

REPORTS OF THE COUNCIL ON MEDICAL SERVICE

The following reports were presented by Lynda M. Young, MD, Chair:

1. COUNCIL ON MEDICAL SERVICE’S SUNSET REVIEW OF 2011 HOUSE POLICIES

Reference committee hearing: see report of Reference Committee G.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED**

Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA’s policy database is current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for review and specifying the procedures to follow:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset “clock,” making the reaffirmed or amended policy viable for another ten years.
2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.
3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its ten-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.
4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.
5. The most recent policy shall be deemed to supersede contradictory past AMA policies.
6. Sunset policies will be retained in the AMA historical archives.

RECOMMENDATION

The Council on Medical Service recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX – Recommended Actions

Policy #	Title	Text	Recommendation
D-125.992	Opposition to Prescription Prior Approval	Our AMA will urge public and private payers who use prior authorization programs for prescription drugs to minimize administrative burdens on prescribing physicians. (Sub. Res. 529, A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 822, I-11)	Retain. Still relevant.

Policy #	Title	Text	Recommendation
D-165.985	Evolving Internet-Based Health Insurance Markets	Our AMA will continue to monitor the evolution of the Internet-based health benefits industry and report to the House of Delegates on important developments. (CMS Rep. 5, A-01; Reaffirmed: CMS Rep. 7, A-11)	<p>Rescind. Superseded by Policy H-165.839, which states:</p> <p>1. Our American Medical Association adopts the following principles for the operation of health insurance exchanges:</p> <p>A) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features.</p> <p>B) Any benefits standards implemented for plans participating in the exchange and/or to determine minimum creditable coverage for an individual mandate should be designed with input from patients and actively practicing physicians.</p> <p>C) Physician and patient decisions should drive the treatment of individual patients.</p> <p>D) Actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options.</p> <p>E) Regulations addressing physician participation in public, private or non-profit health insurance options in the exchange that impact physician practice should ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process.</p> <p>F) Any necessary federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices.</p> <p>2. Our AMA: (A) supports using the open marketplace model for any health insurance exchange, with strong patient and physician protections in place, to increase competition and maximize patient choice of health plans, (B) will advocate for the inclusion of actively practicing physicians and patients in health insurance exchange governing structures and against the categorical exclusion of physicians based on conflict</p>

Policy #	Title	Text	Recommendation
			of interest provisions; (C) supports the involvement of state medical associations in the legislative and regulatory processes concerning state health insurance exchanges; and (D) will advocate that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information.
D-385.960	Appropriate Payments for Vaccine Price Increases	Our AMA will work with national specialty societies to educate physicians to include language in their health insurer contracts to provide for regular updating of vaccine prices and payment levels, which should include real-time adjustments in vaccine pricing. (Res. 807, I-11)	Retain. Still relevant.
D-390.958	The Impact of National Physician Payment Reductions on the National Unemployment Rate	Our AMA will expand its previous studies on the economic impact on the medical practice for the purpose of developing data on the negative economic impact on physician practice employees and communities of incremental SGR cuts and will include in future communications with the US Congress, other stakeholders, and the American people, data-driven information on the national economic impact, including the impact from potential loss of employment of medical practice employees and others, due to payment decreases for physician practices. (Res. 218, I-11)	Rescind. The SGR was repealed in 2015. Moreover, the AMA regularly conducts economic analyses that inform AMA advocacy on behalf of physician practices, including a COVID-19 Physician Practice Financial Impact Survey and Changes in Medicare Physician Spending During the COVID-19 Pandemic .
D-400.991	gCPT Modifiers	(1) Our AMA will continue to actively collect information, through existing processes, including the semi-annual study of non-Medicare use of the Medicare RBRVS conducted by the AMA Department of Physician Payment Policy and Systems and the recently unveiled AMA Private Sector Advocacy (PSA) Health Plan Complaint Form, and solicit input and assistance in this data collection from other interested members of the Federation on the acceptance of CPT modifiers by third party payers. (2) Pertinent information collected by our AMA through existing methods and collected through the AMA PSA Health Plan Complaint Form about acceptance of CPT modifiers by third party payers be shared with applicable state, county and national medical specialty societies in order to promote a greater understanding of third party payer payment policies related to CPT modifiers. (3) Our AMA use the available information to engage in discussions with payers. (4) Aggregate information collected through existing methods and collected through the AMA PSA Health Plan Complaint Form on acceptance for payment of CPT modifiers by third party payers be disseminated to state and federal regulators and legislators. (Sub. Res. 808, I-01; Modified: CMS Rep. 7, A-11)	Rescind. Superseded by Policy D-70.971 which states: (1) Our AMA Private Sector Advocacy Group will continue to collect information on the use and acceptance of CPT modifiers, particularly modifier -25, and that it continue to advocate for the acceptance of modifiers and the appropriate alteration of payment based on CPT modifiers. (2) The CPT Editorial Panel in coordination with the CPT/HCPAC Advisory Committee will continue to monitor the use and acceptance of CPT Modifiers by all payers and work to improve coding methods as appropriate. (3) Our AMA will collect information on the use and acceptance of modifier -25 among state Medicaid plans and use this information to advocate for consistent acceptance and appropriate payment adjustment for modifier -25 across all Medicaid plans. (4) Our AMA will encourage physicians to pursue, in their negotiations with third party payers, contract provisions that will require such payers to adhere to CPT rules concerning modifiers. (5) Our AMA will include in its model managed care contract, provisions that will require managed care plans to

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			<p>adhere to CPT rules concerning modifiers.</p> <p>(6) Our AMA will continue to educate physicians on the appropriate use of CPT rules concerning modifiers.</p> <p>(7) Our AMA will actively work with third party payers to encourage their disclosure to physician providers any exceptions by those payers to CPT guidelines, rules and conventions.</p> <p>(8) Our AMA will include in CPT educational publications (i.e. CPT Assistant) examples of commonly encountered situations where the -25 modifier would and would not apply.</p>
D-400.994	Conscious Sedation	Our AMA will support the efforts of the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee (RUC) as they review the coding and valuation issues related to procedures that are performed using moderate sedation/analgesia (i.e., “conscious sedation”). (Res. 107, A-01; Reaffirmed: CMS Rep. 7, A-11)	Rescind. Directive accomplished. New CPT codes for moderate sedation were implemented and RUC recommendations were adopted by CMS in 2017.
D-435.996	Malpractice Insurance Rate Increases and Physician Reimbursement	Our AMA will: (1) call upon the CMS to use current data in calculating the malpractice insurance portion of the Resource-Based Relative Value Scale and that this calculation take into account inter-specialty and geographic variances; and (2) study the calculated malpractice insurance portion of the RBRVS to determine the effect increasing malpractice insurance costs have on physician reimbursement. (Res. 109, A-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
D-70.983	Inappropriate Bundling of Medical Services by Third Party Payers	Our AMA will: (1) continue to promote its Private Sector Advocacy activities and initiatives associated with the collection of information on third party payer modifier acceptance and inappropriate bundling practices; (2) use the data collected as part of its Private Sector Advocacy information clearinghouse to work, in a legally appropriate manner, with interested state medical associations and national medical specialty societies to identify and address inappropriate third party payer coding and reimbursement practices, including inappropriate bundling of services, rejection of CPT modifiers, and denial and delay of payment; (3) continue to monitor the class action lawsuits of state medical associations, and provide supportive legal and technical resources, as appropriate; (4) develop model state legislation to prohibit third party payers from bundling services inappropriately by encompassing individually coded services under other separately coded services unless specifically addressed in CPT guidelines, or unless a physician has been specifically advised of such bundling practices at the time of entering into a contractual agreement with the physician;	Retain. Still relevant.

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		<p>(5) urge state medical associations to advocate the introduction and enactment of AMA model state legislation on claims bundling by their state legislatures; and.</p> <p>(6) highlight its Private Sector Advocacy document on bundling and downcoding, the related section of the AMA Model Managed Care Contract, and its advocacy initiatives on its web site and other communications measures to assure that physicians are aware of the AMA’s advocacy on this issue. (CMS Rep. 6, I-01; Reaffirmed: CMS Rep. 7, A-11)</p>	
H-100.964	Drug Issues in Health System Reform	<p>The AMA: (1) consistent with AMA Policy H-165.925, supports coverage of prescription drugs, including insulin, in the AMA standard benefits package.</p> <p>(2) supports consumer choice of at least two options for their pharmaceutical benefits program. This must include a fee-for-service option where restrictions on patient access and physician autonomy to prescribe any FDA-approved medication are prohibited.</p> <p>(3) reaffirms AMA Policy H-110.997, supporting the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourage physicians to supplement medical judgments with cost considerations in making these choices.</p> <p>(4) reaffirms AMA Policies H-120.974 and H-125.992, opposing the substitution of FDA B-rated generic drug products.</p> <p>(5) supports a managed pharmaceutical benefits option with market-driven mechanisms to control costs, provided cost control strategies satisfy AMA criteria defined in AMA Policy H-110.997 and that drug formulary systems employed are consistent with standards defined in AMA Policy H-125.991.</p> <p>(6) supports prospective and retrospective drug utilization review (DUR) as a quality assurance component of pharmaceutical benefits programs, provided the DUR program is consistent with Principles of Drug Use Review defined in AMA Policy H-120.978.</p> <p>(7a) encourages physicians to counsel their patients about their prescription medicines and when appropriate, to supplement with written information; and supports the physician’s role as the “learned intermediary” about prescription drugs.</p> <p>(7b) encourages physicians to incorporate medication reviews, including discussions about drug interactions and side effects, as part of routine office-based practice, which may include the use of medication cards to facilitate this process. Medication cards should be regarded as a supplement, and not a replacement, for other information provided by the physician to the patient via oral</p>	<p>Retain-in-part. The following subsections should be rescinded for the reasons provided below. Policy H-100.964 should otherwise be retained as still relevant.</p> <p>(4) Policies H-120.974 and H-125.992 have since sunsetted.</p> <p>(8) <i>Superseded by Policy H-35.999.</i></p> <p>(9) Policies H-115.995 and H-115.997 have since sunsetted.</p> <p>(10) <i>Superseded by Policy H-125.989.</i></p> <p>(15) <i>Superseded by Policy H-120.988.</i></p> <p>(17) Policy H-120.983 has since sunsetted.</p>

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		<p>counseling and, as appropriate, other written information.</p> <p>(8) recognizes the role of the pharmacist in counseling patients about their medicines in order to reinforce the message of the prescribing physician and improve medication compliance.</p> <p>(9) reaffirms AMA Policies H-115.995 and H-115.997, opposing FDA-mandated patient package inserts for all marketed prescription drugs.</p> <p>(10) opposes payment of pharmacists by third party payers on a per prescription basis when the sole purpose is to convince the prescribing physician to switch to a less expensive “formulary” drug because economic incentives can interfere with pharmacist professional judgment.</p> <p>(11) reaffirms AMA Policy H-120.991, supporting the voluntary time-honored practice of physicians providing drug samples to selected patients at no charge, and to oppose legislation or regulation whose intent is to ban drug sampling.</p> <p>(12) supports CEJA’s opinion that physicians have an ethical obligation to report adverse drug or device events; supports the FDA’s MedWatch voluntary adverse event reporting program; and supports FDA efforts to prevent public disclosure of patient and reporter identities.</p> <p>(13) opposes legislation that would mandate reporting of adverse drug and device events by physicians that would result in public disclosure of patient or reporter identities.</p> <p>(14) reaffirms AMA Policy H-120.988, supporting physician prescribing of FDA-approved drugs for unlabeled indications when such use is based upon sound scientific evidence and sound medical opinion, and supporting third party payer reimbursement for drugs prescribed for medically accepted unlabeled uses.</p> <p>(15) encourages the use of three compendia (AMA’s DRUG EVALUATIONS; United States Pharmacopeial-Drug Information, Volume I; and American Hospital Formulary Service-Drug Information) and the peer-reviewed literature for determining the medical acceptability of unlabeled uses.</p> <p>(16) reaffirms AMA Policy H-100.989, supporting the present classification of drugs as either prescription or over-the-counter items and opposing the establishment of a pharmacist-only third (transitional) class of drugs.</p> <p>(17) reaffirms AMA Policy H-120.983, urging the pharmaceutical industry to provide the same economic opportunities to individual pharmacies as given to mail service pharmacies. (BOT Rep. 53, A-94; Reaffirmed by Sub. Res. 501, A-95; Reaffirmed by CSA</p>	

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H-130.945	Overcrowding and Hospital EMS Diversion	<p>Rep. 3, A-97; Amended: CSA Rep. 2, I-98; Renumbered: CMS Rep. 7, I-05; Reaffirmation A-10; Reaffirmed in lieu of Res. 201, I-11)</p> <p>It is the policy of the AMA:</p> <p>(1) that the overall capacity of the emergency health care system needs to be increased through facility and emergency services expansions that will reduce emergency department overcrowding and ambulance diversions; incentives for recruiting, hiring, and retaining more nurses; and making available additional hospital beds;</p> <p>(2) to advocate for increased public awareness as to the severity of the emergency department crisis, as well as the development and distribution of patient-friendly educational materials and a physician outreach campaign to educate patients as to when it is appropriate to go to the emergency department;</p> <p>(3) to support the establishment of local, multi-organizational task forces, with representation from hospital medical staffs, to devise local solutions to the problem of emergency department overcrowding, ambulance diversion, and physician on-call coverage, and encourage the exchange of information among these groups;</p> <p>(4) that hospitals be encouraged to establish and use appropriate criteria to triage patients arriving at emergency departments so those with simpler medical needs can be redirected to other appropriate ambulatory facilities;</p> <p>(5) that hospitals be encouraged to create nurse-staffed and physician-supervised telephone triage programs to assist patients by guiding them to the appropriate facility; and</p> <p>(6) to work with the American Hospital Association and other appropriate organizations to encourage hospitals and their medical staffs to develop diversion policy that includes the criteria for diversion; monitor the frequency of diversion; identify the reasons for diversion; and develop plans to resolve and/or reduce emergency department overcrowding and the number of diversions.</p> <p>Citation: (CMS Rep. 1, A-02; Reaffirmed: BOT Rep. 3, I-02; Modified: BOT Rep. 15, I-04; Reaffirmation A-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, A-08; Reaffirmed: CMS Rep. 3, A-11</p>	Retain. Still relevant.
H-155.974	Excessive Regulatory Costs	<p>Our AMA will: (1) support actively seeking reduction in regulatory requirements such as record review, length-of-stay review, insurance requirements and form completion, and diagnosis coding for physicians and hospitals,</p> <p>(2) vigorously oppose future regulatory requirements for physicians and hospitals that are not compensated;</p> <p>(3) seek through appropriate legislative channels support for an Economic Impact Statement requirement for all legislation and</p>	Retain. Still relevant.

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		<p>regulation affecting the delivery of medical care and that the increased cost be reflected in the RBRVS value; and</p> <p>(4) advocate that all governmental health care cost containment activities must simultaneously evaluate and report the total costs associated with their activities, and that government, federal, state and local, join the medical profession and hospitals in their efforts to contain the cost of health care, by reducing the number of regulations, reports, and forms. (Res. 125, A-79; Reaffirmed: CLRPD Rep. B, I-89; Res. 54, I-90; Res. 147, I-90; Res. 135, A-92; CMS Rep. 12, A-95; Reaffirmation A-00; Reaffirmed: BOT Rep. 25, I-01; Reaffirmation A-02; Reaffirmed: BOT Rep. 7, A-11)</p>	
H-165.862	Evolving Internet-Based Health Insurance Marts	<p>Our AMA endorses the concept and use of Internet-based health insurance marts and health benefits systems as mechanisms for employers and individuals to select and purchase health insurance. (CMS Rep. 5, A-01; Reaffirmed: CMS Rep. 7, A-11)</p>	<p>Rescind. Superseded by Policy H-165.839, which states:</p> <p>1. Our American Medical Association adopts the following principles for the operation of health insurance exchanges:</p> <p>A) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features.</p> <p>B) Any benefits standards implemented for plans participating in the exchange and/or to determine minimum creditable coverage for an individual mandate should be designed with input from patients and actively practicing physicians.</p> <p>C) Physician and patient decisions should drive the treatment of individual patients.</p> <p>D) Actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options.</p> <p>E) Regulations addressing physician participation in public, private or non-profit health insurance options in the exchange that impact physician practice should ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process.</p> <p>F) Any necessary federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and</p>

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			<p>oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices.</p> <p>2. Our AMA: (A) supports using the open marketplace model for any health insurance exchange, with strong patient and physician protections in place, to increase competition and maximize patient choice of health plans, (B) will advocate for the inclusion of actively practicing physicians and patients in health insurance exchange governing structures and against the categorical exclusion of physicians based on conflict of interest provisions; (C) supports the involvement of state medical associations in the legislative and regulatory processes concerning state health insurance exchanges; and (D) will advocate that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information.</p>
H-180.948	Opposition to Incentives for Care in Non-Physician Clinics	Our AMA will communicate with large insurance companies that providing incentives to patients toward non-physician clinics outside the primary care physician relationship can lead to decisions made on limited information, duplication of testing and procedures, ultimately higher health care costs and a reduction in the quality of health care for the patients of America. (Res. 708, A-11)	Retain. Still relevant.
H-185.943	Health Insurance Differences Contribute to Health Care Disparities and Poorer Outcomes	Our AMA affirms its support for elimination of health care disparities caused by differential treatment based on insurance status of Americans. (Res. 119, A-11)	Retain. Still relevant.
H-185.985	Internal Guidelines Used by Third Party Payers to Determine Coverage	Our AMA calls upon all third party payers and appropriate federal regulatory agencies to make all guidelines related to patient coverage a matter of public information and easily obtainable by both patients and physicians. (Res. 126, A-91; Modified: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Rescind. Superseded by Policy H-185.984 , which supports 24-hour-a-day access to patient coverage and benefits information.
H-200.995	Federally Funded Clinic Programs	Our AMA supports the following policy statements regarding federally funded clinics: (1) Physician services should be available in underserved areas and should be provided in a manner which ensures continuity of patient care, integration with the existing health system, and retention of the health providers. (2) Physicians should be sensitive and responsive to indicators of need for additional health personnel or accessibility of health care. Through their component medical society, physicians should seek involvement in the designation process for Health Manpower Shortage Areas and Medically Underserved Areas. The medical community and local	Retain. Still relevant.

