. Retrieved from: https://agingstats.gov/docs/LatestReport/OA20_508_10142020.pdf
2. *Ibid.*
3. Johnson, R. W., Favreault, M. M., Dey, J., Marton, W., & Anderson, L. (2021). Most Older Adults Are Likely to Need and Use Long-Term Services and Supports Issue Brief. *Washington, DC: ASPE, US Department of Health and Human Services*. Accessed June 2, 2023.
4. Arias, J. J. (2019). The last hope: how starting over could save private long-term care insurance. *Health Matrix*, 29, 127.
5. Borsa, A., Bejarano, G., Ellen, M., & Bruch, J. D. (2023). Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: systematic review. *bmj*, 382.

RELEVANT AMA POLICY

Promoting and Ensuring Safe, High Quality, and Affordable Elder Care Through Examining and Advocating for Better Regulation of and Alternatives to the Current, Growing For-Profit Long Term Care Options D-280.982
1. Our AMA will advocate for business models in long term care for the elderly which incentivize and promote the ethical use of resources to maximize care quality, staff and resident safety, and resident quality of life, and which hold patients' interests as paramount over maximizing profit.
2. Our AMA will, in collaboration with other stakeholders, including major payers, advocate for further research into alternatives to current options for long term care to promote the highest quality and value long term care services and supports (LTSS) models as well as functions and structures which best support these models for care.
Citation: Res. 023, A-22

Ensuring Medicare Coverage for Long Term Care D-280.985
Our AMA will work to identify additional mechanisms by which patients' out-of-pocket costs for skilled nursing facility care can be fairly covered.
Citation: Res. 706, A-18

Geriatric and Palliative Care Training For Physicians D-295.969
Our AMA: (1) encourages geriatrics and palliative care training for physicians caring for elderly and terminally ill patients in long-term care facilities; and 2) endorses the concept of affiliation between nursing home facilities for geriatric patients and residency/fellowship programs, where feasible, for the development of physicians' clinical experience in such facilities.
Citation: Res. 305, A-02, Reaffirmed: CCB/CLRPD Rep.4, A-12, Reaffirmed: BOT Rep.05, I-16, Modified: Citation: CME Rep. 01, A-20.

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.

Senior Care H-25.993
Our AMA supports accelerating its ongoing efforts to work responsibly with Congress, senior citizen groups, and other interested parties to address the health care needs of seniors. These efforts should address but not be limited to: (1) multiple hospital admissions in a single calendar year; (2) long-term care; (3) hospice and home health care; and (4) pharmaceutical costs.
Citation: Sub Res. 181, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep.1, A-10; Reaffirmed: CSAPH Rep. 01, A-20.

Financing of Long-Term Services and Supports H-280.945
Our AMA supports:
(1) policies that standardize and simplify private LTCI to achieve increased coverage and improved affordability;
(2) adding transferable and portable LTCI coverage as part of workplace automatic enrollment with an opt-out provision potentially available to both current employees and retirees;
(3) allowing employer-based retirement savings to be used for LTCI premiums and LTSS expenses, including supporting penalty-free withdrawals from retirement savings accounts for purchase of private LTCI;
(4) innovations in LTCI product design, including the insurance of home and community-based services, and the marketing of long-term care products with health insurance, life insurance, and annuities;
(5) permitting Medigap plans to offer a limited LTSS benefit as an optional supplemental benefit or as separate insurance policy;
(6) Medicare Advantage plans offering LTSS in their benefit packages;
(7) permitting Medigap and Medicare Advantage plans to offer a respite care benefit as an optional benefit;
(8) a back-end public catastrophic long-term care insurance program;
(9) incentivizing states to expand the availability of and access to home and community-based services; and
(10) better integration of health and social services and supports, including the Program of All-Inclusive Care for the Elderly.
Citation: CMS Rep. 05, A-18; Reaffirmation: I-18; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep.4, I-21; Reaffirmed: Res. 705, A-23.

