Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION AS AMENDED

1. Resolution 1 – Corporate Practice of Medicine Prohibition
2. Resolution 3 – Access to Covered Benefits with an Out of Network Ordering Physician
3. Resolution 4 – The Role of Maintenance of Certification
4. Resolution 5 – Reforming Stark Law’s Blanket Self-Referral Ban

RECOMMENDED FOR ADOPTION IN LIEU OF

5. Resolution 2 – Billing and Collections Transparency
RECOMMENDED FOR ADOPTION AS AMENDED

(1) RESOLUTION 1 – CORPORATE PRACTICE OF MEDICINE PROHIBITION

RECOMMENDATION A:

The resolve in Resolution 1 be amended by addition to read as follows:

1. Our AMA vigorously opposes any effort to pass federal legislation to preempting state laws prohibiting the corporate practice of medicine by limiting ownership and corporate control of physician medical practices to physicians or physician-owned groups only and ensure private equity/non-medical groups do not have a controlling interest.

2. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations.

3. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues.

(Directive to Take Action).

RECOMMENDATION B:

Resolution 1 be adopted as amended.

RECOMMENDATION C:

Resolution 1 be immediately forwarded for consideration at the 2023 Interim Meeting of the AMA House of Delegates.

Resolved, That our American Medical Association amend policy H-215.981, Corporate Practice of Medicine, by deletion and substitution to read as follows:

1. Our AMA vigorously opposes any effort to pass federal legislation to preempting state laws prohibiting the corporate practice of medicine by limiting ownership of physician medical practices to physicians or physician-owned groups only.
2. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations.

3. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues.

Your Reference Committee heard generally strong support for Resolution 1 with several members testifying to their belief that non-medical interests have found their way into medical practices to the practice’s disadvantage. Testimony also reflected experiences and observations on the need for greater protection at the federal level for medical practices that have been essentially forced into ownership situations with private equity or other non-medical actors that are harming patients in the long term at least in part because they strip physicians of their autonomy in their own practice of medicine.

The Committee found itself in solid agreement with much of the testimony provided. It also agreed that crafting a policy that would ban or otherwise restrict ownership outright may run afoul of standing law, so any path forward to offer real and significant protections for medical practices must be constructed mindfully. It is in this spirit that the Committee believes its amendments to the author’s original amendments will help to strengthen the eventual policy. The Committee believes that calling out specifically that corporate control of physician practices, particularly when that control attempts to use physicians as a figurehead in order to maintain the illusion that the practice is still under physician direction while in practice maintaining controlling decisions from the corporate ownership, should not be permitted.

(2) RESOLUTION 3 – ACCESS TO COVERED BENEFITS WITH AN OUT OF NETWORK ORDERING PHYSICIAN

RECOMMENDATION A:

The first resolve in Resolution 3 be amended by addition and deletion to read as follows:

Resolved, That our American Medical Association craft develop model legislation to protect patients in these direct primary care plans and non-network plans, thus furthering the ability of direct primary care physicians and other out of network physicians to provide covered services, including imaging, laboratory testing, referrals, and medications, and other medically-necessary services for patients under their commercial insurance, even if it is an HMO or POS plan (Directive to Take Action); and be it further
RECOMMENDATION B:

The second resolve in Resolution 3 be amended by addition and deletion to read as follows:

Resolved, That our AMA craft develop model legislation to protect patients in these direct primary care plans and non-network plans, thus furthering the ability of direct primary care physicians and other out network physicians to order or provide such covered services to their patients under their Medicare Advantage plans (Directive to Take Action); and be it further

RECOMMENDATION C:

The third resolve in Resolution 3 be amended by deletion to read as follows:

Resolved, That our AMA will develop resources, tool kits, education, and internal experts to support direct primary care and other out of network models (Directive to Take Action).

RECOMMENDATION D:

Resolution 3 be adopted as amended.

RECOMMENDATION E:

Resolution 3 be immediately forwarded for consideration at the 2023 Interim Meeting of the AMA House of Delegates.

Resolved, That our American Medical Association craft model legislation to protect patients in these plans thus furthering the ability of direct primary care physicians and other out of network physicians to provide covered services, including imaging, laboratory testing, referrals, and medications for patients under their commercial insurance, even if it is an HMO or POS plan (Directive to Take Action); and be it further

Resolved, That our AMA craft model legislation to protect patients in these plans thus furthering the ability of direct primary care physicians and other out network physicians to order or provide such covered services to their patients under their Medicare Advantage plans (Directive to Take Action); and be it further

Resolved, That our AMA will develop resources, tool kits, education, and internal experts to support direct primary care and other out of network models (Directive to Take Action).