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		<p>residents are in an excellent position to ascertain the need for additional health providers in the community, and to support appropriate decisions in that regard.</p> <p>(3) Where need is clearly identified, through a federal designation process or other means, the local medical community should explore alternatives for responding appropriately to meet the need.</p> <p>(4) Where physicians have responded appropriately to needs identified through the designation process, the component medical society should work with the local planning groups to remove the area's designation, so that federal resources are not called on to duplicate services.</p> <p>(5) Where identified needs cannot be met by the local medical community, and all local public and private financial assistance options are determined to be inadequate, federal assistance should be sought. In such cases, the local medical community should assume the responsibility of working with the agency applying for federal funds to facilitate the placement of health personnel with long range service potential.</p> <p>(6) Where inappropriate designations were made leading to capacity which exceeds the need, the patient volume is likely to be low, and the unit costs excessive. In such situations, constructive consultation between the local medical community and the federally funded clinic program should explore options for a resolution of the problem. (Res. 125, A-81; Reaffirmed: Sunset Report, I-98; Reaffirmation A-01; Reaffirmed: CMS Rep. 7, A-11)</p>	
H-215.964	Patient Identification Wrist Bands	<p>Our AMA (1) supports the concept of uniform patient identification wrist bands at all hospitals and other health care facilities where wrist bands are used; (2) encourages the adoption of uniquely colored patient identification wrist bands for specific patient information, such as, patient's name, allergies and those with identified greater fall risk; and (3) will actively pursue national standardization of color-coded wristbands in hospital settings. (Res. 727, A-07; Appended: Res. 720, A-11)</p>	Retain. Still relevant.
H-215.971	Standardization of Emergency Paging Nomenclature	<p>Our AMA urges the development of standardized emergency paging nomenclature for hospitals. (Sub. Res. 805, A-00; Reaffirmation A-09; Reaffirmation A-11)</p>	Retain. Still relevant.
H-215.984	Duplicate Bureaucratic Regulations	<p>Our AMA encourages the identification of duplicate regulatory activities and inspection in hospitals and nursing homes so that these matters may be brought to the attention of legislators, governors and regulatory agencies. It is AMA policy that such information be made available nationally via the AMA and the AHA in an attempt to eliminate duplicate bureaucratic bodies and unnecessary regulations. (Res. 53, I-90; Reaffirmed: Sunset</p>	Retain. Still relevant.

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		Report, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 7, A-11)	
H-215.994	Subrogation by Hospitals	Our AMA urges hospitals to insist that contracts for hospital professional liability insurance require that the carrier obtain the consent of the policy holder prior to initiating legal action against a physician in the name of the hospital. (Res. 2, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-215.996	Compensation for Service on Government Mandated and Funded Hospital Committees	Our AMA believes that federal or third party funds provided for reimbursement of physicians serving on mandated hospital review committees should not be diverted by the hospital for other purposes. (CMS Rep. H, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-220.930	Regulatory Standards Should be Evidence-Based	Our AMA will work through its representatives on the Joint Commission and with other deeming authorities and the Centers for Medicare & Medicaid Services to: (1) ensure that clinical standards imposed on health care institutions and providers be evidence-based with significant efficacy and value, as demonstrated by best available evidence; and (2) require that appropriate citations(s) from the peer reviewed scientific literature be appended to the documentation for every clinical standard imposed on health care institutions and providers. (Res. 727, A-10; Reaffirmed: BOT Rep. 7, A-11)	Retain. Still relevant.
H-220.950	Medical Staff Involvement in Hospital Compliance With Accrediting Organization Standards Plans of Action to Correct Deficiencies	Our AMA: (1) adopts the policy that a hospital medical staff must be appropriately involved in a surveyed organization's development of a plan of action to correct a deficiency and that such involvement be consistent with existing medical staff bylaws, rules and regulations; (2) encourages hospital medical staffs to amend their bylaws, if necessary, to establish processes to ensure appropriate medical staff input into the development of a plan of action to correct a deficiency; and (3) urges accrediting organizations to work to ensure that these principles are part of their accreditation standards. (Res. 810, I-91; Reaffirmed: Sunset Report, I-01; Modified: CMS Rep. 7, A-11)	Retain. Still relevant.
H-220.953	Quality Improvement Requirements for Leadership Structures of Health Care Organizations	Our AMA supports the following concepts for incorporation in The Joint Commission's accreditation programs for health care organizations: (1) establish accreditation programs with greater emphasis on the assessment of the effect that actions and decisions of the administrative and governing bodies of health care organizations have on the quality of patient care; (2) establish the requirement that management efforts must be made in concert with those of physicians, nurses and other health care professionals pursuant to the needs of the	Retain. Still relevant.

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		<p>patients served by these professionals and the prevailing standards of practice;</p> <p>(3) establish the requirement of assessing major processes in the health care organization with the goal of continuous improvement rather than intensely focusing on individual persons or services;</p> <p>(4) establish the requirement that risk management processes be established that will emphasize prevention of problems rather than policies that call for taking action only after a problem has arisen;</p> <p>(5) establish accountability of the management and governance elements of a health care organization to its professional staff of physicians and nurses; and</p> <p>(6) require that the bylaws of the governing body provide a process through which the medical staff could appeal any decision made by the administration and/or the governing body which has an adverse effect on the quality of care rendered to patients, require that medical staff bylaws provide a process by which the need for such an appeal is identified, and provide a process for making the appeal. (Res. 822, I-91; Reaffirmed: Sunset Report, I-01; Modified: CMS Rep. 7, A-11)</p>	
H-220.995	Hospital Guidelines Impact Statement	<p>Our AMA recommends that when guidelines, rules and specific recommendations to hospitals and other medical facilities are originated by accreditation, certification or regulatory agencies, they include a proof of impact statement to include (1) actual or estimated costs of implementation (as a total cost or cost per bed). Included in the costs should be estimates of volunteer medical staff time required to implement the policy; (2) a brief statement of the expected benefit, goal or improvement in health care or reduction in health care costs; (3) a brief outline of the data tending to prove that the guidelines and rules will actually and significantly improve patient care, not have an adverse impact, and will accomplish the intended goal stated in the benefit statement; and (4) cost estimates of implementation and ongoing compliance, for small, medium, and large hospitals, and/or other health care facilities. (Res. 37, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed in lieu of Res. 816, I-93; Amended: Sub. Res. 805, I-01; Modified: CMS Rep. 7, A-11)</p>	Retain. Still relevant.
H-225.952	The Physician's Right to Exercise Independent Judgement in All Organized Medical Staff Affairs	<p>Our AMA supports the unfettered right of a physician to exercise his/her personal and professional judgment in voting, speaking and advocating on any matter regarding: [i] patient care interests; [ii] the profession; [iii] health care in the community; [iv] medical staff matters; [v] the independent exercise of medical judgment as appropriate interests to be incorporated into physician employment and independent contractor agreements; the right [vi] not to be deemed in breach of his/her</p>	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		employment or independent contractor agreement for asserting the foregoing enumerated rights; and [vii] not to be retaliated against by his/her employer in any way, including, but not limited to, termination of his/her employment or independent contractor agreement, commencement of any disciplinary action, or any other adverse action against him/her based on the exercise of the foregoing rights. (BOT Rep. 2, I-11)	
H-225.972	AMA Sponsored Leadership Training for Hospital Medical Staff Officers and Committee Chairs	It is the policy of the AMA (1) to offer, both regionally and locally, extensive training and skill development for emerging medical staff leaders to assure that they can effectively perform the duties and responsibilities associated with medical staff self-governance; and (2) that training and skill development programs for medical staff leaders be as financially self-supporting as feasible. (Res. 808, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-235.974	Autonomy of the Hospital Medical Staff	Our AMA (1) believes strongly in the autonomy of the hospital medical staff and does not support automatic inclusion of the medical staff in hospital personnel policies and programs; (2) believes hospital medical staffs should develop personnel policies and programs for members of the hospital medical staff and incorporate these policies in the medical staff bylaws or rules and regulations; and (3) understands that there are physicians who are not members of the medical staff but who are employees of the hospital and their participation in hospital programs should be dictated by their employment agreements. (Res. 832, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-240.997	Patient Signatures for Medicare Payment	Our AMA endorses a proposal to permit all physicians to use the patient signature on hospital records in completing any claim form accepted by CMS for Medicare payment for inpatient hospital care. (Res. 15, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-25.989	Long-Term Care Prescribing of Atypical Antipsychotic Medications	Our AMA: (1) will collaborate with appropriate national medical specialty societies to create educational tools and programs to promote the broad and appropriate implementation of non-pharmacological techniques to manage behavioral and psychological symptoms of dementia in nursing home residents and the cautious use of medications; (2) supports efforts to provide additional research on other medications and non-drug alternatives to address behavioral problems and other issues with patients with dementia; and (3) opposes the proposed requirement that physicians who prescribe medications with “black box warnings on an off-label basis certify in writing that the drug meets the minimum criteria for coverage and reimbursement by	Retain. Still relevant.

Policy #	Title	Text	Recommendation
H-285.920	Criteria for Level of Care Status	<p>virtue of being listed in at least one of the authorized drug compendia used by Medicare.” (Res. 819, I-11)</p> <p>(1) Our AMA support the development and use of level of care guidelines that meet the following criteria: (a) Level of care guidelines should function as guidelines only, and should not be used as requirements for all instances and cases. That is, level of care guidelines must allow for appropriate physician autonomy in making responsible medical decisions;</p> <p>(b) Level of care guidelines should acknowledge the complexity of care for each patient under the particular set of clinical circumstances;</p> <p>(c) Level of care guidelines should apply to all facility support systems so that patients are not assigned a level of care that slows or stalls their treatment;</p> <p>(d) Level of care guidelines should be developed under the direction of actively practicing physicians;</p> <p>(e) Level of care guidelines should be developed based on individual patient severity of illness and intensity of service;</p> <p>(f) Level of care guidelines should be validated through standard data quality control checks and professional advisory consensus;</p> <p>(g) Level of care guidelines should be reviewed and updated; and</p> <p>(h) Level of care guidelines should allow for a timely appeal process.</p> <p>(2) It is the policy of the AMA that private sector accrediting organizations, where applicable, should adopt standards that are consistent with AMA criteria for the development and use of level of care status guidelines. (CMS Rep. 5, I-01; Reaffirmed: CMS Rep. 7, A-11)</p>	Retain. Still relevant.
H-285.921	Managed Behavioral Health Organizations (MBHOs)	<p>It is the policy of our AMA that, when requested, Managed Behavioral Health Organizations (MBHOs) should share their written disease management protocols with primary care and other treating physicians. When a patient is receiving treatment for mental illness and/or chemical dependency through an MBHO, with the patient’s permission and in accordance with relevant legal requirements, the primary care physician should be notified immediately; and, if requested, be kept apprised of the patient’s treatment (including all medications prescribed) and progress, so that the primary care and other treating physicians can coordinate the patient’s health care needs in optimal fashion. (Res. 702, I-01; Reaffirmed: CMS Rep. 7, A-11)</p>	Retain. Still relevant.
H-290.981	Out-of-State Medicaid Patients	<p>The AMA encourages the CMS to propose regulations that prohibit state Medicaid programs from requiring physicians and other providers to be credentialed in the patient’s state of residency, as long as the physician or</p>	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		provider is credentialed where the care is rendered. (Res. 136, A-98; Reaffirmed: BOT Rep. 23, A-09; Reaffirmation A-11)	
H-330.891	Payment and Coverage for Voluntary Discussions of End-of-Life Issues	Our AMA encourages the Centers for Medicare & Medicaid Services to designate voluntary discussions of end-of-life issues as covered services as part of the 2012 Medicare Physician Fee Schedule rule. (Res. 225, A-11)	Rescind. Accomplished in 2019 when the Centers for Medicare & Medicaid Services began paying for advanced care planning using CPT codes 99497 and 99498.
H-330.954	Mandatory Transmission of Electronic Claims	Our AMA opposes the policy of local Medicare carriers of mandating that physicians choose between electronic remittance advice or standard paper remittance report until all secondary insurers accept the electronic remittance advice explanation of benefits in its present format. (Res. 815, A-93; Appended: Res. 107, I-00; Reaffirmation A-01; Modified: CMS Rep. 7, A-11)	Retain. Still relevant.
H-340.997	Medicare Preauthorization Review	Our AMA opposes the mandating of blanket hospital preadmission review for all patients or for specific categories of patients by government or hospital edict, and supports the prerogative of physician-directed peer review organizations to implement focused preadmission review on a voluntary basis. (CMS Rep. G, A-84; Reaffirmed by CLRPD Rep. 3-I-94; Reaffirmation A-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-345.976	Medicaid Coverage of Adults in Psychiatric Hospitals	1. Our AMA will monitor the Medicaid Emergency Psychiatric Demonstration Project established by the Patient Protection and Affordable Care Act for consistency with AMA policy, especially the impact on access to psychiatric care and treatment of substance use disorders. 2. Our AMA supports the evolution of psychiatrist-supervised mental health care homes. 3. Our AMA encourages states that maintain low numbers of inpatient psychiatric beds per capita to strive to offer more comprehensive community based outpatient psychiatric services. (CMS Rep. 3, A-11)	Retain. Still relevant.
H-35.992	Reimbursement for Allied Health Personnel	Our AMA believes that (1) reimbursement systems should pay physicians or their institutions directly for the services of allied health personnel; and (2) such personnel should be under the supervision of practicing physicians. (BOT Rep. A, NCCMC Rec. 41, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: BOT Rep. H, A-93; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 9, I-11)	Retain. Still relevant.
H-380.995	Insurance Carrier Terminology	Our AMA urges individual physicians to consider including in their patient information materials an explanation as to why the amount billed may in some cases be more than the insurance benefit paid. (CMS Rep. F, I-81; CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Rescind. Superseded by Policy H-390.865 , which calls for a universal EOB to be issued to both the patient and the physician that includes an explanation of billed, covered and patient responsibility amounts.

Policy #	Title	Text	Recommendation
H-383.994	Managed Care Plans and the Right to Set Fees	Our AMA opposes any government or hospital requirement that a hospital-based physician must accept the terms of any managed care plan accepted by the hospital. (Sub. Res. 704, A-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-385.916	Reimbursement for Office-Based Surgery Facility Fees	Our AMA urges third party payers to include facility fee payments for procedures using more than local anesthesia in accredited office-based surgical facilities. (Res. 716, A-11)	Retain. Still relevant.
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)	Retain. Still relevant.
H-385.925	Selective Revenue Taxation of Physicians and Other Health Care Providers	Our AMA: (1) strongly opposes the imposition of a selective revenue tax on physicians and other health care providers; (2) will continue to work with state medical societies on issues relating to physician and other provider taxes, providing assistance and information as appropriate; (3) strongly opposes the use of provider taxes or fees to fund health care programs or to accomplish health system reform; and (4) believes that the cost of taxes which apply to medical services should not be borne by physicians, but through adequate broad-based taxes for the appropriate funding of Medicaid and other government health care programs. (Sub. Res. 258, A-92; Reaffirmed: Res. 134, A-93; Res. 207, I-93; Reaffirmation A-99; Reaffirmation A-00; Appended Res. 132, A-01; Reaffirmation A-05; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmed: CMS Rep. 6, I-11)	Retain. Still relevant.
H-385.932	Contact Capitation Contracts	Our AMA strongly encourages all physicians contemplating entering into contact capitation agreements to exercise extreme caution, with attention to business skills and competencies needed to successfully practice under contact capitation arrangements and potentially uncontrollable market forces that may impact upon ones ability to provide quality patient care. (CMS Rep. 1, A-01; Modified: CMS Rep. 7, A-11)	Retain. Still relevant.
H-385.940	CPT Codes for Evening and Night Services	Our AMA will continue its efforts to advocate for the fair and equitable payment of services described by CPT codes, including those CPT codes which already exist for off-hour services and unusual travel. (Sub. Res. 821, A-98; Reaffirmed: BOT Rep. 6, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-385.967	Incentives and Penalties to Encourage Third Party Payers to Make Prompt	It is the policy of our AMA to investigate and document reports of problems with delays in payments by third party payers, including the federal government, and to seek legislation or	Retain. Still relevant.

Policy #	Title	Text	Recommendation
	Payment of Health Insurance Claims	regulations that assure prompt payment by all third party payers. (Res. 113, I-91; Reaffirmed: Res. 138, A-98; Reaffirmation I-01; Reaffirmation I-04; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmed: Res. 216, A-11)	
H-385.968	Physician Fee Determination by Contractual Arrangements Between Third Party Payers and Hospital	Our AMA condemns the practice of negotiating or creating contractual arrangements between third party payers and hospitals limiting reimbursement to physicians unless those physicians have been involved in the negotiation process and have been given a good faith opportunity to participate. (Sub. Res. 248, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-385.970	Payment of Physicians' Services for Patients in Observational or Short Stay Units	Our AMA supports seeking reimbursement from all third party payers for physicians' services to patients who are appropriately managed in short stay units. (Res. 182, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-385.995	Manipulative Casting of Congenital Deformities of the Extremities	Our AMA encourages all third party payers to classify manipulative casting of congenital deformities of the extremities as a surgical procedure, whether performed in the office or hospital. (CMS Rep. L, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-390.889	Medicare Reimbursement of Telephone Consultations	It is the policy of the AMA to: (1) support and advocate with all payers the right of physicians to obtain payment for telephone calls not covered by payments for other services; (2) continue to work with CMS and the appropriate medical specialty societies to assure that the relative value units assigned to certain services adequately reflect the actual telephone work now performed incident to those services; (3) continue to work with CMS, other third party payers and appropriate medical specialty societies to establish the criteria by which certain telephone calls would be considered separate services for payment purposes; (4) request the CPT Editorial Panel to identify or consider developing the additional service code modifiers that may be required to certify specific types of telephone calls as separate from other services; and (5) seek enactment of legislation as needed to allow separate Medicare payment for those telephone calls that can be considered discrete and medically necessary services performed for the patient without his/her presence. (CMS Rep. N, A-92; Reaffirmed: Res. 122, I-97; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-01; Reaffirmation A-07; Reaffirmed in lieu of Res. 824, I-11)	Retain. Still relevant.