Policy Directions for the Financing of Long-Term Care H-280.991
The AMA believes that programs to finance long-term care should: (1) assure access to needed services when personal resources are inadequate to finance care; (2) protect personal autonomy and responsibility in the selection of LTC service providers; (3) prevent impoverishment of the individual or family in the face of extended or catastrophic service costs; (4) cover needed services in a timely, coordinated manner in the least restrictive setting appropriate to the health care needs of the individual; (5) coordinate benefits across different LTC financing program; (6) provide coverage for the medical components of long-term care through Medicaid for all individuals with income below 100 percent of the poverty level; (7) provide sliding scale subsidies for the purchase of LTC insurance coverage for individuals with income between 100-200 percent of the poverty level; (8) encourage private sector LTC coverage through an asset protection program; equivalent to the amount of private LTC coverage purchased; (9) create tax incentives to allow individuals to prospectively finance the cost of LTC coverage, encourage employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage, and allow tax-free withdrawals from IRAs and Employee Trusts for payment of LTC insurance premiums and

expenses; and (10) authorize a tax deduction or credit to encourage family care giving. Consumer information programs should be expanded to emphasize the need for prefunding anticipated costs for LTC and to describe the coverage limitations of Medicare, Medicaid, and traditional medigap policies. State medical associations should be encouraged to seek appropriate legislation or regulation in their jurisdictions to: (a) provide an environment within their states that permit innovative LTC financing and delivery arrangements, and (b) assure that private LTC financing and delivery systems, once developed, provide the appropriate safeguards for the delivery of high quality care. The AMA continues to evaluate and support additional health system reform legislative initiatives that could increase states flexibility to design and implement long-term care delivery and financing programs. The AMA will also encourage and support the legislative and funding changes needed to enable more accurate and disaggregated collection and reporting of data on health care spending by type of service, so as to enable more informed decisions as to those social components of long-term care that should not be covered by public or private health care financing mechanisms.
Citation: BOT Rep.0, A-88; BOT Rep. X, I-88; Reaffirmed: CMS Rep. 3, A-94; BOT Rep. S,I-87; Reaffirmed: CMS Rep. 3-A-94; CMS Rep. 11, I-95; Reaffirmation A-04; Modified: CMS Rep. 6, I-05; Reaffirmed: BOT Rep. 32, A-09; Reaffirmation A-11; Reaffirmed: CMS Rep. 05, A-18; Appended: Res. 110, A-23.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 817
(I-23)

Introduced by: The American Academy of Pediatrics

Subject: Expanding AMA Payment Reform Work and Advocacy to Medicaid and other non-Medicare payment modules for Pediatric Healthcare and Specialty Populations

Referred to: Reference Committee J

Whereas, Current American Medical Association payment reform efforts are centered upon and prioritize Medicare payment reform; and

Whereas, Payment models that rely on shared savings, two-sided risk, and other financial incentives tied to reductions in total spending are based upon the premise that investment in delivery system reform can reduce unnecessary services and reduce health care expenditures while maintaining or improving quality of care and health outcomes within a short timeframe; and

Whereas, Children make up nearly one quarter of the US population but account for less than 10% of total health care expenditures[1]; and

Whereas, Children are excluded from most CMMI payment reform models which drive innovations in financing healthcare delivery; and

Whereas, Investments in child health reap long-term benefits beyond savings measured in the health care system, including in the child welfare, education, and juvenile justice systems, and such investments significantly lower long-term costs associated with prisons and adult chronic care[2], yet such return on investment is not recognized nor incentivized in short-term payment models; and

Whereas, Our AMA has decided to focus payment reform efforts on Medicare while holding off on efforts to improve and reform Medicaid payments as a strategic decision; and

Whereas, Our AMA's payment reform priorities may leave behind large populations of patients such as children or those in rural regions, and essential services such as mental and behavioral health, oral health, home care, and others; and

Whereas, Insufficient Medicaid fee-for-service and managed care payment rates can present tremendous barriers to care that result in a lack of patient access to care; and

Whereas, Medicaid is the largest insurer of patients across the country; therefore be it

RESOLVED, That our American Medical Association examine and report back on demonstration projects, carve outs, and adjustments for pediatric patients and services provided to pediatric patients within the payment reform arena (Directive to Take Action); and be it further