Your Reference Committee heard testimony in support of Resolution 3, though it agreed that the resolve clauses could be strengthened by more directly calling out the types of
plans that the clauses would speak to. The Committee is also aware that other groups outside of the AMA are working on this issue and wondered if engaging would be duplicative of the efforts that are already organized. The Committee ultimately came to believe that the AMA has a principled position in this case and that care for how out of network physicians get coverage and reimbursement for services rendered is a primary mission of the organization and so it should be engaged.

The only caveat the Committee offers is just to say that there is a significant amount of nuance that will need to be taken into consideration when drafting any model legislation because of the complicated nature of insurance plans and physician networks, and it urges that any final model legislation be evaluated broadly within the AMA community to make sure that member needs would be met under it.

(3) RESOLUTION 4 – THE ROLE OF MAINTENANCE OF CERTIFICATION

RECOMMENDATION A:

The first resolve in Resolution 4 be amended by addition and deletion to read as follows:

Resolved, That our American Medical Association adopt policy that states—1) that MOC requirements should not be duplicative of CME requirements, and 2) that MOC requirements should not be used to determine or dictate hospital privileges, insurance network credentialing, or hiring practices (Directive to Take Action New HOD Policy); and be it further

RECOMMENDATION B:

The third resolve in Resolution 4 be amended by addition and deletion to read as follows:

Resolved, That our American Medical Association undertake a comprehensive review of the available evidence concerning the impact of maintenance of certification on the quality and safety of patient care and report the findings of this investigation to its members and stakeholders, including policymakers and legislators, to inform future healthcare policy with a report back to the House of Delegates by Interim 2024 (Directive to Take Action); and be it further

RECOMMENDATION C:

The fourth and fifth resolves in Resolution 4 be deleted:
Resolved, That our American Medical Association report the findings of this study to the House of Delegates by Annual 2024 (Directive to Take Action); and be it further

Resolved, That our American Medical Association report the findings of this investigation to its members and stakeholders, including policymakers and legislators, to inform future healthcare policy (Directive to Take Action).

RECOMMENDATION D:

Resolution 4 be adopted as amended.

RECOMMENDATION E:

Resolution 4 be forwarded for consideration at the 2024 Annual Meeting of the AMA House of Delegates.

Resolved, That our American Medical Association adopt policy that states 1) that MOC requirements should not be duplicative of CME requirements, and 2) that MOC requirements should not be used to determine or dictate hospital privileges, insurance network credentialing, or hiring practices (Directive to Take Action); and be it further

Resolved, That our American Medical Association recognizes the importance of fostering competition in the market for board certification, allowing physicians to have the autonomy to choose the most suitable pathway for their individual learning and professional development needs (New HOD Policy); and be it further

Resolved, That our American Medical Association undertake a comprehensive review of the available evidence concerning the impact of maintenance of certification on the quality and safety of patient care (Directive to Take Action); and be it further

Resolved, That our American Medical Association report the findings of this study to the House of Delegates by Annual 2024 (Directive to Take Action); and be it further

Resolved, That our American Medical Association report the findings of this investigation to its members and stakeholders, including policymakers and legislators, to inform future healthcare policy (Directive to Take Action).

Your Reference Committee heard testimony in support of Resolution 4, though some testimony reflected a desire for the AMA to go further than simply study the issue of maintenance of certification and instead take more direct action to oppose it. The Committee found itself conceptually sympathetic to many of these comments, however it ultimately believes that a thorough evaluation and study of the issue will prove to be a more advantageous route.

The Committee was slightly concerned that offering five resolve clauses could ultimately water down the desired result of the resolution. It is in that spirit that the Committee offers its amendments to consolidate the clauses and help them to stand together,
hopefully to ensure the same final product as the author intended but with a greater likelihood of passage through the House of Delegates.

Finally, while the Committee strongly supports the resolution, it struggled to justify the content under the rubric of advocacy, which is the directive of resolutions submitted at Interim meetings. To best ensure that the resolution is heard before the House of Delegates and not rejected on the basis of being unrelated to advocacy, the Committee thus recommends the Section adopt the resolution but hold it back and instead forward it to the House of Delegates for the 2024 Annual Meeting, where it should have a better likelihood of being received.

(4) RESOLUTION 5 – REFORMING STARK LAW’S BLANKET SELF-REFERRAL BAN

RECOMMENDATION A:

The first resolve in Resolution 5 be amended by addition and deletion to read as follows:

Resolved, That our American Medical Association recognizes the substantial impact of the Stark law’s unequal restrictions on independent physicians, contributing to the growing trend of hospital consolidation, which has led to negative consequences of restricted access to care and inflated costs within the healthcare landscape (New HOD Policy); and be it further

RECOMMENDATION B:

The third resolve in Resolution 5 be amended by deletion to read as follows:

Resolved, That our American Medical Association is committed to advocating for equitable and balanced Stark law reform that fosters fair competition, incentivizes innovation, and facilitates the delivery of high-quality, patient-centered care across the healthcare industry (New HOD Policy).