Policy #	Title	Text	Recommendation
H-390.895	Medicare Patient Surveys	It is the policy of the AMA to negotiate with CMS to rescind rules and regulations that inordinately withhold payment to physicians for services rendered to Medicare beneficiaries until the beneficiary completes a survey or questionnaire. (Res. 102, I-91; Reaffirmation A-01; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-390.901	Medicare Outpatient Service Charge Limit	Our AMA vigorously opposes the Medicare Part B Policy of Outpatient Physician Charge Limit. (Res. 70, A-91; Modified: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-390.906	Medicare Notification of Payment	Our AMA requests CMS to direct Medicare Part B carriers to furnish all physicians with an Explanation of Medicare Benefits on all claims whether assigned or nonassigned. (Res. 62, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-405.980	Caller Identification	Our AMA, based on the concerns of protecting physicians' privacy, supports efforts to allow individuals to block caller identification at no cost to the caller. (Sub. Res. 225, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Rescind. No longer relevant.
H-45.986	Protection of Insurance Coverage for Medical Attendants Aboard Non-Scheduled Aircraft	Our AMA supports seeking appropriate action, including legislation if necessary, which would result in an exemption or exception to the exclusion of benefits clauses of insurance policies for all medical care providers and others when they are participating in medical aircraft flights, even though such flights might otherwise be considered as "non-scheduled." (Sub. Res. 144, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Rescind. Superseded by Policy H-45.997 , which supports legislation to provide immunity to physicians providing care during an in-flight medical emergency.
H-450.961	Health Plan "Report Cards"	The AMA: (1) supports the development and appropriate use of health plan performance standards; (2) The AMA urges all organizations that are developing, or planning to develop, health plan performance measures to include actively practicing physicians, physician organizations, and consumers in the development, evaluation and refinement of such measures; (3) The AMA urges all organizations that are developing health plan performance measures to work toward greater uniformity both in the content of such measures and in the formulas used for calculating performance results; (4) The AMA encourages national medical specialty societies and state medical associations to participate in the development, evaluation, and refinement of health plan performance measures; (5) The AMA advocates that individual health plans, government entities, private sector accreditation organizations and others that develop performance measures for use in programs to evaluate the performance of health plans adhere to the following principles:	Retain-in-part. The text of the policy remains relevant and should be retained. To better reflect the content of the policy, the title should be amended by addition and deletion as follows: Health Plan "Report Cards" Health Plan Performance Measures

Policy #	Title	Text	Recommendation
		<p>(a) Health plan performance measures shall be developed for a variety of users, including health care purchasers, physicians and other health care providers, and the public.</p> <p>(b) The involvement of actively practicing physicians and physician organizations in the development, evaluation, refinement, and use of health plan performance measures shall be essential.</p> <p>(c) Health plan performance measures shall include an appropriate mix of process-oriented and outcomes-oriented measures.</p> <p>(d) Health plan performance measures shall be representative of the full range of services typically provided by health plans, including preventive services.</p> <p>(e) The limitations of data sources used in health plan performance measures shall be clearly identified and acknowledged.</p> <p>(f) Valid health plan performance data collection and analysis methodologies, including establishment of statistically significant sample sizes for areas being measured, shall be developed.</p> <p>(g) Performance data used to compare performance among health plans shall be adjusted for severity of illness, differences in case-mix, and other variables such as age, sex, and occupation and socioeconomic status.</p> <p>(h) Health plan performance data that are self-reported by health plans shall be verified through external audits.</p> <p>(i) The methods and measures used to evaluate health plan performance shall be disclosed to health plans, physicians and other health care providers, and the public.</p> <p>(j) Health plans being evaluated shall be provided with an adequate opportunity to review and respond to proposed health plan performance data interpretations and disclosures prior to their publication or release.</p> <p>(k) Effective safeguards to protect against the unauthorized use or disclosure of health plan performance data shall be developed.</p> <p>(l) The validity and reliability of health plan performance measures shall be evaluated regularly. (CMS Rep. 10, I-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmation A-11)</p>	
H-450.975	Definition of Quality	Our AMA adopts the following statement defining patient care quality: Quality of care is defined as the degree to which care services influence the probability of optimal patient outcomes. (CMS Rep. E, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain. Still relevant.
H-450.976	Corrective Action and Exclusive Contracts	It is the policy of the AMA that exclusive contracts should never be used as a mechanism to solve quality assurance problems in lieu of appropriate peer review processes. (Res. 3, A-91; Modified: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.

Policy #	Title	Text	Recommendation
H-465.984	Access to Physician Services in Rural Health Clinics	Our AMA strongly encourages CMS and appropriate state departments of health to review the Rural Health Clinic Program eligibility and certification requirements to ensure that independent (e.g., physician) and provider-based (e.g., hospital) facilities are certified as Rural Health Clinics only in those areas that truly do not have appropriate access to physician services. (Sub. Res. 717, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-465.997	Access to and Quality of Rural Health Care	(1) Our AMA believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or state level by a similar voluntary health planning entity. Regional or statewide coordination of local efforts will not only help to remedy a particular community's problems, but will also help to avoid and, if necessary, resolve existing duplication of health care resources. (2) In addition to local solutions, our AMA believes that on a national level, the implementation of Association policy for providing the uninsured and underinsured with adequate protection against health care expense would be an effective way to help maintain and improve access to care for residents of economically depressed rural areas who lack adequate health insurance coverage. Efforts to place National Health Service Corps physicians in underserved areas of the country should also be continued. (CMS Rep. G, A-87; Modified: Sunset Report, I-97; Reaffirmation A-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-478.989	Biometric Technologies Used to Enhance Security	Our AMA encourages the use of biometric technologies where feasible, such as, but not limited to, fingerprint and palm scanners in hospitals and clinics (1) for patient identification to improve patient safety while reducing health insurance fraud and (2) for providers to streamline and secure user authentication processes and better protect patient privacy. (Res. 816, I-11)	Retain. Still relevant
H-478.996	Medical Care Online	It is the policy of the AMA to support efforts to address the economic, literacy, and cultural barriers to patients utilizing information technology. (CMS Rep. 4, A-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-70.917	Ensuring CPT Usage of the Term Physician is Consistent with AMA Policy	1. Our AMA will ensure that CPT employ the term "physician" consistent with our AMA's policy in all internal and external communications, publications and products. 2. As a condition for licensure of CPT intellectual property by outside entities, references to the term "physicians" within CPT must remain consistent with our AMA's policy, and the AMA will take appropriate enforcement action against violators. 3. Our AMA will ensure that the CPT code set continues to be applicable and relevant to	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		physicians and qualified healthcare professionals who may report the professional services described therein. (Res. 602, I-11)	
H-70.974	CPT Coding System	<p>1. The AMA supports the use of CPT by all third-party payers and urges them to implement yearly changes to CPT on a timely basis.</p> <p>2. Our AMA will work to ensure recognition of and payment for all CPT codes approved by the Centers for Medicare & Medicaid Services (CMS) retroactive to the date of their CMS approval, when the service is covered by a patient's insurance. (Sub. Res. 809, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07; Appended: Res. 803, I-11)</p>	Retain. Still relevant.

2. CONTINUITY OF CARE FOR PATIENTS DISCHARGED FROM HOSPITAL SETTINGS (RESOLUTION 212-A-19, SECOND RESOLVE)

Reference committee hearing: see report of Reference Committee A.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF THE SECOND RESOLVE OF RESOLUTION 212-A-19
REMAINDER OF REPORT FILED**

See Policies H-125.974, H-125.979, D-160.945 and D-330.910

At the 2019 Annual Meeting, the House of Delegates (HOD) referred the second resolve clause of Resolution 212, which was introduced by the New York Delegation and directed our American Medical Association (AMA) to advocate to ensure that medications prescribed during hospitalization with ongoing indications for the outpatient and other non-hospital-based care settings continue to be covered by pharmacy benefit management (PBM) companies, health insurance companies, and other payers after hospital discharge. The referred second resolve clause was crafted by the reference committee and was assigned by the Board of Trustees to the Council on Medical Service for a report back.

This report discusses strategies to ensure continuity of care and safe transitions after hospital discharge; highlights real-time pharmacy benefit (RTPB) tools intended to generate cost and coverage data at the point of care; summarizes relevant AMA policy; and makes policy recommendations.

BACKGROUND

The intent of the reference committee's second resolve clause of Resolution 212-A-19 is to ensure continuity of care for patients transitioning from a hospital to an outpatient setting by ensuring coverage of hospital prescribed medications that are to be continued after discharge. Adherence to medications has long been recognized to be a key component of effective medical treatment and is associated with decreases in morbidity, mortality, and hospitalizations. As discussed in [Council on Medical Service Report 7-I-16, Hospital Discharge Communications](#), patients often experience medication-related problems during the period following hospital discharge, and more than a third of post-discharge follow-up testing is never completed.

Medications are frequently prescribed or changed during care transitions, including hospital admissions and discharges, which can be confusing for patients and put them at risk of nonadherence. Medication reconciliation—the process of reviewing and resolving discrepancies between medications a patient is using and new medications that have been ordered for the patient—is employed by hospitals during the discharge process to boost adherence to prescribed regimens and prevent adverse health outcomes. Medication reconciliation is built into the National Patient Safety Goals developed by The Joint Commission,¹ which recognizes that organizations face challenges with medication reconciliation and that its effectiveness will increase as more advanced health information technology (IT) systems are adopted.²

Importantly, barriers to filling or refilling hospital discharge medications remain even when medications have been effectively reconciled. Some discharge prescriptions go unfilled due to mobility or transportation issues, or because of the high cost of certain medications. Outpatient formulary restrictions and adverse formulary tiering may similarly thwart medication adherence, a problem that is amplified when hospital-based prescribers do not have access to a patient's outpatient formulary information through the inpatient electronic health record (EHR) or other easily accessible tool. Accordingly, access to outpatient drug formularies is vital to medication management and continuity of care during patient hospitalizations and the period after discharge.

Formulary systems can be complicated and confusing for both patients and physicians. First, hospital inpatient formulary systems have traditionally been distinct from health plan outpatient formularies, which differ among themselves and are frequently adjusted (even during the benefit year). Hospitals that have merged with or grown into larger health systems, including those that have integrated with payers, may have multiple formularies in place, each of which is continuously evaluated against lists of available medications and prescribing guidelines.³ Hospital formulary systems are managed by a pharmacy and therapeutics committee (P&T committee), which oversees medication management and use at the hospital. A P&T committee usually reports to the medical staff, which should have final approval over the hospital's medication-use policy.⁴ Because hospitals/health systems are unable to procure, stock and administer all available medications, most hospital formularies make one or two medications available for each therapeutic class. A hospital formulary may also restrict the prescribing of some medications to certain specialties, although medications not available on the formulary can generally be requested.⁵

Upon admission to a hospital, hospitals may substitute a patient's home (outpatient) medication through approved therapeutic interchange if that medication is not part of the hospital's formulary. Ideally, at the time of discharge, patients should be reconciled back to their home medications to ensure continued adherence. Hospital physicians may also prescribe new medications intended for use after discharge, and those prescriptions may be based on the hospital formulary. Without access to outpatient formulary information, hospital physicians may unwittingly prescribe discharge medications that are subject to restrictions such as adverse tiering or prior authorization (PA). Accordingly, patients may be discharged with prescriptions that will not be adequately covered or paid for by their pharmacy benefits plan.

Strategies to ensure continuity of care after hospital discharge

Strategies to ensure continuity of care after hospital discharge are numerous and varied and include pharmacist interventions to address medication and/or insurance issues, as well as discharge checklists that require confirmation of coverage of prescribed discharge medications. Examples of care transition interventions centered on discharge include the SafeMed care transitions model and Project BOOST (Better Outcomes for Older Adults through Safe Transitions). SafeMed uses intensive medication reconciliation and home visits to manage high-risk/high needs patients as they transition from the hospital to outpatient setting. As part of its Steps Forward™ initiative, the AMA developed a [module](#) for implementing the SafeMed model within primary care practices. Project BOOST is the Society of Hospital Medicine's signature mentoring program for improving the care of patients as they transition home from the hospital or to other care facilities. Among other interventions, Project BOOST identifies patients at high risk of hospital readmission and follows up with them to monitor adherence after discharge.

Some hospitals have established bedside medication delivery services to help mitigate the number of hospital prescriptions that go unfilled after discharge. Also known as "meds-to-beds" or "meds-in-hand" interventions, these services are provided by hospitals in partnership with their outpatient pharmacies, which are able to access outpatient formulary information⁶ and coordinate PA requirements. A study of one hospital's "meds-in-hand" process highlighted use of the hospital outpatient pharmacy to reliably verify insurance coverage of prescribed outpatient medications, and further posited that patients may incur lower costs from receiving medications from the outpatient pharmacy rather than the inpatient pharmacy.⁷ Another study found that a pediatric "meds-in-hand" project increased the proportion of patients discharged in possession of their medications and may have decreased unplanned visits to the emergency department in the 30 days after discharge.⁸ In addition to bedside medication delivery services, some hospitals provide a transitional supply of medications to high-risk uninsured patients at the time of discharge and also help patients obtain medications through patient assistance programs.⁹ Many hospitals routinely follow up with patients after discharge to check on medication access and adherence.

Real-time pharmacy benefit (RTPB) tools

Transparency of drug coverage and formulary information in EHRs could prove useful in preventing medication nonadherence and treatment abandonment during the post-discharge period. To ensure such transparency, accurate, real-time information needs to be available at the point of prescribing. Although the AMA has been advocating that insurers, PBMs, and EHR vendors move quickly to develop point-of-care software that provides patient coverage and cost-sharing information, problems remain. Specifically, there are concerns with the accuracy of Formulary and Benefit (F&B) files based on how often payers update their formularies and provide the F&B update files to intermediaries and EHR vendors. Notably, F&B files are static and may not represent the most current formulary data. Moreover, these files do not provide drug coverage information at a granular, patient-specific level of detail.

In contrast, real-time pharmacy benefit (RTPB) technology holds promise for improving continuity of care for patients discharged from the hospital setting. Although RTPB tools are relatively new and have not yet been widely implemented, adoption continues to improve, and prescribers should have greater access to real-time benefit and coverage restriction information at the point of care through RTPB tools in the near future. To accelerate the use of electronic RTPB tools in the Medicare Part D program, the Centers for Medicare & Medicaid Services (CMS) requires every Part D plan to support one or more real-time benefit tools capable of integrating with at least one e-prescribing system or EHR, effective January 1, 2021. While this requirement falls short of ensuring that all prescribers have access to RTPB information for every patient they encounter, it is a positive step for increasing RTPB tool adoption and improving access to benefit information. In addition, CMS will require Part D plans to offer a consumer-facing RTPB tool starting January 1, 2023, which will allow patients to obtain information about medication costs and possible lower-cost alternatives under their prescription drug benefit plan.¹⁰

Over the past few years, the National Council for Prescription Drug Programs (NCPDP) has been developing an electronic standard for the communication of real-time prescription drug coverage and pricing information, including therapeutic alternatives, between payers and prescribers. The AMA actively participates in the NCPDP effort to ensure that the standard will provide the prescription drug information that physicians need at the point of prescribing. Based on progress of the NCPDP work, it is expected that an RTPB standard will be recommended to CMS for an eventual federal mandate under the Part D program in late 2021. Because there are several proprietary RTPB systems on the market, the AMA supports a standardized RTPB process that allows providers to access information for all of their patients, regardless of what payer the patient is covered under or what EHR/e-prescribing system is used by the provider. The AMA also strongly advocates for alignment between the prescription drug data offered in physician-facing and consumer-facing RTPB tools, as any discrepancies in the pricing or coverage information presented to these different audiences will result in increased administrative burdens for physicians, patient dissatisfaction, and mutual confusion.

AMA ACTIVITY

The AMA engages in robust federal and state advocacy on a range of policy issues relevant to improving continuity of care and preventing treatment delays after hospital discharge. The Council has previously discussed concerns related to transparency in drug formularies, which make it exceedingly difficult for physicians to determine which treatments are preferred by a particular health plan at the point-of-care (see [Council on Medical Service Report 5-A-19. The Impact of Pharmacy Benefit Managers on Patients and Physicians](#)). For patients, lack of transparency in drug coverage information may lead to treatment delays as well as being unaware of their cost-sharing responsibilities which can affect medication adherence. To expose the opaque process that pharmaceutical companies, PBMs, and health insurers engage in when pricing prescription drugs and to rally grassroots support to call on lawmakers to demand transparency, the AMA launched a grassroots campaign and website, [TruthInRx.org](#), in 2016. At the time this report was written, nearly 350,000 individuals had signed a petition to members of Congress in support of greater drug pricing transparency, with the campaign also generating more than one million messages sent to Congress demanding drug price transparency. The AMA has also developed model state legislation which addresses issues related to stabilized formularies and cost transparency.