RESOLVED, That our AMA extend ongoing payment reform research, education, and advocacy to address the needs of specialties and patient populations not served by current CMMI models or other Medicare-focused payment reform efforts (Directive to Take Action); and be it further

RESOLVED, That our AMA support and work with medical specialty societies who are developing alternative payment models for pediatric healthcare (New HOD Policy); and be it further

RESOLVED, That our AMA consider improved Medicaid payment rates to be a priority given the critical impact these payment rates have on patient care and patient access to care. (New HOD Policy)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 9/27/23

REFERENCES

1. https://www.healthsystemtracker.org/chart-collection/health-expenditures-vary-across-population/#Proportion%20of%20individuals%20by%20health%20status,%202019
2. Flanagan P, Tigue PM, Perrin J. The Value Proposition for Pediatric Care. JAMA Pediatr. 2019;173(12):1125-1126. doi:10.1001/jamapediatrics.2019.3486

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 818
(I-23)

Introduced by: New England

Subject: Amendment to AMA Policy on Healthcare System Reform Proposals

Referred to: Reference Committee J

Whereas, almost 100 million Americans are either uninsured or underinsured, leading to worse health outcomes via inadequate access to necessary healthcare and adverse financial outcomes including bankruptcy[1-5]; and

Whereas, America's fragmented and disorganized health insurance system places too much power in the hands of for-profit insurers who are strongly incentivized to erect barriers to adequate healthcare, leading to the proliferation of "utilization management" methods like prior authorization that delay or deny necessary care and contribute to physician burnout[6-13]; and

Whereas, unified financing refers to any system of healthcare financing that provides uniform and universal access to healthcare coverage that is high quality and affordable, which can include single payer or multi-payer systems based on managed competition between private insurers[14-19], and does not necessarily mean "government run"; and

Whereas, our American Medical Association staunchly opposed the creation of Medicare, and was therefore not included in its creation, leading to the decades of poor reimbursement and other issues we have with it today; and

Whereas, ample evidence shows that single payer proposals, and other unified financing proposals based on other models, can be constructed that provide equitable, universal, and timely access to high quality care by simplifying our fragmented system and placing decision making power back in the hands of physicians and patients, but current oppositional AMA policy mandates opposition based on the label of single payer; therefore be it

RESOLVED, that our American Medical Association remove opposition to single-payer healthcare delivery systems from its policy, and instead evaluate all healthcare system reform proposals based on our stated principles as in AMA policy (Directive to Take Action); and be it further

RESOLVED, that our AMA support a national unified financing healthcare system that meets the principles of freedom of choice, freedom and sustainability of practice, and universal access to quality care for patients. (New HOD Policy)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 10/3/23

REFERENCES

1. https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey,
2. https://aspe.hhs.gov/sites/default/files/documents/15c1f9899b3f203887deba90e3005f5a/Uninsured-Q1-2022-Data-Point-HP-2022-23-08.pdf
3. http://medicine.tums.ac.ir/filegallery/2299016929/nezamoleslami%2031%20ordibehesht.pdf
4. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01150?casa_token=FqmCYfmNIN8AAAAA%3AdrF2Hngg6yz64J-23CgVo-JVMv-nMWWV_-GjcvzJu-2CEJCJNcSj-pXKsh4gJHUXjvgBOdgPYZM,
5. https://onlinelibrary.wiley.com/doi/full/10.1111/1475-6773.13085
6. National Academies of Sciences, Engineering, and Medicine. 2019. Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being. Washington, DC: The National Academies Press. https://doi.org/10.17226/25521.
7. Colligan L, Sinsky C, Goeders L, Schmidt-Bowman M, Tutty M. Sources of physician satisfaction and dissatisfaction and review of administrative tasks in ambulatory practice: A qualitative analysis of physician and staff interviews. October 2016. Available at: ama-assn.org/go/psps.
(Taking Action Against Clinician Burnout.pdf, ps2-dartmouth-study-111016.pdf
8. https://www.ama-assn.org/press-center/press-releases/insurer-inaction-prior-authorization-reform-requires-federal-response
9. https://www.hhs.gov/guidance/document/medicare-parts-and-b-coverage-and-prior-authorization-0
10. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9745939/,
11. https://www.sciencedirect.com/science/article/pii/S0190962219307911?casa_token=71jQFkrVyQkAAAAA:VVE8KqX5qkKBcdP_A5I0yDAK9TCLL1WwTkk2d1o35WLTwznjzosQyf6sxe1qhOEn0rDEJeficw
12. https://onlinelibrary.wiley.com/doi/full/10.1002/acr.24062?casa_token=cTxc52YTlxoAAAAA%3Apkd-CjcQBHqF4neDDbvXdd51w8ziPP8txrTEP84jY31qDrHAfUgPkqOqB3AqKPQdcXNKtHI_juQ9Dg
13. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
14. https://www.chhs.ca.gov/wp-content/uploads/2022/04/Key-Design-Considerations_April-2022_Final-Report-for-Distribution.pdf
15. https://www.commonwealthfund.org/international-health-policy-center/countries
16. https://www.commonwealthfund.org/international-health-policy-center/countries/france
17. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4195085/
18. https://www.commonwealthfund.org/international-health-policy-center/countries/netherlands
19. https://www.commonwealthfund.org/international-health-policy-center/countries/germany