RECOMMENDATION C:

Resolution 5 be adopted as amended.

RECOMMENDATION E:

Resolution 5 be immediately forwarded for consideration at the 2023 Interim Meeting of the AMA House of Delegates.
Resolved, That our American Medical Association recognizes the substantial impact of the Stark law’s unequal restrictions on independent physicians, contributing to the growing trend of hospital consolidation within the healthcare landscape (New HOD Policy); and be it further

Resolved, That our American Medical Association supports comprehensive Stark law reform aimed at rectifying the disparities by ending the blanket ban on self-referral practices, particularly in the context of capitated, risk-adjusted payment programs such as Medicare Advantage and Medicaid managed care (Directive to Take Action); and be it further

Resolved, That our American Medical Association is committed to advocating for equitable and balanced Stark law reform that fosters fair competition, incentivizes innovation, and facilitates the delivery of high-quality, patient-centered care across the healthcare industry (New HOD Policy).

Your Reference Committee heard universal support for Resolution 5 with testimony in the Online Forum reflecting the need and desire for changes to Stark law and support for the AMA for taking on such a task. The Committee only diverged slightly from the original language in that it believed adding context about what the negative implications of Stark has been for physicians would strengthen the resolve clause. Other changes are offered merely to streamline the clauses.
RECOMMENDED FOR ADOPTION IN LIEU OF

(5) RESOLUTION 2 – BILLING AND COLLECTIONS
TRANSPARENCY

RECOMMENDATION A:

Alternate Resolution 2 be adopted in lieu of Resolution 2.

Resolved, That our American Medical Association will work with the appropriate legislative and/or regulatory bodies to establish the requirement that revenue cycle management entities, regardless of their ownership structure, and/or employers will directly provide each physician it bills or collects for with a detailed, itemized statement of billing and remittances for medical services they provide in real time and at any time upon request. Additionally, the physician shall not be asked to waive access to this information (Directive to Take Action).

RECOMMENDATION B:

Alternate Resolution 2 be immediately forwarded for consideration at the 2023 Interim Meeting of the AMA House of Delegates.

Resolved, That our American Medical Association amend policy H-225.950, Principles for Physician Employment, by addition of a new item under Section 6 to read:

6. Payment Agreements

a. Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.

b. Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer’s billing for physician services, which violation is not the fault of the employee.

c. The AMA will petition the appropriate legislative and/or regulatory bodies to establish the requirement that revenue cycle management entities, regardless of their ownership structure, and/or employers will directly provide each physician it bills or
collects for with a detailed, itemized statement of billing and remittances for medical
services they provide biannually and at any time upon request. Additionally, the
physician shall not be asked to waive access to this information. Our AMA will seek
federal legislation requiring this, if necessary, (Directive to Take Action); and be it further
Resolved, That our AMA will educate physicians as to the importance of billing
transparency and advocate for employed physicians to have full access to this
information (Directive to Take Action).

Your Reference Committee heard testimony strongly supporting Resolution 2. Several
specifically referenced difficulties experienced under recent federal legislation, such as
the No Surprises Act, that may have been intended to benefit patients and, by extension,
physicians for making charging and reimbursement pathways clear, but in practice have
placed more barriers on physician practices and made it more difficult to operate.
Several members testified that they would, in fact, prefer the resolution go further its
proposed amendments.

While the Committee agreed with member testimony and found Resolution 2's proposed
amendments to existing policy H-225.950 to be reasonable and sound, it did struggle to
fit those amendments in the context of H-225.950. That policy specifically relates to
employed physicians, a category that is largely not represented in the Private Practice
Physicians Section. Additionally, the Committee wondered if the proposed addition to H-
225.950 was out of place given the context and the rest of the policy. The Committee did
not believe, however, that any of these misgivings should interfere with the proposed
policy change, which the Committee agreed is necessary and should be enacted. To
resolve this tension, the Committee thus recommends that Resolution 2's original
proposed amendment be adopted as its own independent policy and thus recommends
that an alternate resolution, with some minor alterations, be adopted instead to give the
provisions their own standing.
Doctor Chair, this concludes the report of the Private Practice Physicians Section Reference Committee. I would like to thank Dr. Carl Knopke and Dr. Charles Rainey, as well as all those who testified before the Committee.

Christopher Garofalo, MD  
Chair, PPPS Reference Committee

Carl Knopke, MD

Charles Rainey, MD, JD