To educate the public about problems associated with PA and to gather stories from physicians and patients about how they have been affected by it, the AMA launched a second grassroots website, [FixPriorAuth.org](#), in 2018. This site showcases an array of stories about PA requirements delaying care, including [one video](#) about a patient who had undergone heart stenting but was unable to fill a discharge prescription for a blood thinner because of a PA hurdle.

The physician was unaware that the insurer would not approve the prescription, and the patient ended up back in the hospital after suffering another heart attack.

More broadly, the AMA is very active in advocating for a reduction in both the number of physicians subjected to PA and the overall volume of PA (see Council on Medical Service Report 4-JUN-21, Accountability in Prior Authorization). In January 2017, the AMA and a coalition of state and specialty medical societies, national provider organizations and patient organizations developed and released a set of 21 [Prior Authorization and Utilization Management Principles](#) intended to ensure that patients receive timely and medically necessary care and medications and reduce administrative burdens. Four of these principles speak directly to continuity of care, and Principle #8 addresses formulary data transparency in EHRs. In January 2018, the AMA joined the American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield Association and the Medical Group Management Association in a [Consensus Statement](#) outlining a shared commitment to industry-wide improvements to PA processes and patient-centered care. The Consensus Statement underscores that continuity of care is vitally important for patients undergoing an active course of treatment when there is a formulary or treatment coverage change and/or a change of health plan, and also addresses making PA requirements and other formulary information electronically accessible in EHRs. Additionally, the AMA has model legislation addressing PA and works closely with many state medical associations to enact legislation.

The AMA continues to advocate with the Office of the National Coordinator for Health Information Technology (ONC) and CMS around opportunities to improve health IT and EHRs, including standards, certification and vendor requirements that will help improve interoperability, EHR performance and data usability. As stated previously, the AMA participates in the NCPDP effort to advocate for physicians' interests and supports a standardized RTPB process that ensures alignment between physician-facing and patient-facing RTPB tools.

RELEVANT AMA POLICY

The AMA has extensive policy on hospital discharge and medication reconciliation. Policy D-160.945 advocates for timely and consistent communication between physicians in inpatient and outpatient settings to decrease gaps in care coordination and improve quality and patient safety. Evidence-based principles of discharge and discharge criteria are outlined in Policy H-160.942. Policy H-160.902, established with [Council Report 7-I-16](#), 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. This policy also encourages hospital engagement of patients and families in the discharge process, supports implementation of medication reconciliation as part of the discharge process, and encourages patient follow-up in the early time period after discharge. Policy D-120.965 also supports medication reconciliation to improve patient safety.

The AMA also has substantial policy on drug plans and formularies. Policy D-330.910 states that the AMA will explore problems with prescription drug plans, including issues related to continuity of care, PA, and formularies, and work with CMS and other organizations to resolve them. AMA policy objectives addressing managed care cost containment involving prescription drugs are outlined in Policy H-285.965, which speaks to mechanisms to appeal formulary exclusions and urges pharmacists to contact prescribing physicians if prescriptions violate the managed care formulary so that physicians can prescribe an alternative drug that may be on the formulary. Under Policy H-285.952, the AMA will continue providing assistance to state medical associations in support of state legislative and regulatory efforts to ensure continuity of care protections for patients in an active course of treatment.

Policy H-125.979 directs the AMA to: work with PBMs, health insurers and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing; promote that, in the event that a drug is no longer on the formulary when a prescription is presented, notice of covered formulary alternatives shall be provided to the prescriber so that appropriate medication can be provided; and promote the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers. [Council on Medical Service Report 5-A-19](#) established Policy D-110.987, which supports regulation of PBMs and improved transparency of PBM operations, including disclosing formulary information such as whether certain drugs are preferred over others and patient cost-sharing responsibilities, which should be made available to patients and to prescribers at the point-of-care in EHRs. Policies D-125.997 and H-185.942 support protecting patient-physician relationships from interference by PBMs and payers. Policy H-125.979 aims to prohibit drugs from being removed from the formulary or moved to a higher cost tier during the duration of a patient's plan year.

Drug formularies, P&T committees, and therapeutic interchange are addressed in Policy H-125.991, which outlines standards that must be satisfied in order for drug formulary systems to be acceptable. This policy also insists that health plans have well-defined processes for physicians to prescribe non-formulary drugs when medically indicated and discourages the switching to therapeutic alternates in chronic disease patients who are stabilized on drug therapy. Finally, the AMA has numerous policies on usability and interoperability of EHRs, including Policy D-478.995 on health IT which, among other directives, supports AMA advocacy for standardization of key elements of the EHR.

DISCUSSION

Although the referred second resolve clause of amended Resolution 212-A-19 focuses on continued coverage of prescribed discharge medications, the Council believes that continuity of care for medical services is also vital to improving the health outcomes of patients transitioning out of hospitals. The Council recognizes that, because inpatient and outpatient formularies differ, ensuring continuous coverage of medications and medical services is not always feasible, in part because some hospital physicians lack access to patients' outpatient formulary information. Accordingly, the Council recommends that our AMA 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.

The Council recognizes that there are multiple ways for hospitals to carry out medication reconciliation and does not wish to prescribe how this process should be accomplished. Some hospitals assign staff (usually pharmacy staff) to work through coverage issues and facilitate patient access to discharge medications. Others utilize hospital outpatient pharmacies to review coverage and PA requirements during the reconciliation process. The Council recommends supporting—but not requiring—medication reconciliation that includes confirmation that prescribed discharge medications will be covered by a patient's health plan and completion of PA requirements.

Aside from medication reconciliation, the Council identified other innovative strategies employed by hospitals to improve medication adherence after hospital discharge. “Meds-to-beds”/“meds-in-hand” services take a variety of forms and can be administered hospital-wide or for specific patient populations. However, these programs may not be achievable at all facilities, particularly those without an outpatient pharmacy on site. Safety-net hospitals are more likely to provide an initial 30-day supply of medications to uninsured patients, and the Council supports these efforts—and broadening them—while acknowledging the cost implications for hospitals. Accordingly, the Council recommends a more general policy statement supportive of strategies to address coverage barriers and facilitate patient access to prescribed discharge medications, such as bedside medication delivery services and the provision of transitional supplies of discharge medications.

The Council believes that RTPB systems hold promise for improving continuity of care during the discharge period and looks forward to the release of an RTPB standard, widespread implantation of this technology in physicians' and hospitals' EHR systems, and ongoing evaluations of and improvements to these tools to ensure that RTPB technology meets the needs of prescribers. At this time, the Council believes it is premature to require EHR vendors to incorporate RTPB for certification. Instead, the Council recommends that our AMA advocate that ONC and CMS work with physician and hospital organizations, and health IT developers, to identify RTPB 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 EHR vendors. The Council further recommends that any policies requiring health IT developers to integrate RTPB systems within their products do so with minimal disruption to EHR usability and cost to physicians and hospitals. Finally, the Council believes that it is critically important for the data offered on emerging consumer-facing RTPB tools to match the drug pricing and coverage information displayed in physicians' and hospitals' EHRs, as discrepancies will lead to confusion and dissuade both physicians and patients from using these technologies. Accordingly, the Council recommends that our AMA support alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTPB tools.

The Council acknowledges the strength of AMA policy on problems with prescription drug plans and formulary transparency and recommends reaffirmation of Policies H-125.979 and D-330.910. Previous Council reports on [hospital discharge communications](#) and [physician communication and care coordination during patient hospitalizations](#) underscored that consistent physician-to-physician communication across care settings is integral to achieving a safe and efficient discharge process. The Council recommends reaffirmation of Policy D-160.945, which supports timely and consistent communication between physicians in inpatient and outpatient care settings.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of the second resolve of amended Resolution 212-A-19, and the remainder of the report be filed.

1. That our American Medical Association (AMA) 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. That our AMA support 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. That our AMA support 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. That our AMA 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. That our AMA 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 with minimal disruption to EHR usability and cost to physicians and hospitals.
6. That our AMA support alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTPB tools.
7. That our AMA reaffirm Policy H-125.979, which directs the AMA to work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing, and promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers.
8. That our AMA reaffirm Policy D-330.910, which directs the AMA to explore problems with prescription drug plans, including issues related to continuity of care, prior authorization, and formularies, and work to resolve them.
9. That our AMA reaffirm Policy D-160.945, which directs the AMA to advocate for timely and consistent communication between physicians in inpatient and outpatient settings to decrease gaps in care coordination and improve quality and patient safety, and to explore new mechanisms to facilitate and incentivize this communication.

REFERENCES

1. The Joint Commission. National Patient Safety Goals Effective January 2020. Home Care Accreditation Program. Available online at: https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/npsg_chapter_ome_jan2020.pdf.
2. Ibid.
3. Stefanacci, RG. Dealing with new formulary types: Health system outpatient formularies. *Journal of Clinical Pathways*. April 2018.
4. American Society of Health-System Pharmacists. ASHP Guidelines on the Pharmacy and Therapeutics Committee and the Formulary System. 2008. Available online at: <https://www.ashp.org/-/media/assets/policy-guidelines/docs/guidelines/gdl-pharmacy-therapeutics-committee-formulary-system.ashx?la=en&hash=9EC241A67B0A5A6412E18B9D05876B2470B67DA7>.
5. Barbee J, Lauderdale K, and Smith A. Hospital Formulary Management. *Pharmacy Times*. September 28, 2017. Available online at: <https://www.pharmacytimes.com/publications/health-system-edition/2017/september2017/hospital-formulary-management>.

6. Hatoun JH, Bair-Merritt M, Cabral H and Moses J. Increasing Medication Possession at Discharge for Patients with Asthma: The Meds-in-Hand Project. *Pediatrics*. 2016;137(3):e20150461. Available online at: <https://pediatrics.aappublications.org/content/137/3/e20150461>.
7. Hoefgen ER, Jones Y et al. Leveraging the outpatient pharmacy to reduce medication waste in pediatric asthma hospitalizations. *Journal of Hospital Medicine* Vol 14, No 1. January 2020. Available online at: <https://www.journalofhospitalmedicine.com/jhosmed/article/206278/hospital-medicine/leveraging-outpatient-pharmacy-reduce-medication-waste>.
8. Hatoun J, Bair-Merritt M et al. Increasing medication possession at discharge for patients with asthma: The meds-in-hand project. *Pediatrics*. Vol. 137(3)Le20150461. 2016. Available online at: <https://pediatrics.aappublications.org/content/137/3/e20150461>.
9. American Society of Health-System Pharmacists and American Pharmacists Association. Best practices from the ASHP-APhA medication management in care transitions initiative. February 2013. Available online at: <https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/quality-improvement/learn-about-quality-improvement-medication-management-care-transitions.ashx>.
10. Centers for Medicare & Medicaid Services. Final Rule. Medicare and Medicaid Programs; Contract Year 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly. Available online at <https://www.federalregister.gov/documents/2021/01/19/2021-00538/medicare-and-medicaid-programs-contract-year-2022-policy-and-technical-changes-to-the-medicare>.

3. UNIVERSAL BASIC INCOME PILOT STUDIES (RESOLUTION 236-A-19)

Reference committee hearing: see report of Reference Committee G.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 236-A-19
REMAINDER OF REPORT FILED**

See Policies H-290.986, H-290.997, H-350.974, D-290.979, D-290.985 and D-440.916

At the 2019 Annual Meeting, the House of Delegates referred Resolution 236, which was sponsored by the Medical Student Section and asks that the American Medical Association (AMA) support federal, state, local, and/or private Universal Basic Income pilot studies in the United States that intend to measure health outcomes and access to care for participants.

This report provides background on Universal Basic Income (UBI) proposals, outlines potential funding mechanisms for a UBI program, provides numerous examples of past and current UBI pilot programs and, where available, any resulting outcomes, details relevant AMA policy, and provides recommendations consistent with ongoing AMA advocacy efforts.

BACKGROUND

Some economists and policymakers argue that, although there was strong 3.4 percent growth in gross domestic product (GDP) in 2019 and low rates of unemployment, those numbers conceal the fact that many families are struggling financially. Wage growth remains stagnant, and nearly 1 in 10 employed adults work as contractors with limited job security and therefore employment benefits such as health insurance and long-term financial security. Moreover, the novel coronavirus (COVID-19) pandemic is severely exacerbating these health and economic issues. There have been more than 48 million jobless claims in the US since March. At the time this report was written, about 31.8 million people are receiving unemployment benefits, which equates to about 1 in 5 individuals in the workforce.¹ Simultaneously, the US continues to set record numbers of COVID-19 cases with cases trending upward in 39 states.² In light of the pandemic, the International Monetary Fund projects that growth in the US will fall 8 percent in 2020 and overall worldwide output will fall 4.9 percent.³

UBI is one method that is being suggested as having the potential to address current income inequality and to mitigate the loss of jobs caused by technological advances and COVID-19. UBI is an economic support mechanism typically intended to reach all or a large portion of the population.⁴ It is particularly noteworthy and contrasted with current US welfare programs in that receipt of UBI comes with no or minimal conditions. According to the International Monetary

Fund, in formulating a UBI plan, policymakers generally grapple with three primary considerations: who is eligible, the generosity of the UBI transfers, and the fiscal cost.⁵ Some UBI proposals are universal while others are targeted to lower-income populations. Additionally, policymakers must weigh the incentives and disincentives of the generosity of transfers. For example, they must determine how UBI will affect decisions to enter the workforce and the number of hours worked. Finally, and perhaps most importantly, policymakers must determine the fiscal cost of implementing UBI to governments in an environment of limited financial resources.⁶

Proponents of UBI claim that it would help break the poverty cycle and dependency on welfare programs. They claim UBI will give the disadvantaged the time and money to seek higher education and needed job training.⁷ Others claim that UBI would disincentivize work. However, decreased working hours has not been established in UBI trials to date.⁸

Advocates mention that UBI could replace the current complicated safety net. The US has a patchwork benefits system with programs including but not limited to:

- Supplemental Nutrition Assistance Program: Provides nutrition benefits to supplement the food budget of families in need so they can purchase healthy food.
- Temporary Assistance for Needy Families: A time-limited program that assists families with children when the parents or other responsible relatives cannot provide for the family's basic needs.
- Children's Health Insurance Program (CHIP): Provides health coverage to children in families that earn too much money to qualify for Medicaid. In some states, CHIP also covers pregnant women.
- Section 8: Housing choice voucher program assisting low-income families, the elderly, and the disabled, to afford safe and sanitary housing in the private market.
- Earned Income Tax Credit: A refundable tax credit to low- and moderate-income individuals, particularly those with children.
- Special Supplemental Nutrition Program for Women, Infants, and Children: Provides federal grants to states for supplemental food, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and postpartum women, and to infants and children up to age five who are at nutritional risk.
- Supplemental Security Income: Program providing cash benefits to meet the needs of elderly, blind, and disabled individuals who otherwise have challenges paying for food and shelter.

Every year, the US spends nearly \$1 trillion across dozens of state and federal programs amounting to significant administrative oversight across multiple agencies.⁹ However, some critics of the programs state that the complex network of resources is a consequence of having different programs intentionally target different populations with varying needs and that the purpose of each program is distinct.¹⁰ Critics of UBI state that it amounts to redistribution but does not necessarily advance mobility or represent an investment in human capital. Rather, they believe, society should focus its collective efforts on reforming current safety net programs to better meet their intended goals.¹¹

FUNDING

Regardless of where one stands on UBI, how to pay for it is the primary challenge. Some estimates put the annual price for a US program in the trillions. Presumably, such a high cost would have to be funded through some type of taxation.

Some UBI advocates claim that such a high cost would be offset by savings as fewer people require welfare, food stamps, and other social programs. Moreover, advocates argue, UBI could be funded through savings from averting prisons, emergency care, and homelessness,¹² based on the evidence that high health care spending in the US is a direct result of low social safety net spending.¹³ In fact, the significant literature on social determinants of health (SDOH) establishes a direct link between social factors and health status, and some evidence points to a link between social spending and health outcomes.¹⁴ However, it remains unclear exactly how much low spending on SDOH impacts health spending and therefore how much overall spending could be reduced in a UBI program.

Former 2020 presidential candidate and current New York City mayoral candidate Andrew Yang has run on a platform of a guaranteed income. Yang's proposal, called the Freedom Dividend, suggested giving \$1,000 per month to all US citizens over the age of 18 unconditionally. Yang proposed funding his UBI proposal through four sources. First, he proposed streamlining and consolidating several welfare programs. Second, he suggested implementing a Value Added Tax of ten percent to generate revenue. Third, he stated that UBI would put money into the hands of American

consumers and would thereby generate economic growth. And fourth, he proposed taxing top earners and pollution through such actions as a financial transactions tax and a carbon fee.¹⁵

UBI PILOT PROGRAMS AND RESULTS

Manitoba Basic Annual Income Experiment (Mincome)

In 1975, the Canadian government began the Manitoba Basic Annual Income Experiment (Mincome), which lasted three years. The results of this experiment were published in 2011. Unlike most UBI pilots, Mincome allowed researchers to compare the health of those receiving UBI to the health of similar people not receiving UBI. The experiment involved 1,300 urban and rural families with incomes below \$16,000 in Canadian dollars for a family of four. Families with higher incomes still received the UBI but at a reduced rate. Therefore, working was still rewarded, and the results of the pilot show that the majority of Mincome participants kept working. Importantly, families receiving the UBI had fewer hospitalizations, accidents, and injuries. Additionally, mental health hospitalizations fell dramatically in the population receiving UBI. Further, the high school completion rate for 16- to 18-year-old boys increased, and adolescent girls were less likely to give birth before the age of 25. The experiment was terminated after three years when Canada's governing party changed midway through the proposed duration of the pilot.¹⁶ To date, Mincome remains one of the few UBI experiments measuring any health outcome related data.