RELEVANT AMA POLICY

Evaluating Health System Reform Proposals H-165.888

1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:
A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
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.
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.
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 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.
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.
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.
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.
H. True health reform is impossible without true tort reform.
2. Our AMA supports health care reform that meets the needs of all Americans including people with

injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.

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.

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.
Res. 118, I-91; Res. 102, I-92; BOT Rep. NN, I-92; BOT Rep. S, A-93; Reaffirmed: Res. 135, A-93; Reaffirmed: BOT Reps. 25 and 40, I-93; Reaffirmed in lieu of Res. 714, I-93, Res. 130, I-93, Res. 316, I-93, Sub. Res. 718, I-93; Reaffirmed: CMS Rep. 5, I-93; Res. 124, A-94; Reaffirmed by BOT Rep.1- I-94; CEJA Rep. 3, A-95; Reaffirmed: BOT Rep. 34, I-95; Reaffirmation A-00; Reaffirmation A-01; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CME Rep. 2, A-03; Reaffirmed and Modified: CMS Rep. 5, A-04; Reaffirmed with change in title: CEJA Rep. 2, A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation I-07; Reaffirmed in lieu of Res. 113, A-08; Reaffirmation A-09: Res. 101, A-09, Sub. Res. 110, A-09, Res. 123, A-09; Reaffirmed in lieu of Res. 120, A-12; Reaffirmation: A-17

Health System Reform Legislation H-165.838
1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy: a. Health insurance coverage for all Americans; b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps; c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials; d. Investments and incentives for quality improvement and prevention and wellness initiatives; e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care; f. Implementation of medical liability reforms to reduce the cost of defensive medicine; g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens
…
4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.

5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.
…
12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.
…
Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed in lieu of: Res. 805, I-17; Reaffirmed: CMS Rep. 03, A-18; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmation: A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 819
(I-23)

Introduced by: New York

Subject: Amend Virtual Credit Card Policy

Referred to: Reference Committee J

Whereas, our American Medical Association (AMA) has taken numerous steps to protect physicians from inappropriate delays and deductions from health insurance plans; and

Whereas, our AMA has previously adopted resolutions on Virtual Credit Card (VCC) Payments such as H-190.955, which calls for our AMA to educate its members about the use of virtual credit cards by third party payers, the costs of accepting virtual credit card payments from third party payers, the beneficiaries of the administrative fees paid by the physician practice inherent in accepting such payments, and the lower cost alternative of electronic funds transfer (EFT) via the Automated Clearing House; and

Whereas, an Interim Final Rule on EFT from the Centers for Medicare & Medicaid Services (CMS) allows payment by VCCs; and

Whereas, while CMS guidance states that health plans must comply with a physician's request to receive EFT instead of a VCC and that a physician cannot be forced to accept additional services with EFT, there is no specific prohibition on health plans or their vendors charging fees for EFTs; and

Whereas, Policy D-190.970[2] advocates that CMS resolve all complaints related to the non-compliant payment methods including opt-out VCCs, charging processing fees for electronic claims and other illegal EFT fees; therefore be it

RESOLVED, that our American Medical Association make no further statements regarding the "legality" of Virtual Credit Cards (VCCs) (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for legislation or regulation that would prohibit the use of VCCs for electronic health care payments (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate on behalf of physicians and plainly state that in no circumstance is it advisable or beneficial for medical practices to get paid by VCCs. (Directive to Take Action)

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

Received: 9/26/23

REFERENCES
Dyrda, Laura. "Private practice physicians drop to 26%." Becker's ASC Review, 20 April 2022, https://www.beckersasc.com/asc-transactions-and-valuation-issues/private-practice-physicians-drop-to-26.html

RELEVANT AMA POLICY

Virtual Credit Card Payments H-190.955
1. Our American Medical Association will educate its members about the use of virtual credit cards by third party payers, including the costs of accepting virtual credit card payments from third party payers, the beneficiaries of the administrative fees paid by the physician practice inherent in accepting such payments and the lower cost alternative of electronic funds transfer via the Automated Clearing House.
2. Our AMA will advocate for advance disclosure by third-party payers of transaction fees associated with virtual credit cards and any rebates or other incentives awarded to payers for utilizing virtual credit cards.
3. Our AMA supports transparency, fairness, and provider choice in payers' use of virtual credit card payments, including: advanced physician consent to acceptance of this form of payment; disclosure of transaction fees; clear information about how the provider can opt out of this payment method at any time; and prohibition of payer contracts requiring acceptance of virtual credit card payments for network inclusion.
Policy Timeline: Sub. Res. 704, A-15

Physician Credit Card Payments by Health Insurance Companies D-190.972
Our AMA will consider legislation on behalf of physicians that any credit card transaction/bank fees are paid by the insurer and not the health care provider.
Policy Timeline: Res. 225, I-14

CMS Administrative Requirements D-190.970
Our AMA will: (1) forcefully advocate that the Centers for Medicare and Medicaid Services (CMS) investigate all valid allegations of HIPAA Administrative simplification requirements thoroughly and offers transparency in its processes and decisions as required by the Administrative Procedure Act (APA); (2) forcefully advocate that the CMS resolve all complaints related to the non-compliant payment methods including opt-out virtual credit cards, charging processing fees for electronic claims and other illegal electronic funds transfer (EFT) fees; (3) communicate its strong disapproval of the failure by the CMS Office of Burden Reduction to effectively enforce the HIPAA administrative simplification requirements as required by the law and its failure to impose financial penalties for non-compliance by health plans; and (4) through legislation, regulation or other appropriate means, advocate for the prohibition of health insurers charging physicians and other providers to process claims and make payment.
Policy Timeline: Res. 229, I-21; Reaffirmation: A-22

Author's Priority Statement:
Virtual credit cards, debit, and other payment cards, as well as ERA/EFT fees, impose a significant hardship on the financial viability of independent physician practices. As a result, a recent survey shows that private practice physicians drop to 26%.

Physician practices have experienced consecutive years of decreasing reimbursement in the face of raging inflation and cannot afford to absorb the progressively increasing burden of such fees.

Private and independent medical practices are the most adaptable and provide a large proportion of low-cost care to the underinsured with high copays and high deductibles.

This is an urgent matter for physicians and patients whose access to treatment is limited or delayed by the loss of independent physician practices.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 820
(I-23)

Introduced by: Oregon

Subject: Affordability and Accessibility of Treatment of Overweight and Obesity

Referred to: Reference Committee J

Whereas, the prevalence of overweight and obesity in the United States is approaching 50% and together they account for at least $174 billion in annual excess health care spending; and

Whereas, obesity is a major contributor to serious chronic diseases such as diabetes, hypertension, and degenerative joint disease and thus a major contributor to poor health outcomes; and

Whereas, evidence-based medicine recognizes obesity as a chronic disease resulting from both genetic and environmental factors rather than from moral failure; and

Whereas, the best available evidence suggests that modifications of diet and exercise are unlikely to result in long-term benefits; and

Whereas, the treatment of obesity has progressed to the point where an individualized approach utilizing appropriate combinations of behavioral, surgical, and pharmacological interventions is considered the standard of care; and