Finland's Basic Income Experiment

In 2017, Finland launched a UBI experiment involving a guaranteed tax-free income of about \$590 per month to 2,000 randomly selected unemployed citizens. The trial experiment lasted nearly two years. As researchers explore the effects of the experiment, one general finding is that happiness and overall sense of wellbeing improved. Participants also stated that the income gave them a sense of autonomy and allowed them to return to meaningful activities. Regarding employment, the results are mixed. Employment went up slightly in the second year of the trial but not significantly. Participants stated that there were still no jobs available in the areas in which they were trained. Others noted that, due to the basic income, they were more prepared to take on lower paying jobs to enable them to reenter the workforce.¹⁷

Ontario Basic Income Pilot

In March 2017, the government of Ontario, Canada began the Ontario Basic Income Pilot. The pilot was undertaken in three sites in Ontario with 4,000 low-income individuals participating with an additional 2,000 people participating in the comparison group. The participants were eligible to receive up to \$16,989 per year for a single person, less 50 percent of any earned income or up to \$24,027 per year for a couple, less 50 percent of any earned income. The pilot measured, among other markers, food security, stress and anxiety, mental health, housing stability, and health and health care usage. Additionally, participants receiving support through social assistance needed to withdraw from those programs to participate and receive the UBI. In 2019, Ontario terminated the pilot earlier than planned two months after a change in the control of the province's government from the Liberal Party to the Progressive Conservatives Party. The new government stated that winding down the pilot will enable participants to transition back to more proven support systems without putting an undue burden on taxpayers.

Stockton Economic Empowerment Demonstration

In February 2019, the city of Stockton, California began giving 125 city residents a guaranteed income of \$500/month for 18 months.¹⁸ The monthly income was unconditional, and it was intended to test UBI as a solution to poverty and inequality. Though the program was scheduled to end in June 2020, it was renewed until January 2021 due to the COVID-19 pandemic. The 125 residents participated in individual onboarding appointments, which included informed consent and benefits counseling. According to the Stockton Economic Empowerment Demonstration (SEED), the purpose of the benefits counseling was to ensure that the participants were aware of any risks associated with the UBI disbursements possibly impacting their health insurance or other benefits such as food stamps or Supplemental Security Income. One of the primary outcomes that the SEED researchers planned to measure was the effect of the UBI on the participants' functioning and well-being. One of the early program results observed was that most recipients spent their money on groceries and utility bills. In the early phase of the program, food spending made up about 30 percent to 40 percent of the spending each month. However, after the pandemic started, the share of food spend increased to almost 50 percent.¹⁹ After initial results were released, a group of mayors announced the formation

of the Guaranteed Income Coalition, which is committed to investigating how to successfully build and launch UBI projects in their cities.

In March 2021, SEED released the results from the first year of the experiment. A primary finding is that the individuals who received the monthly UBI payment secured fulltime employment at more than twice the rate of those in the control group. Additionally, within a year, the proportion of recipients receiving the cash payments who had a fulltime job went from 28 percent to 40 percent. Meanwhile, the control group saw a 5 percent increase in full time employment. Another positive finding is that those receiving cash payments reported being less anxious and depressed compared to the control group. As far as how the group spent the money, of the money tracked, recipients spent more on necessities like food (37 percent), home goods and clothes (22 percent), utilities (11 percent), and car costs (10 percent). The recipients spent less than 1 percent of the UBI payment on alcohol or cigarettes. Although the study's sample size is small, the early results indicate that UBI payments give recipients stability and enhance health.^{20 21}

OpenResearch

Another UBI pilot being undertaken is by OpenResearch, a non-profit research lab. The study, which started in 2020, recruited about 3,000 people across two states. It randomly assigned 1,000 of those individuals to receive \$1,000 per month for three years while using the other 2,000 individuals as the control group. Importantly, the pilot will measure health outcomes including health markers (e.g., body mass index, hypertension), healthy behaviors, health insurance coverage, food security, housing quality and stability, physician and mental health care utilization, crime victimization, and mental health.

RELEVANT AMA POLICY

The AMA has myriad policies on health disparities, health inequities, and diversity, and the AMA continues to provide leadership in addressing disparities (Policies H-350.974, D-350.991, D-350.995, D-420.993, H-65.973, H-60.917, H-440.869, D-65.995, H-150.944, H-185.943, H-450.924, H-350.953, H-350.957, D-350.996, H-350.959). Policy H-350.974 affirms that the AMA maintains a zero-tolerance policy toward racially or culturally based disparities in care and states that the elimination of racial and ethnic disparities in health care are an issue of highest priority for the organization. The policy encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, Policy H-350.974 supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons. Moreover, the policy actively supports the development and implementation of training regarding implicit bias and cultural competency. Policy H-280.945 calls for better integration of health care and social services and supports. Additionally, Policy D-350.995 promotes diversity within the health care workforce, which can help expand access to care for vulnerable and underserved populations.

The AMA also has strong policy supporting Medicaid. Policy H-290.986 states that the Medicaid program is a safety net for the nation's most vulnerable populations. Moreover, the AMA is committed to expanding Medicaid coverage. In particular, Policy D-290.979 directs the AMA to work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility as authorized by the Affordable Care Act. Finally, Policy D-290.985 encourages sufficient federal and state funding for Medicaid to support enrollment and the provision of appropriate services.

DISCUSSION

There are risks to replacing targeted social safety net programs, which protect the most vulnerable, with a UBI program. The AMA strongly supports these existing evidence-based safety net programs. Of note, AMA Ethics Opinion 11.1.1 states that health care is a fundamental human good and the Council believes physicians have a responsibility to work to ensure access to care. The Council advises caution regarding support for any proposal that may have the effect of jeopardizing access to care.

The AMA continues to advocate for Medicaid funding and other safety net program funding. Medicaid and other safety net programs increase vital access to care for patients, reduce the number of uninsured individuals, and improve the lives of working Americans. The Council believes the AMA should continue its efforts to improve upon and expand Medicaid and other programs that improve the health of patients. Therefore, the Council recommends reaffirming the AMA's comprehensive policy on addressing health disparities, the role of Medicaid as a vital safety

net program, the AMA's enduring commitment to expanding Medicaid eligibility, and sufficient funding for the program.

An evidence-based method to analyze UBI is currently unavailable. Models have been population-based and generally do not meet minimum standards for randomized control studies. They have also been subject to political influence and change. Experiments are key to understanding how and if UBI would work on a large scale. Consequently, there is a void of data on how a sustained UBI program would operate and the far-reaching effects the program would have once implemented. The Council does not believe that there are adequate data to actively support UBI pilots at this time. However, the Council recognizes that UBI may be one of myriad solutions to help address growing inequity and health care disparities. Therefore, the Council recommends that the AMA actively monitor UBI pilots moving forward, especially pilots that intend to measure the health outcomes and access to care of its participants.

The Council understands that the concept of UBI is evolving rapidly, particularly in light of the COVID-19 pandemic. The pandemic is catalyzing support for UBI not only in the US but also worldwide. Since February 2020, governments all over the world, including the US, have started distributing direct cash payments among large portions of their populations in order to mitigate the loss of jobs and financial disruption of the pandemic. A report from the United Nations recently stated that temporary basic income payments could stem the spread of the pandemic by enabling workers, particularly those living below the poverty line, to stay at home.²² Additionally, Spain started a UBI program offering monthly payments up to \$1,145 to its poorest families in 850,000 households. The program is the largest test of UBI seen thus far. The program is seen as a way to not only soften the impact of the COVID-19 pandemic but also to become a structural instrument of stability in the country. Also, in March 2021, Congress passed, and the president signed into law the third pandemic aid package that once again includes direct payments to millions of Americans. Importantly, the law, the American Rescue Plan, substantially expands the Child Tax Credit and supplements the earnings of families receiving the credit. Under the law, most Americans will receive \$3,000 a year for each child ages 6-17, and \$3,600 per year for each child under 6. The provision lasts one year and will be sent via direct deposit on a "periodic" basis. This provision represents a major expansion of the child tax credit, and the proposed "periodic" payments mirror a UBI payment.²³

As the COVID-19 pandemic and its economic fallout continue, the US and society must consider the appropriate responses to not only the pandemic but also deepened and newly exposed financial inequities. The AMA is committed to following and analyzing the relevant research to confront these issues and propose solutions.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 236-A-19, and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-350.974, which states that the elimination of racial and ethnic disparities in health care are an issue of highest priority for the organization.
2. That our AMA reaffirm Policy H-290.986, which states that the Medicaid program is a safety net for the nation's most vulnerable populations.
3. That our AMA reaffirm Policy D-290.979, which directs the AMA to work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility as authorized by the Affordable Care Act.
4. That our AMA reaffirm Policy D-290.985, which encourages sufficient federal and state funding for Medicaid to support enrollment and the provision of appropriate services.
5. That our AMA reaffirm Policy H-290.997 stating that greater equity in the Medicaid program should be achieved through the creation of adequate payment levels to ensure broad access to care.
6. That our AMA actively monitor Universal Basic Income pilot studies that intend to measure participant health outcomes and access to care.
7. That our AMA encourage Universal Basic Income pilot studies to measure health outcomes and access to care for patients to increase data on the health effects of these programs.

REFERENCES

1. Ivanova, Irina. “Unemployment Claims Rise for First Time in Months as Coronavirus Rages On.” CBS News. July 2020, <https://www.cbsnews.com/news/unemployment-jobless-claims-rise-layoffs-2020-07-18/>
2. “Coronavirus Live Updates: US Surpasses 4 Million Known Infections.” New York Times, July 2020, <https://www.nytimes.com/2020/07/23/world/coronavirus-covid-19.html>
3. “A Crisis Like No Other,” International Monetary Fund. June 2020, <https://www.imf.org/en/Publications/WEO/Issues/2020/06/24/WEOUpdateJune2020>
4. Francese, Maura, and Delphine Prady. “What Is Universal Basic Income?” – IMF Finance & Development Magazine | Dec. 2018, www.imf.org/external/pubs/ft/fandd/2018/12/what-is-universal-basic-income-basics.htm.
5. Francese, Maura, and Delphine Prady. “What Is Universal Basic Income?” – IMF Finance & Development Magazine | Dec. 2018, www.imf.org/external/pubs/ft/fandd/2018/12/what-is-universal-basic-income-basics.htm.
6. Francese, Maura, and Delphine Prady. “What Is Universal Basic Income?” – IMF Finance & Development Magazine | Dec. 2018, www.imf.org/external/pubs/ft/fandd/2018/12/what-is-universal-basic-income-basics.htm.
7. Ezrati, Milton. “Universal Basic Income: A Thoroughly Wrongheaded Idea.” Forbes Magazine, 15 Jan. 2019, www.forbes.com/sites/miltonezrati/2019/01/15/universal-basic-income-a-thoroughly-wrongheaded-idea/#3207b2d145e1.
8. “The Concept of a Universal Basic Income Is Gaining Currency.” Time, 14 Aug. 2019, www.time.com/collection/davos-2019/5502590/universal-basic-income.
9. Andrewflowers. “What Would Happen If We Just Gave People Money?” FiveThirtyEight, Apr. 2016, www.fivethirtyeight.com/features/universal-basic-income.
10. Kearney, Melissa, and Magne Mogstad, “Universal Basic Income (UBI) as a Policy Response to Current Challenges.” The Aspen Institute Economic Strategy Group, August 2019, <https://www.brookings.edu/wp-content/uploads/2019/08/UBI-ESG-Memo-082319.pdf>.
11. Kearney, Melissa, and Magne Mogstad, “Universal Basic Income (UBI) as a Policy Response to Current Challenges.” The Aspen Institute Economic Strategy Group, Aug. 2019, <https://www.brookings.edu/wp-content/uploads/2019/08/UBI-ESG-Memo-082319.pdf>.
12. “The Concept of a Universal Basic Income Is Gaining Currency.” Time, 14 Aug. 2019, www.time.com/collection/davos-2019/5502590/universal-basic-income.
13. Papanicolas I, Cooper Z, Martin AB, et al. The Relationship Between Health Spending and Social Spending In High-Income Countries: How Does The US Compare? Health Affairs. Aug. 2019. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05187>.
14. Papanicolas I, Cooper Z, Martin AB, et al. The Relationship Between Health Spending and Social Spending In High-Income Countries: How Does The US Compare? Health Affairs. Aug. 2019. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05187>.
15. <https://www.yang2020.com/what-is-freedom-dividend-faq/>
16. Andrewflowers. “What Would Happen If We Just Gave People Money?” FiveThirtyEight, FiveThirtyEight, 25 Apr. 2016, www.fivethirtyeight.com/features/universal-basic-income.
17. McRae, M. “Latest Report on Finland’s Universal Basic Income Trial Says it Makes People Happier.” Science Alert. May 2020. <https://www.sciencealert.com/latest-report-on-finland-s-universal-basic-income-trial-suggests-we-d-be-happier-with-it>.
18. Martin-West S, Castro Baker A, Balakrishnan S, Rao K, Tan G. Pre-Analysis Plan: Stockton Economic Empowerment Demonstration. July 2019. <https://www.stocktondemonstration.org/wp-content/uploads/2019/08/SEED-Pre-analysis-Plan.-8.6.19-1.pdf>.
19. Sarah Holder. “Support Grows for Guaranteed Income Among America’s Mayors.” Bloomberg. July 2020, <https://www.bloomberg.com/news/articles/2020-07-02/to-expand-the-safety-net-more-mayors-back-ubi>
20. Samuel, S. “When a California City Gave People a Guaranteed Income, They Worked More—Not Less.” Vox. <https://www.vox.com/future-perfect/22313272/stockton-basic-income-guaranteed-free-money>.
21. West, S. et al. Stockton Economic Empowerment Demonstration. “Preliminary Analysis: SEED’s First Year.” https://static1.squarespace.com/static/6039d612b17d055cac14070f/t/603ef1194c474b329f33c329/1614737690661/SEED_Preliminary+Analysis-SEEDs+First+Year_Final+Report_Individual+Pages+-2.pdf.
22. Prinesha Naidoo. “A Temporary Basic Income Could Curb Coronavirus in Poor Nations, UN Says..” Time. July 2020, <https://time.com/5870438/basic-income-payments-coronavirus-u-n/>
23. Fact Sheet: The American Rescue Plan Will Deliver Immediate Economic Relief to Families. US Department of the Treasury. <https://home.treasury.gov/news/featured-stories/fact-sheet-the-american-rescue-plan-will-deliver-immediate-economic-relief-to-families>.

4. PROMOTING ACCOUNTABILITY IN PRIOR AUTHORIZATION

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS

REMAINDER OF REPORT FILED

See Policies H-285.939, H-285.998, H-320.939, H-320.945, H-320.948, H-320.949, H-320.961, D-285.960 and D-320.983

At the 2019 Annual Meeting, the House of Delegates adopted Policy D-320.983, which asks that the American Medical Association (AMA) study the frequency by which health plans and utilization review entities are using peer-to-peer (P2P) review prior authorization (PA) processes, and the extent to which these processes reflect AMA policies, including H-285.987, “Guidelines for Qualifications of Managed Care Medical Directors,” H-285.939, “Managed Care Medical Director Liability,” H-320.968, “Approaches to Increase Payer Accountability,” and the AMA *Code of Medical Ethics* Policy 10.1.1, “Ethical Obligations of Medical Directors,” with a report back to the House of Delegates.

This report provides background on PA, an overview of the P2P PA process, outlines the significant AMA advocacy efforts on PA and utilization management (UM) review, and proposes recommendations to strengthen AMA policy on PA and, in particular, P2P reviews.

BACKGROUND

Health plans employ PA, step therapy, and other forms of UM to control access to certain treatments and reduce health care expenses. The medical literature clearly establishes the time and cost burdens associated with UM requirements on physician practices. UM often involves manual, time-consuming processes that can divert valuable and scarce physician resources away from direct patient care. More importantly, PA and other UM methods interfere with patients receiving timely and optimal treatment selected in consultation with their physicians. At the very least, UM requirements can delay access to needed care. In some cases, the barriers to care imposed by UM may lead to patients receiving less effective therapy, no treatment at all, or even potentially harmful therapies.

PEER-TO-PEER REVIEWS

P2P conversations refer to discussions between a physician and an insurance company physician employee. The discussion generally occurs after an initial PA denial that typically involves questions of medical necessity or treatment requests that are considered investigational. However, numerous physicians have stated that some insurers are starting to require P2Ps for first-line PAs. The rationale behind P2P is to provide a more transparent PA process that is collaborative and appropriately follows relevant clinical guidelines. However, for many treating physicians, P2P review simply represents another time-consuming and potentially detrimental use of UM by insurance companies. Peer reviewers can be unqualified to assess the need for services for an individual patient for whom they have minimal information and have never evaluated or spoken with. These issues are exacerbated if physicians are required to participate in P2P for first-line PAs.

RELEVANT AMA ADVOCACY

PA and other UM programs are a high-priority advocacy issue for the AMA. Several current AMA initiatives address the concerns raised in Policy D-320.983 and strengthen the AMA’s ability to effectively advocate on UM issues:

1. State Legislative Activity: In response to the numerous concerns raised by AMA members and the Federation of Medicine, the AMA’s Advocacy Resource Center works closely with state and specialty medical societies to address PA and other UM-related issues through state legislation. The AMA’s model bill on PA, the “Ensuring Transparency in Prior Authorization Act,” addresses a variety of concerns related to UM programs, including response timeliness, duration of authorizations, public reporting of UM program results, retroactive denials, and electronic PA. Additionally, the bill states that UM staff have experience treating patients with the medical condition or disease for which the health care service is requested.¹ At the time of writing, there were nearly 40 bills related to PA and step therapy in the state legislatures, several of which are broad reform efforts based on the AMA model bill, as well as several directed at reducing UM requirements for individuals with HIV/AIDS,

cancer, substance use disorder and other chronic diseases and conditions. Additionally, as part of the state policymakers' responses to COVID-19, commercial plans and Medicaid in many states were required (or urged) to reduce certain UM requirements to ensure safe access to care during state stay-at-home orders and other restrictions.