Whereas, newer pharmacological treatments include medications that are very expensive and whose cost in the United States exceeds that in other countries; and

Whereas, currently, third-party payors, including Medicare, many state Medicaid programs, and many commercial insurance companies do not cover these and other established medications for weight loss consequently resulting in inequities in care and disparities in outcomes: therefore be it

RESOLVED, that our American Medical Association join in efforts to convince Congress to address the affordability and accessibility of prevention and evidence-based treatment of obesity across the United States as well as, urge individual state delegations to directly advocate for their state insurance agencies and insurance providers in their jurisdiction to: 1. Revise their policies to ensure that prevention and evidence-based treatment of obesity is covered for patients who meet the appropriate medical criteria; and 2. Ensure that insurance policies in their states do not discriminate against potential evidence-based treatment of obese patients based on age, gender, race, ethnicity, socioeconomic status. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 10/10/23

REFERENCES

1. Christine Laine, Christina C. Wee. Overweight and Obesity: Current Clinical Challenges. Ann Intern Med. [Epub 14 March 2023]. Doi:10.7326/M23-0628.
2. Khrysta Baig, Stacie B. Dusetzina, David D. Kim, Ashley A. Leech. Medicare Part D Coverage of Antiobesity Medications – Challenges and Uncertainty Ahead. N Engl J Med 388;11. March 16, 2023
3. Obesity Clinical Guidance. https://www.aafp.org/family-physician/patient-care/clinical-recommendations/clinical-guidance-obesity.html. AAFP: Clinical Guidance: Obesity and Healthy Lifestyle: Clinical Guidance and Practice Resources. Date accessed: March 15, 2023. Date published: February 28, 2023.
4. About Overweight and Obesity. https://www.cdc.gov/obesity/about-obesity/index.html. Centers for Disease Control and Prevention. Date accessed: March 15, 2023. Date published: February 24, 2023.
5. Müller, T.D., Blüher, M., Tschöp, M.H. et al. Anti-obesity drug discovery: advances and challenges. Nat Rev Drug Discov 21, 201–223 (2022). https://doi.org/10.1038/s41573-021-00337-8.
6. Foster, D., Sanchez-Collins, S., & Cheskin, L. J. (2017). Multidisciplinary Team-Based Obesity Treatment in Patients With Diabetes: Current Practices and the State of the Science. Diabetes spectrum : a publication of the American Diabetes Association, 30(4), 244–249. https://doi.org/10.2337/ds17-0045.
7. Anti-obesity medications are set to skyrocket this year. But how will we afford them? https://www.usatoday.com/story/news/health/2023/02/19/anti-obesity-medications-cost/11069886002/. USA Today. Date accessed: March 15, 2023. Date published: February 20, 2023.

RELEVANT AMA POLICY

Addressing Adult and Pediatric Obesity D-440.954

1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.
2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).
3. Our AMA will work with interested national medical specialty societies and state medical associations to increase public insurance coverage of and payment for the full spectrum of evidence-based adult and pediatric obesity treatment.
4. Our AMA will: (a) work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment; and (b) work with interested state medical societies and other stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.
5. Our AMA will leverage existing channels within AMA that could advance the following priorities:
· Promotion of awareness amongst practicing physicians and trainees that obesity is a treatable chronic disease along with evidence-based treatment options.
· Advocacy efforts at the state and federal level to impact the disease obesity.
· Health disparities, stigma and bias affecting people with obesity.
· Lack of insurance coverage for evidence-based treatments including intensive lifestyle intervention, anti-obesity pharmacotherapy and bariatric and metabolic surgery.
· Increasing obesity rates in children, adolescents and adults.
· Drivers of obesity including lack of healthful food choices, over-exposure to obesogenic foods and food marketing practices.
6. Our AMA will conduct a landscape assessment that includes national level obesity prevention and treatment initiatives, and medical education at all levels of training to identify gaps and opportunities where AMA could demonstrate increased impact.
7. Our AMA will convene an expert advisory panel once, and again if needed, to counsel AMA on how best to leverage its voice, influence and current resources to address the priorities listed in item 5. Above.