2. Prior Authorization and Utilization Management Reform Principles: To improve access to care and reduce practice burdens, the AMA convened a workgroup of state and specialty medical societies, national provider associations, and patient representatives to create a set of best practices related to PA and other UM requirements. The workgroup identified the most common provider and patient complaints associated with UM programs and developed the Prior Authorization and Utilization Management Reform Principles to address these priority concerns. These 21 principles seek to improve PA and UM programs by addressing the following 5 broad categories of concern:
 - a. Clinical validity
 - b. Continuity of care
 - c. Transparency and fairness
 - d. Timely access and administrative efficiency
 - e. Alternatives and exemptions

These “best practice” principles have served as the foundation for an extensive, multi-pronged advocacy campaign to reform and improve UM programs. Workgroup members directly advocate with health plans, benefit managers, and other UM entities to voluntarily adopt these principles; urge accreditation organizations, such as the National Committee for Quality Assurance and the Utilization Review Accreditation Commission, to include these concepts in criteria for utilization review programs; introduce bills based on these principles to state legislatures; encourage technological standards organizations to support improved UM processes; and launch a media campaign to raise awareness of the principles and requested reforms.

Additionally, two of the PA principles specifically reference the qualifications that health plan reviewers should possess. Principle 3 states that utilization review entities should offer an appeals system for their UM programs that allows a prescribing/ordering provider direct access, such as a toll-free number, to a provider of the same training and specialty/sub-specialty for discussion of medical necessity issues. Principle 16 states that, should a provider determine the need for an expedited appeal, a decision on such an appeal should be communicated by the utilization review entity to the provider and patient within 24 hours. Moreover, providers and patients should be notified of decisions on all other appeals within ten calendar days. And all appeal decisions should be made by a provider who is not only of the same specialty and subspecialty, whenever possible, as the prescribing/order physician, but also, the reviewing provider must not have been involved in the initial adverse determination.²

3. The Consensus Statement on Improving the Prior Authorization Process: The release of the 21 PA reform principles initiated meaningful discussions with the health insurance industry about reducing PA burdens. These discussions led to the development of the Consensus Statement on Improving the Prior Authorization Process—created by the AMA, American Hospital Association, America’s Health Insurance Plans, American Pharmacists Association, BlueCross BlueShield Association and Medical Group Management Association. The AMA continues to advocate for insurers to operationalize the concepts outlined in the Consensus Statement in their PA programs.³
4. Prior Authorization Research: The lack of alignment between physician and health plan interests on PA and other UM programs creates significant challenges in achieving meaningful reform on this issue. Recognizing the key role that credible evidence plays in successful advocacy on this topic, the AMA is engaged in research to gather data regarding the impact of PA on patients and physician practices, including an annual physician survey assessing the burdens associated with UM programs.

PA Physician Survey – In conjunction with a market research partner, the AMA fielded a web-based survey of 1000 practicing physicians in December 2019. The survey sample comprised 40 percent primary care and 60 percent specialty physicians and only included physicians who provide at least 20 hours of patient care during a typical week and routinely complete PAs in their practice. Along with gathering data on the impact of PA on both patient access to timely care and practice burdens, the survey also assessed physicians’ perception of the frequency of P2P review requirements and the qualifications of insurer “peers.”

One survey question asked physicians: “How often are you involved in a peer-to-peer review during the prior authorization process?”

- Never – 6%
- Rarely – 30%
- Sometimes – 45%
- Often – 15%
- Always – 3%
- Don’t know – 1%

Another survey question asked physicians: “How has the frequency of peer-to-peer reviews during the prior authorization process changed over the last five years?”

- Increased significantly or increased somewhat – 60%
- No change – 35%
- Decreased somewhat or decreased significantly – 5%

An additional survey question asked physicians: “When completing a peer-to-peer review during the prior authorization process, how often does the health plan’s ‘peer’ have the appropriate qualifications to assess and make a determination regarding the prior authorization request?”

- Always – 2%
- Often – 13%
- Sometimes – 41%
- Rarely – 28%
- Never – 4%
- Don’t know – 11%

Note: Percentages do not sum to 100 percent due to rounding.

DISCUSSION

The Council recognizes the value and importance of the AMA’s current multi-pronged advocacy efforts related to PA and applauds the House of Delegates for highlighting the issue of P2P PA and its effect on physicians and most importantly patients. To continue its effective advocacy efforts regarding PA, the Council recommends reaffirming several AMA policies and recommends a number of new policies specifically related to P2P PA. First, the Council recommends reaffirming Policy H-320.939, which states that the AMA will continue its widespread PA advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, the Consensus Statement on Improving the Prior Authorization Process, AMA model legislation, Prior Authorization Physician Survey and other PA research, and educational tools aimed at reducing administrative burdens for physicians and their staff; 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.

Additionally, the Council recommends reaffirming Policies H-320.948 and H-320.961, which encourage sufficient clinical justification for any retrospective payment denial and prohibition of retrospective payment denial when treatment was previously authorized. Further, the Council recommends reaffirming Policy H-320.949, which states that UM criteria should be based upon sound clinical evidence, permit variation to account for individual patient differences, and allow physicians to appeal decisions, and Policies H-285.998 and H-320.945, which further underscore the importance of a clinical basis for health plans’ coverage decisions and policies.

While physicians have the freedom to choose their method of making a living, physicians employed by insurance companies must not have their ethical obligations discharged. Insurance companies know that many patients and physicians do not appeal PA decisions, and even fewer seek an external review. However, when an external review is sought, nearly one-third of external reviews of insurer denials are overturned.⁴ These overturned denials demonstrate that insurers’ processes for determining medical necessity often do not reflect current clinical standards of care. It is imperative to patient safety and quality of care that physicians make utilization review decisions in good faith and follow evidence-based guidelines in their work for insurers. Therefore, the Council recommends reaffirming Policy

H-285.939, which states that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine and that medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services.

Furthermore, the Council recommends addressing the timeframe for PA decisions for P2P discussions. Physicians generally receive the PA decision at the end of the P2P discussion. However, insurers have suggested that plans should have two business days after the P2P to make a decision. A recent operating rule for electronic PA has this longer specification. Specifically, it states that once a health plan receives a complete PA request, including any P2P medical reviews conducted, the health plan must return an approval or denial to such request within two business days.⁵ Further delaying the PA determination harms all patients and has a disproportionately negative effect on vulnerable populations. Therefore, the Council recommends requiring that PA decisions be made at the end of the P2P review discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion. The Council believes such mitigating circumstances include instances wherein a physician involved in the P2P discussion requests additional time to read relevant medical literature. Importantly, the Council notes that such an extension shall not be permitted where the PA request is urgent.

As highlighted in Policy D-320.983, care must be taken to ensure that plan reviewers are, in fact, physician peers with the appropriate experience treating the condition in question and from the same specialty or subspecialty. The AMA already has strong policy stating that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review (e.g., Policy H-320.968). Nevertheless, the Council believes that policy should be strengthened to ensure that not only is the reviewing physician of the same specialty and licensed to practice in the jurisdiction, but also has the expertise to treat the medical condition or disease under review according to up-to-date evidence-based guidelines and has knowledge of novel treatments.

Moreover, as directed by Policy D-320.983, the Council highlights Ethics Opinion 10.1 regarding ethical guidance for physicians in nonclinical roles. Ethics Opinion 10.1 states that physicians earn and maintain the trust of their patients and the public by upholding norms of fidelity to patients, on which the physician's professional identity rests, and that, despite not directly providing care to patients, physicians employed by insurers have committed themselves to the values and norms of medicine. Accordingly, the Council recommends that physicians employed by insurance companies must follow current evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable.

The Council notes that the AMA's efforts to reduce PA burdens are particularly important during public health emergencies, such as the novel coronavirus (COVID-19) pandemic. Recognizing the enormous strain placed on physicians and the entire US health care system and, more importantly, the impact that delayed care has on patients during the COVID-19 crisis, the AMA and other organizations have successfully advocated for many commercial health plans to temporarily suspend or otherwise adjust PA requirements. Meanwhile, legislators and regulators have reduced PA in both the commercial and Medicaid markets via legislation, executive orders, and waivers. While the AMA strongly supports relaxation in PA requirements during the COVID-19 emergency, there is considerable variation in the adjustments being made across the commercial health insurer market and corresponding effective dates, with some plans quickly reinstating regular PA processes only a few months into the pandemic. The AMA is tracking individual health plan COVID-19-related PA program updates to help physicians stay informed of these rapidly changing policies (see <https://www.ama-assn.org/system/files/2020-04/prior-auth-policy-covid-19.pdf>). To that end, the Council recommends that the AMA urge temporary suspension of all prior authorizations and calls for the extension of existing approvals during a declared public health emergency.

Finally, the Council notes that PA remains a top-of-mind issue for physicians and, as such, deserves substantial AMA attention and resources. As detailed in this report, the AMA prioritizes PA as one of its key advocacy issues and continues to collaborate with relevant stakeholders to address physician concerns on this topic. The AMA is committed to ensuring that tackling PA and UM issues will continue to be a leading priority for the AMA.

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) reaffirm Policy H-320.939 which states that the AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and adoption of the Prior Authorization and Utilization Management Reform Principles, the Consensus Statement on Improving the Prior Authorization Process, AMA model legislation, the Prior Authorization Physician Survey and other PA research, and educational tools aimed at reducing administrative burdens for physicians and their staff; 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.
2. That our AMA reaffirm Policies H-320.948 and H-320.961 which encourage sufficient clinical justification for any retrospective payment denial and prohibition of retrospective payment denial when treatment was previously authorized.
3. That our AMA reaffirm Policy H-320.949 which states that utilization management criteria should be based upon sound clinical evidence, permit variation to account for individual patient differences, and allow physicians to appeal decisions.
4. That our AMA reaffirm Policies H-285.998 and H-320.945 which underscore the importance of a clinical basis for health plans' coverage decisions and policies.
5. That our AMA reaffirm Policy H-285.939 which states that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine and that medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services.
6. That our AMA advocate that peer-to-peer (P2P) PA determinations must be made and actionable at the end of the P2P discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion.
7. That our AMA advocate that the reviewing P2P physician must have the clinical expertise to treat the medical condition or disease under review and have knowledge of the current, evidence-based clinical guidelines and novel treatments.
8. That our AMA advocate that P2P PA reviewers follow evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable.
9. That our AMA continue to advocate for a reduction in the overall volume of health plans' PA requirements and urge temporary suspension of all PA requirements and the extension of existing approvals during a declared public health emergency.
10. That our AMA rescind Policy D-320.983, which directed the AMA to conduct the study herein.
11. That our AMA advocate that health plans must undertake every effort to accommodate the physician's schedule when requiring peer-to-peer prior authorization conversations.
12. That our AMA advocate that health plans must not require prior authorization on any medically necessary surgical or other invasive procedure related or incidental to the original procedure if it is furnished during the course of an operation or procedure that was already approved or did not require prior authorization.

REFERENCES

1. Model Bill: Ensuring Transparency in Prior Authorization Act. American Medical Association. Available at: <https://www.ama-assn.org/system/files/2019-08/model-bill-ensuring-transparency-in-prior-authorization.pdf>
2. Prior Authorization and Utilization Management Review Principles. American Medical Association. Available at: <https://www.ama-assn.org/system/files/2019-06/principles-with-signatory-page-for-slsc.pdf>
3. Consensus Statement on Improving the Prior Authorization Process. Available at: <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf>
4. Private Health Insurance: Data on Application and Coverage Denials. Government Accountability Office. Available at: <https://www.gao.gov/new.items/d11268.pdf>

5. CAQH CORE Prior Authorization & Referrals (278) Infrastructure Rule Version PA.2.0. CAQH CORE. Available at: https://www.caqh.org/sites/default/files/core/phase-iv/452_278-infrastructure-rule.pdf

5. MEDICAL CENTER PATIENT TRANSFER POLICIES (RESOLUTION 818-I-19)

Reference committee hearing: see report of Reference Committee G.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 818-I-19
REMAINDER OF REPORT FILED**

*See Policies H-130.965, H-130.982, H-225.942, H-225.957, H-225.971, H-285.904 and
H-320.939*

At the 2019 Interim Meeting, the House of Delegates referred Resolution 818, which was sponsored by the Organized Medical Staff Section. Resolution 818-I-19 asked the American Medical Association (AMA) to: (1) study the impact of “auto accept” policies (i.e., unconditional acceptance for the care of a patient) on public health, as well as their compliance with the Emergency Medical Treatment and Labor Act (EMTALA) in order to protect the safety of our patients; and (2) advocate that if a medical center adopts an auto accept policy, it must have been ratified, as well as overseen and/or crafted, by the independent medical staff. Reference Committee J from the 2019 Interim Meeting noted that the resolution simultaneously called for study and new policy, and it emphasized the importance of first studying the issue of auto accept policies. Accordingly, this report explores patient transfer issues, with consideration of potential clinical and financial impacts on patients, and legal, accreditation, and medical staff bylaws implications for physicians and medical centers.

BACKGROUND

Optimal patient health and well-being should be the principal goals of patient transfer, but disagreements can arise in pursuing those goals. Some physicians have observed that medical centers where they practice can automatically accept the transfer of patients with emergent and/or serious conditions, and they have voiced concern that accepting transfer patients without adequate input from the medical staff could jeopardize patient care. The term “auto accept policies” encompasses a variety of medical center policies that address how patients may be “automatically” received at their institutions. For example, one large public health system has implemented an auto accept policy whereby critical care nurses answer phone calls from transferring physicians and accept patient transfers instantaneously—transfer requests are not denied.¹ As part of this system, physicians are paid to be on call and to receive patients from the region. Another medical center will automatically accept any acute critical transfer, with a specially educated triage registered nurse gathering clinical and basic demographic information, locating an accepting physician, and arranging for a bed in the appropriate level of care that will be ready when the patient arrives.² As a third example, another medical center has a pilot program to automatically accept into their Emergency Department (ED) stable patients from other medical centers who need specific services.³ These varied auto accept policies highlight the challenges that are inherent in transferring patients among medical centers and the critical role that physicians must play in these processes.

Any time a patient is transferred from one facility to another, it is essential that both transferring and receiving facilities ensure that there is an accepting physician who is capable of taking responsibility for the care of the transferred patient, and medical centers receiving a transferred patient must affirmatively accept the patient. Under certain conditions, acceptance will be mandatory. Nevertheless, medical center transfer policies, including auto accept policies, that fail to identify the appropriate physicians and their capabilities run the risk of suboptimal care for the patient and delays while the appropriate physicians and resources are identified. In addition, transfers of patients with emergent and/or serious conditions carry implications not only for individual patients, but also public health and legal implications for individual physicians and medical centers, so patient transfer policies must address all of these implications.

KEY CHALLENGES ARISING WITH PATIENT TRANSFERS

Interhospital transfer is an understudied area, with little known about institutional variations in information transfer and impacts on patient outcomes.⁴ A recent survey of 32 tertiary care centers in the United States studied communication and documentation practices during interhospital patient transfers and found that practices vary widely among tertiary care centers, and the level of transfer center involvement in oral and written handoff was inconsistent.⁵ Moreover, patients may be transferred from one medical center to another for a variety of reasons, including to receive specific expert medical services such as monitoring, tests, or procedures, or to accommodate patient or family preference.⁶ With a variety of specialists involved in the care of patients with emergent and/or serious conditions requiring transfer, communication and coordination are critical, but complicated.⁷ Often, the physicians who will be directly caring for a transferred patient want to be involved early in the transfer process to ensure that their specific questions are answered.⁸ In an attempt to address transfer challenges, some hospitals have established dedicated call centers, often staffed by senior-level nurses, to coordinate communication between accepting and receiving physicians.⁹ However, studies have found such call centers to be highly variable in their functionality and effectiveness.¹⁰

Non-medical factors have been found to influence decisions regarding whether a stable patient will be transferred to another facility for inpatient care, but again, the impact on quality of care is unknown. An analysis of all-payer administrative data from a representative sample of community hospitals in the United States found that uninsured patients and women were significantly less likely to be transferred to another acute care hospital.¹¹ The study authors were surprised to find the lower rate of transfer for uninsured patients, expecting that a hospital would seek to transfer uninsured patients as soon as they fulfilled their EMTALA obligations. Instead, the study authors suspected that the lower transfer rates for uninsured patients can be explained by an unwillingness of receiving hospitals to accept uninsured transfer patients. At the same time, the study authors emphasized that economic factors are unlikely to explain the lower transfer rates they found for women, and they expressed concern for the potential of implicit or explicit biases contributing to this disparity. Critically, though, it is unknown whether the differences in transfer patterns identified in this study led to differences in health outcomes.

Hospitals' interfacility transfer agreements and protocols can impact patient care not only within inpatient departments, but in the ED as well. To the extent that inpatient beds are reserved for specific categories of patients, including interfacility transfer patients, challenges can arise when there are insufficient inpatient beds available to receive transfers from the medical center's ED.¹² Patients who stay in the ED for longer than the time required for a "timely transfer" to an inpatient bed are considered "boarders," and challenges surrounding boarding patients in the ED are well-established.¹³ (Definitions of "timely transfer" vary, but experts often look for a period of less than two hours from the admission order.) Boarding can exacerbate health disparities, with Black, female, elderly, and psychiatric patients being more likely to board for longer periods of time.¹⁴ Moreover, patients with medically treated conditions are more likely to board than those with surgically treated conditions.¹⁵ With the ED being the dominant source of hospital admissions,¹⁶ it is critical for medical center transfer policies to promote optimal care for the patients who present with emergent and/or serious conditions, both before and after their stabilization. The problems associated with patient boarding are so severe, there is evidence that they increase in-hospital death rates substantially.¹⁷ Reflecting these problems, The Joint Commission (TJC) imposes requirements that hospitals address boarding for purposes of accreditation.¹⁸ Importantly, reservation of inpatient beds for interfacility transfer patients is just one factor contributing to the complex challenge of ED boarding, and solving the broader issue of ED boarding is beyond the scope of this report.

When contemplating the transfer of a stable patient who is not receiving care in an ED, in addition to the critical clinical implications of the transfer, patient financial impacts must also be considered. Prior to transferring a patient to a new medical center, it is important to consider whether the new facility is in-network under the patient's health plan. If the intended transfer facility is out-of-network (OON), the patient and/or family will need to be prepared for the financial implications of receiving OON care. Additionally, if the patient is receiving, or intends to receive, care that requires prior authorization (PA), it is important to recognize that site of service can be an essential element of PA approval,¹⁹ so a service approved at an originating facility may require reapproval for a new site of service. Transfer decisions should include a patient-centered discussion between a patient and/or family and a referring physician that addresses the various potential merits and risks of undergoing a transfer.²⁰

The novel coronavirus (COVID-19) pandemic has posed unprecedented challenges, including managing patient transfers. Geographically localized surges in COVID-19 cases put extreme pressure on local health care facilities, as

hospitals strive to transfer COVID-19 patients to sites where they can receive optimal care and/or transfer non-COVID-19 patients out of their facility to protect uninfected patients and free up resources to care for more COVID-19 patients.²¹ State and local emergency medical planners have taken a variety of approaches in rising to meet the pandemic's challenges, and the Centers for Disease Control and Prevention (CDC) has issued guidance around patient safety and relief for health care facility operations.²² The CDC emphasizes the importance of communication between health care professionals at both the transferring and receiving facilities with accurate clinical descriptions of patients and clear acceptance by receiving facilities.

Balancing the complex considerations surrounding patient transfers, the American College of Emergency Physicians (ACEP) has published guidelines on Appropriate Interfacility Patient Transfer, and AMA policy (Policies H-130.982 and H-130.961) expressly supports these guidelines. Key elements of the ACEP guidelines specify, "The medical facility's policies and procedures and/or medical staff bylaws must define who is responsible for accepting and transferring patients on behalf of the hospital . . . Agreement to accept the patient in transfer should be obtained from a physician or responsible individual at the receiving hospital in advance of the transfer. When a patient requires a higher level of care other than that provided or available at the transferring facility, a receiving facility with the capability and capacity to provide a higher level of care may not refuse any request for transfer. When transfer of patients is part of a regional plan to provide optimal care at a specialized medical facility, written transfer protocols and interfacility agreements should be in place."²³ These guidelines, developed by subject matter experts and supported by the AMA, help to ensure that high quality patient care drives interfacility patient transfers, with physician input into the decision-making process.

EXTERNAL FACTORS SHAPING PATIENT TRANSFER POLICIES

Medical centers' ability to implement transfer policies such as the auto accept policies described in Resolution 818-I-19 is influenced by a number of external factors, including Medicare Conditions of Participation (COPs), accreditation standards, medical staff governing documents, and in certain cases, state and/or federal law. Medicare COPs govern patient transfer in the context of discharge planning, requiring that hospitals transfer or refer patients to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.²⁴ Moreover, Medicare COPs make clear that the medical staff "is responsible for the quality of medical care provided to patients by the hospital,"²⁵ and TJC provides an accreditation framework to guide medical center and physician collaboration. As outlined by TJC, "The organized medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process."²⁶ Additionally, for a medical center's "governing body to effectively fulfill its accountability for the safety and quality of care, it must work collaboratively with the medical staff leaders toward that goal."²⁷ While accreditation standards do not have the force of law, TJC's long history of hospital accreditation and its recognition by federal and private payers have made its standards nationally accepted practices.²⁸ Additionally, medical staff documents including bylaws, rules and regulations, and policies govern the relationship between medical centers and their medical staff. The bylaws describe the rights, responsibilities, and accountabilities of the medical staff and specify how the organized medical staff works with and is accountable to the governing body. Medical staff rules and regulations usually address patient care issues across the organization and typically contain provisions about patient transfers.²⁹

As the sponsors of Resolution 818-I-19 indicate, EMTALA provides a legal framework for many interhospital transfers, with specific mandates for both facilities and physicians. EMTALA was established as federal law in 1986, and many states have related laws and regulations that impose additional duties on hospitals and physicians.³⁰ EMTALA was designed to prevent hospitals from transferring uninsured or Medicaid patients to public hospitals without minimally providing a medical screening examination to ensure the patients were stable for transfer. Additionally, under EMTALA, hospitals with specialized capabilities must accept patient transfers from hospitals that lack the capability to treat unstable emergency medical conditions, and EMTALA transfer obligations apply, even under the extraordinary circumstances posed by COVID-19.³¹ However, EMTALA does not apply to the transfer of stable patients. Importantly, both hospitals and physicians can be penalized for EMTALA violations, with penalties including termination of the hospital or physician's Medicare provider agreement and fines of up to \$104,826 per violation.³² With both the hospital and the physician individually liable under EMTALA, it is critical that both work together to ensure that patient transfers further the shared goal of optimal patient care.

RELEVANT AMA POLICY

AMA policy directly responds to the resolves of referred Resolution 818-I-19. First, a comprehensive array of policy guides collaboration between medical centers and medical staff. Policy H-225.957 sets forth principles for strengthening the physician-hospital relationship, emphasizing the interdependence between the organized medical staff and the hospital governing body, while highlighting the medical staff's role in quality-of-care issues. Similarly, Policy H-225.971 provides a strong framework for how hospitals and medical staff ought to collaborate and articulates the primary role of the medical staff on matters of quality of care and patient safety. In addition, Policy H-225.942 provides a set of physician and medical staff member bill of rights, which include the right to be well-informed and share in the decision-making of the health care organization's operational and strategic planning. Finally, Policy H-225.961 states that in crafting medical staff development plans, hospitals/health systems should incorporate the principles that the medical staff and its elected leaders must be involved in the hospital/health system's leadership function, including in developing operational plans, service design, resource allocation, and organizational policies. The policy further insists that the medical staff must ensure that quality patient care is not harmed by economic motivations.

Long-standing policy also guides the transfer of patients among medical centers. Policy H-130.982 provides principles to guide interfacility transfers of unstable emergency patients, detailing the critical roles of both the transferring and receiving physicians and endorsing ACEP's Appropriate Interfacility Patient Transfer guidelines. Similarly, Policy H-130.961 also endorses the ACEP guidelines, encouraging county medical societies and local hospitals to review and utilize the ACEP guidelines as they develop local transfer arrangements. In addition, Policy H-130.965 supports working with the American Hospital Association (AHA) to develop model agreements for appropriate patient transfer.

Finally, AMA policy and advocacy strive to protect patients and physicians facing burdens from health plan OON restrictions and PA requirements. Policy H-285.904 sets forth principles related to unanticipated OON care, and Policy H-320.939 details the AMA's position on PA and utilization management (UM) reform.

In addition to AMA policy, AMA ethics opinions also guide physicians and medical centers as they refine patient transfer policies. *Code of Medical Ethics* Opinion 9.5.1 guides the relationship between an organized medical staff and hospital and establishes that the core responsibilities of the organized medical staff are the promotion of patient safety and the quality of care.³³ Additionally, *Code of Medical Ethics* Opinion 9.4.2 provides a series of steps physicians should take if they become aware of or strongly suspect that conduct threatens patient welfare or otherwise appears to violate ethical or legal standards.³⁴

DISCUSSION

The Council thanks the sponsors of Resolution 818-I-19 for highlighting the critical intersection of medical center transfer policies with quality of care, public health, legal/regulatory, and medical staff concerns. Existing AMA policy lays the groundwork to protect patients and physicians in the context of patient transfers, and this policy can be expanded. First, the Council recommends amending Policy H-130.982, changing the title of the policy and broadening the language used, so that this long-standing policy guiding the transfer of emergency patients would apply to protect all transferred patients. Similarly, the Council recommends building upon the strong policy that establishes a physician and medical staff member bill of rights and outlines the rights and responsibilities of organized medical staff. Policy H-225.942 emphasizes the importance of physicians' treatment decisions remaining insulated from commercial or other motivations that could threaten high-quality patient care and the medical staff's responsibility to participate in the health care organization's operational and strategic planning to safeguard the interests of patients, the community, the health care organization, and the medical staff and its members. The policy also outlines medical staff rights, including the right to be well-informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts, or close medical staff departments. The Council recommends amending Policy H-225.942 to articulate the medical staff's right to be well-informed and share in the decision-making regarding transferring patients into, out of, or within the health care organization. Additionally, the Council recommends amending Policy H-130.965 to support working with both the AHA and other interested parties to develop model agreements for appropriate patient transfer.

Finally, recognizing the significant patient, physician, and medical center time and talent involved in obtaining PA approval, the Council believes that when circumstances (such as the site of service) change, the PA process should support revisions to pending or existing approvals rather than require re-initiation of the PA request. In articulating

the AMA's position on PA and UM reform, Policy H-320.939 emphasizes that the AMA will continue its widespread 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. Building upon this strong advocacy position, the Council recommends amending Policy H-320.939 by adding a new section four stating that health plans should minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending PA requests.

The Council also recommends reaffirming several policies that address key concerns raised by Resolution 818-I-19. Speaking to physician and medical staff roles in decision-making regarding patient transfers, Policy H-225.957 provides principles for strengthening the physician-hospital relationship. Policy H-225.957 emphasizes that the primary responsibility for the quality of care rendered and for patient safety is vested with the organized medical staff and sets forth parameters for collaboration and dispute resolution between the medical staff and hospital governing body. In addition, Policy H-225.971 details the roles that medical staff and hospital governing bodies and management each and collectively play in quality of care and credentialing and reaffirms TJC standard that medical staffs have "overall responsibility for the quality of the professional services provided by individuals with clinical privileges." Moreover, the policy states that hospital administrative personnel performing quality assurance and other quality activities related to patient care should report to and be accountable to the medical staff committee responsible for quality improvement activities. Reaffirming these policies underscores the AMA's longstanding and continuing commitment to productive collaboration between physicians and medical centers in developing patient transfer practices that are focused on providing high-quality patient care. Finally, the Council recommends reaffirming Policy H-285.904, which sets forth principles to protect patients receiving unanticipated OON care. Policy H-285.904 states that patients must not be financially penalized for receiving unanticipated care from an OON provider; insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties; and patients who are seeking emergency care should be protected under the "prudent layperson" legal standard, without regard to PA or retrospective denial for services after emergency care is rendered.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 818-I-19 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) amend Policy H-130.982 by addition and deletion as follows:

H-130.982 Interfacility Patient Transfers of Emergency Patients

Our AMA: (1) supports the following principles for ~~the interfacility patient transfers of emergency patients~~: (a) all physicians and health care facilities have an ethical obligation and moral responsibility to provide needed medical care to all emergency patients, regardless of their ability to pay; (b) an interfacility patient transfer ~~of an unstabilized emergency patient~~ should be undertaken only for appropriate medical purposes, i.e., when in the physician's judgment it is in the patient's best interest to receive needed medical ~~service~~ care at the receiving facility rather than the transferring facility; and (c) all interfacility patient transfers ~~of emergency patients~~ should be subject to the sound medical judgment and consent of both the transferring and receiving physicians to assure the safety and appropriateness of each proposed transfer; (2) urges ~~county medical societies~~ physician organizations to develop, in conjunction with their local hospitals, protocols and interhospital transfer agreements addressing the issue of economically motivated transfers of emergency patients in their communities. At a minimum, these protocols and agreements should address the condition of the patients transferred, the responsibilities of the transferring and accepting physicians and facilities, and the designation of appropriate referral facilities. The American College of Emergency Physicians' Appropriate Interfacility Patient Transfer should be reviewed in the development of such community protocols and agreements; and (3) urges state medical associations to encourage and provide assistance to physician organizations that are their county medical societies ~~as they developing~~ such protocols and interhospital agreements with their local hospitals.

2. That our AMA amend subsection II(d) of Policy H-225.942 by addition and deletion as follows:

d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts, ~~or~~ close medical staff departments, or to transfer patients into, out of, or within the health care organization.

3. That our AMA amend Policy H-130.965 by addition as follows:

Our AMA (1) opposes the refusal by an institution to accept patient transfers solely on the basis of economics; (2) supports working with the American Hospital Association (AHA) and other interested parties to develop model agreements for appropriate patient transfer; and (3) supports continued work by the AMA and the AHA on the problem of providing adequate financing for the care of these patients transferred.

4. That our AMA amend Policy H-320.939 by addition of a fourth section as follows:

4. Our AMA advocates 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.

5. That our AMA reaffirm Policy H-225.957, which provides principles for strengthening the physician-hospital relationship. Policy H-225.957 sets forth parameters for collaboration and dispute resolution between the medical staff and the hospital governing body, and it establishes that the primary responsibility for the quality of care rendered and for patient safety is vested with the organized medical staff.
6. That our AMA reaffirm Policy H-225.971, which details the roles that medical staff and hospital governing bodies and management each and collectively play in quality of care and credentialing. Policy H-225.971 states that hospital administrative personnel performing quality assurance and other quality activities related to patient care should report to and be accountable to the medical staff committee responsible for quality improvement activities.
7. That our AMA reaffirm Policy H-285.904, which sets forth principles related to unanticipated out-of-network care.

REFERENCES

- Alia Paavola. Steal this idea: The call center that enables Erlanger to care for 1,500 more patients a year. *Becker's Hospital Review*. March 7, 2018. Available at: <https://www.beckershospitalreview.com/hospital-management-administration/steal-this-idea-the-call-center-that-enables-erlanger-to-care-for-1500-more-patients-a-year.html>. Accessed 8-31-20.
- Lehigh Valley Health Network. One-Call Transfer Center. Available at: [https://www.lvh.org/one-call-transfer-center#:~:text=One%2Dcall%20transfer%20\(24%2F.and%20two%20critical%20care%20ambulances](https://www.lvh.org/one-call-transfer-center#:~:text=One%2Dcall%20transfer%20(24%2F.and%20two%20critical%20care%20ambulances). Accessed 8-31-20.
- SUNY Upstate Medical University. Transfer Center. Available at: <https://www.upstate.edu/triage-transfer/transfer-center.php>. Accessed 8-31-20.
- Dana J. Herrigel, et. al. Interhospital Transfer Handoff Practices Among US Tertiary Care Centers: A Descriptive Survey. *J Hosp Med*. 2016 Jun; 11(6): 413–417. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5739590/>. Accessed 7-15-20.
- Dana J. Herrigel, et. al. Interhospital Transfer Handoff Practices Among US Tertiary Care Centers: A Descriptive Survey. *J Hosp Med*. 2016 Jun; 11(6): 413–417. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5739590/>. Accessed 7-15-20.
- Jason Wagner, et. al. Reasons Underlying Interhospital Transfers to an Academic Medical Intensive Care Unit. *J Crit Care*. 2013 April ; 28(2): 202–208. doi:10.1016/j.jcrc.2012.07.027. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3554843/>. Accessed 7-15-20.
- Julie Knudson. Streamlining Patient Transfers. *ACP Hospitalist*. October 2014. Available at: <https://acphospitalist.org/archives/2014/10/transfer.htm>. Accessed 6-29-20.
- Julie Knudson. Streamlining Patient Transfers. *ACP Hospitalist*. October 2014. Available at: <https://acphospitalist.org/archives/2014/10/transfer.htm>. Accessed 6-29-20.
- Julie Knudson. Streamlining Patient Transfers. *ACP Hospitalist*. October 2014. Available at: <https://acphospitalist.org/archives/2014/10/transfer.htm>. Accessed 6-29-20.
- Julie Knudson. Streamlining Patient Transfers. *ACP Hospitalist*. October 2014. Available at: <https://acphospitalist.org/archives/2014/10/transfer.htm>. Accessed 6-29-20.
- Janel Hanmer, et. al. Insurance status and the transfer of hospitalized patients: an observational study. *Ann Intern Med*. January 2014. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4157678/>. Accessed 6-30-20.
- Elaine Rabin, et. al. Solutions To Emergency Department ‘Boarding’ And Crowding Are Underused And May Need To Be Legislated. *Health Affairs*. August 2012. Available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0786>. Accessed 7-15-20.
- Elaine Rabin, et. al. Solutions To Emergency Department ‘Boarding’ And Crowding Are Underused And May Need To Be Legislated. *Health Affairs*. August 2012. Available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0786>. Accessed 7-15-20.

14. Elaine Rabin, et. al. Solutions To Emergency Department ‘Boarding’ And Crowding Are Underused And May Need To Be Legislated. *Health Affairs*. August 2012. Available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0786>. Accessed 7-15-20.
15. Elaine Rabin, et. al. Solutions To Emergency Department ‘Boarding’ And Crowding Are Underused And May Need To Be Legislated. *Health Affairs*. August 2012. Available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0786>. Accessed 7-15-20.
16. James J. Augustine. Latest Data Reveal the ED’s Role as Hospital Admission Gatekeeper. *ACEP Now*. December 20, 2019. Available at: <https://www.acepnow.com/article/latest-data-reveal-the-eds-role-as-hospital-admission-gatekeeper/>. Accessed 7-1-20.
17. Elaine Rabin, et. al. Solutions To Emergency Department ‘Boarding’ And Crowding Are Underused And May Need To Be Legislated. *Health Affairs*. August 2012. Available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0786>. Accessed 7-15-20. Adam J Singer, et. al. The association between length of emergency department boarding and mortality. *Acad Emerg Med*. 2011 Dec;18(12):1324-9. doi: 10.1111/j.1553-2712.2011.01236.x. Available at: <https://pubmed.ncbi.nlm.nih.gov/22168198/>. Accessed 8-31-20.
18. Elaine Rabin, et. al. Solutions To Emergency Department ‘Boarding’ And Crowding Are Underused And May Need To Be Legislated. *Health Affairs*. August 2012. Available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0786>. Accessed 7-15-20.
19. Workgroup for Electronic Data Exchange, Prior Authorization Subworkgroup. Prior Authorization Workflow Barriers and Guiding Principles (whitepaper in progress as of 9-2-20). Anticipated publication via WEDI Knowledge Center: <https://www.wedi.org/knowledge-center/>
20. Jason Wagner, et. al. Reasons Underlying Interhospital Transfers to an Academic Medical Intensive Care Unit. *J Crit Care*. 2013 April ; 28(2): 202–208. doi:10.1016/j.jcrc.2012.07.027. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3554843/>. Accessed 7-15-20.
21. Kristen Schorsch, The Pandemic Revealed Another Gap In Chicago Health Care: Hospitals Are On Their Own To Transfer Patients. *WBEZ, Chicago’s NPR News Source*. June 29, 2020. Available at: <https://www.wbez.org/stories/one-chicago-hospital-called-for-8-hours-to-transfer-covid-19-patients-thats-problematic-for-future-outbreaks/1ecd60f3-f185-4deb-ae65-3e3ca25f0063>. Accessed 3-2-21.
22. Centers for Disease Control and Prevention. Coronavirus Disease 2019 Transferring Patients to Relief Healthcare Facilities. Updated July 12, 2020. Available at: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/relief-healthcare-facilities.html>. Accessed 3-1-21.
23. American College of Emergency Physicians. Appropriate Interfacility Patient Transfer. Revised January 2016. Available at: <https://www.acep.org/patient-care/policy-statements/appropriate-interfacility-patient-transfer/>. Accessed 3-1-21.
24. 42 C.F.R. § 482.43. Available at: <https://www.govinfo.gov/content/pkg/CFR-2017-title42-vol5/xml/CFR-2017-title42-vol5-part482.xml>. Accessed 7-6-20.
25. 42 C.F.R. §482.22. Elizabeth A. Snelson. *American Medical Association Physician’s Guide to Medical Staff Organization Bylaws*. Sixth Edition, Revised. 2017.
26. The Governance Institute. *Leadership in Healthcare Organizations: A Guide to Joint Commission Leadership Standards*. Second Edition. 2017. Available at: https://nrchealth.com/wp-content/uploads/2017/06/WP_JC_Leadership-in-Healthcare-Organizations_Second_Schyve_Carr.pdf. Accessed 7-2-20.
27. The Governance Institute. *Leadership in Healthcare Organizations: A Guide to Joint Commission Leadership Standards*. Second Edition. 2017. Available at: https://nrchealth.com/wp-content/uploads/2017/06/WP_JC_Leadership-in-Healthcare-Organizations_Second_Schyve_Carr.pdf. Accessed 7-2-20.
28. Elizabeth A. Snelson. *American Medical Association Physician’s Guide to Medical Staff Organization Bylaws*. Sixth Edition, Revised. 2017.
29. The Joint Commission. *Medical Staff Essentials: Your Go To Guide*. Sample Available at: <https://store.jcrinc.com/assets/1/14/EBMSE17SamplePages.pdf>. Accessed 7-27-20.
30. American College of Emergency Physicians. Appropriate Interfacility Patient Transfer. Revised January 2016. Available at: <https://www.acep.org/patient-care/policy-statements/appropriate-interfacility-patient-transfer/>. Accessed 6-29-20.
31. Centers for Medicare & Medicaid Services. Frequently Asked Questions for Hospitals and Critical Access Hospitals regarding EMTALA. April 30, 2020. Available at: <https://www.cms.gov/files/document/frequently-asked-questions-and-answers-emtala-part-ii.pdf>. Accessed 7-15-20.
32. American College of Emergency Physicians. EMTALA Fact Sheet. Available at: <https://www.acep.org/life-as-a-physician/ethics--legal/emtala/emtala-fact-sheet/>. Accessed 7-15-20. Robert Bitterman. Feds Increase EMTALA Penalties against Physicians and Hospitals. *Emergency Physicians Monthly*. October 2017. Available at: <https://epmonthly.com/article/feds-increase-emtala-penalties-physicians-hospitals/>. Accessed 7-15-20. Advisory Board. Nearly 1,700 hospitals violated ‘the Golden Rule of emergency care,’ according to a new investigation. Available at: <https://www.advisory.com/daily-briefing/2018/12/10/hospital-ed>. Accessed 7-15-20.
33. American Medical Association. Code of Medical Ethics Opinion 9.5.1 Organized Medical Staff. Nov 14, 2016. Available at: ama-assn.org/delivering-care/ethics/organized-medical-staff. Accessed 7-15-20.
34. American Medical Association. Code of Medical Ethics Opinion 9.4.2 Reporting Incompetent or Unethical Behaviors by Colleagues. Available at: <https://www.ama-assn.org/delivering-care/ethics/reporting-incompetent-or-unethical-behaviors-colleagues>. Accessed 7-15-20.

APPENDIX - Policies Recommended for Amendment or Reaffirmation

H-130.965 Refusal of Appropriate Patient Transfers

Our AMA (1) opposes the refusal by an institution to accept patient transfers solely on the basis of economics; (2) supports working with the American Hospital Association to develop model agreements for appropriate patient transfer; and (3) supports continued work by the AMA and the AHA on the problem of providing adequate financing for the care of these patients transferred. (Sub. Res. 155, I-89Reaffirmed: Sunset Report and Reaffirmation A-00Reaffirmed: CMS Rep. 6, A-10Reaffirmed: CMS Rep. 01, A-20)

H-130.982 Transfer of Emergency Patients

Our AMA: (1) supports the following principles for the transfer of emergency patients: (a) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed medical care to all emergency patients, regardless of their ability to pay; (b) an interfacility transfer of an unstabilized emergency patient should be undertaken only for appropriate medical purposes, i.e., when in the physician's judgment it is in the patient's best interest to receive needed medical service care at the receiving facility rather than the transferring facility; and (c) all interfacility transfers of emergency patients should be subject to the sound medical judgment and consent of both the transferring and receiving physicians to assure the safety and appropriateness of each proposed transfer; (2) urges county medical societies to develop, in conjunction with their local hospitals, protocols and interhospital transfer agreements addressing the issue of economically motivated transfers of emergency patients in their communities. At a minimum, these protocols and agreements should address the condition of the patients transferred, the responsibilities of the transferring and accepting physicians and facilities, and the designation of appropriate referral facilities. The American College of Emergency Physicians' Appropriate Interfacility Patient Transfer should be reviewed in the development of such community protocols and agreements; and (3) urges state medical associations to encourage and provide assistance to their county medical societies as they develop such protocols and interhospital agreements with their local hospitals. (CMS Rep. H, A-86Reaffirmed: BOT Rep. BB, A-90Reaffirmed: CMS Rep. F, I-92Reaffirmation A-00Reaffirmed: CMS Rep. 6, A-10Modified: CMS Rep. 01, A-20)

H-225.942 Physician and Medical Staff Member Bill of Rights

Our AMA adopts and will distribute the following Medical Staff Rights and Responsibilities:

Preamble

The organized medical staff, hospital governing body and administration are all integral to the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated.

The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients.

Medical staff self-governance is vital in protecting the ability of physicians to act in their patients' best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.

From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:

I. Our AMA recognizes the following fundamental responsibilities of the medical staff:

- a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization's governing body.
- b. The responsibility to provide leadership and work collaboratively with the health care organization's administration and governing body to continuously improve patient care and outcomes.
- c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.
- d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.
- e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.
- f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review.

II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff's ability to fulfill its responsibilities:

- a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.
- b. The right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body.
- c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.

- d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments.
- e. The right to be represented and heard, with or without vote, at all meetings of the health care organization's governing body.
- f. The right to engage the health care organization's administration and governing body on professional matters involving their own interests.

III. Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:

- a. The responsibility to work collaboratively with other members and with the health care organization's administration to improve quality and safety.
- b. The responsibility to provide patient care that meets the professional standards established by the medical staff.
- c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.
- d. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization.
- e. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.
- f. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.

IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:

- a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.
- b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.
- c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the health care organization's administration or governing body.
- d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.
- e. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.
- f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities.

(BOT Rep. 09, A-17Modified: BOT Rep. 05, I-17Appended: Res. 715, A-18Reaffirmed: BOT Rep. 13, A-19)

H-225.957 Principles for Strengthening the Physician-Hospital Relationship

The following twelve principles are AMA policy:

PRINCIPLES FOR STRENGTHENING THE PHYSICIAN-HOSPITAL RELATIONSHIP

1. The organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes, with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff. These activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations.
2. The organized medical staff, a self-governing organization of professionals, possessing special expertise, knowledge and training, discharges certain inherent professional responsibilities by virtue of its authority to regulate the professional practice and standards of its members, and assumes primary responsibility for many functions, including but not limited to: the determination of organized medical staff membership; performance of credentialing, privileging and other peer review; and timely oversight of clinical quality and patient safety.
3. The leaders of the organized medical staff, with input from the hospital governing body and senior hospital managers, develop goals to address the healthcare needs of the community and are involved in hospital strategic planning as described in the medical staff bylaws.
4. Ongoing, timely and effective communication, by and between the hospital governing body and the organized medical staff, is critical to a constructive working relationship between the organized medical staff and the hospital governing body.
5. The organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. The organized medical staff and hospital bylaws, rules and regulations should be aligned, current with all applicable law and accreditation body requirements and not conflict with one another. The hospital bylaws, policies and other governing documents do not conflict with the organized medical staff bylaws, rules, regulations and policies, nor with the organized medical staff's autonomy and authority to self-govern, as that authority is set forth in the governing documents of the organized medical staff. The organized medical staff, and the hospital governing body/administration, shall, respectively, comply with the bylaws, rules, regulations, policies and procedures of one another. Neither party is authorized to, nor shall unilaterally amend the bylaws, rules, regulations, policies or procedures of the other.
6. The organized medical staff has inherent rights of self-governance, which include but are not limited to:

- a) Initiating, developing and adopting organized medical staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital governing body, which approval shall not be unreasonably withheld. The organized medical staff bylaws shall be adopted or amended only by a vote of the voting membership of the medical staff.
- b) Identifying in the medical staff bylaws those categories of medical staff members that have voting rights.
- c) Identifying the indications for automatic or summary suspension, or termination or reduction of privileges or membership in the organized medical staff bylaws, restricting the use of summary suspension strictly for patient safety and never for purposes of punishment, retaliation or strategic advantage in a peer review matter. No summary suspension, termination or reduction of privileges can be imposed without organized medical staff action as authorized in the medical staff bylaws and under the law.
- d) Identifying a fair hearing and appeals process, including that hearing committees shall be composed of peers, and identifying the composition of an impartial appeals committee. These processes, contained within the organized medical staff bylaws, are adopted by the organized medical staff and approved by the hospital governing board, which approval cannot be unreasonably withheld nor unilaterally amended or altered by the hospital governing board or administration. The voting members of the organized medical staff decide any proposed changes.
- e) Establishing within the medical staff bylaws: 1) the qualifications for holding office, 2) the procedures for electing and removing its organized medical staff officers and all organized medical staff members elected to serve as voting members of the Medical Executive Committee, and 3) the qualifications for election and/or appointment to committees, department and other leadership positions.
- f) Assessing and maintaining sole control over the access and use of organized medical staff dues and assessments, and utilizing organized medical staff funds as appropriate for the purposes of the organized medical staff.
- g) Retaining and being represented by legal counsel at the option and expense of the organized medical staff.
- h) Establishing in the organized medical staff bylaws, the structure of the organized medical staff, the duties and prerogatives of organized medical staff categories, and criteria and standards for organized medical staff membership application, reapplication credentialing and criteria and processing for privileging. The standards and criteria for membership, credentialing and privileging shall be based only on quality-of-care criteria related to clinical qualifications and professional responsibilities, and not on economic credentialing, conflicts of interest or other non-clinical credentialing factors.
- i) Establishing in the organized medical staff bylaws, rules and regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other organized medical staff activities, and engaging in all activities necessary and proper to implement those bylaw provisions including, but not limited to, periodic meetings of the organized medical staff and its committees and departments and review and analysis of patient medical records.
- j) The right to define and delegate clearly specific authority to an elected Medical Executive Committee to act on behalf of the organized medical staff. In addition, the organized medical staff defines indications and mechanisms for delegation of authority to the Medical Executive Committee and the removal of this authority. These matters are specified in the organized medical staff bylaws.
- k) Identifying within the organized medical staff bylaws a process for election and removal of elected Medical Executive Committee members.
- l) Defining within the organized medical staff bylaws the election process and the qualifications, roles and responsibilities of clinical department chairs. The Medical Executive Committee must appoint any clinical chair that is not otherwise elected by the vote of the general medical staff.
- m) Enforcing the organized medical staff bylaws, regulations and policies and procedures.
- n) Establishing in medical staff bylaws, medical staff involvement in contracting relationships, including exclusive contracting, medical directorships and all hospital-based physician contracts, that affect the functioning of the medical staff.
7. Organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body, as well as between those two entities and the individual members of the organized medical staff.
8. The self-governing organized medical staff determines the resources and financial support it requires to effectively discharge its responsibilities. The organized medical staff works with the hospital governing board to develop a budget to satisfy those requirements and related administrative activities, which the hospital shall fund, based upon the financial resources available to the hospital.
9. The organized medical staff has elected appropriate medical staff member representation to attend hospital governing board meetings, with rights of voice and vote, to ensure appropriate organized medical staff input into hospital governance. These members should be elected only after full disclosure to the medical staff of any personal and financial interests that may have a bearing on their representation of the medical staff at such meetings. The members of the organized medical staff define the process of election and removal of these representatives.
10. Individual members of the organized medical staff, if they meet the established criteria that are applicable to hospital governing body members, are eligible for full membership on the hospital governing body. Conflict of interest policies developed for members of the organized medical staff who serve on the hospital's governing body are to apply equally to all individuals serving on the hospital governing body.
11. Well-defined disclosure and conflict of interest policies are developed by the organized medical staff which relate exclusively to their functions as officers of the organized medical staff, as members and chairs of any medical staff committee, as chairs of departments and services, and as members who participate in conducting peer review or who serve in any other positions of leadership of the medical staff.
12. Areas of dispute and concern, arising between the organized medical staff and the hospital governing body, are addressed by well-defined processes in which the organized medical staff and hospital governing body are equally represented. These processes are determined by agreement between the organized medical staff and the hospital governing body.

(Res. 828, I-07Reaffirmed in lieu of Res. 730, A-09Modified: Res. 820, I-09Reaffirmed: Res. 725, A-10Reaffirmation A-12Reaffirmed: CMS Rep. 6, I-13)

H-225.971 Credentialing and the Quality-of-Care

It is the policy of the AMA: (1) that the hospital medical staff be recognized within the hospital as the entity with the overall responsibility for the quality of medical care; (2) that hospital medical staff bylaws reaffirm The Joint Commission standard that medical staffs have “overall responsibility for the quality of the professional services provided by individuals with clinical privileges”; (3) that each hospital’s quality assurance, quality improvement, and other quality-related activities be coordinated with the hospital medical staff’s overall responsibility for quality of medical care; (4) that the hospital governing body, management, and medical staff should jointly establish the purpose, duties, and responsibilities of the hospital administrative personnel involved in quality assurance and other quality-related activities; establish the qualifications for these positions; and provide a mechanism for medical staff participation in the selection, evaluation, and credentialing of these individuals; (5) that the hospital administrative personnel performing quality assurance and other quality activities related to patient care report to and be accountable to the medical staff committee responsible for quality improvement activities; (6) that the purpose, duties, responsibilities, and reporting relationships of the hospital administrative personnel performing quality assurance and other quality-related activities be included in the medical staff and hospital corporate bylaws; (7) that the general processes and policies related to patient care and used in a hospital quality assurance system and other quality-related activities should be developed, approved, and controlled by the hospital medical staff; and (8) that any physician hired or retained by a hospital to be involved solely in medical staff quality of care issues be credentialed by the medical staff prior to employment in the hospital.

(BOT Rep. T, I-92Reaffirmed: CMS Rep. 10, A-03Modified: CMS Rep. 4, A-13)

H-285.904 Out-of-Network Care

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. Mediation should be permitted in those instances where a physician’s unique background or skills (e.g., the Gould Criteria) are not accounted for within a minimum coverage standard.

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

H-320.939 Prior Authorization and Utilization Management Reform

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.

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

6. URGENT CARE CENTERS

Reference committee hearing: see report of Reference Committee G.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED**

See Policies H-160.888, H-385.926, H-385.940, H-440.877 and D-35.985

Similar to retail health clinics, urgent care centers (UCC) are proliferating and quickly changing the health care landscape. The rise in the number of UCCs is partially driven by the public's desire and expectation of prompt, available, and convenient care.¹ The Council noted that American Medical Association (AMA) policy is largely silent on UCCs and the extent UCCs should play a role in meeting the health care needs of patients.

This report, initiated by the Council, provides background on UCCs, notes the various types of ownership models, outlines the extent of physician oversight and physician employment in the centers, summarizes relevant policy, and proposes new recommendations that expand upon the current body of policy on stand-alone health care clinics.

BACKGROUND

UCCs are free-standing same-day clinics focused on caring for patients who need expedient medical care but who are not experiencing a life-threatening emergency. In 2019, there were more than 9,600 UCCs in the US, representing a 9.6 percent jump in the number of centers since 2018.² They provide unscheduled, episodic care to patients. These centers usually provide services such as treating earaches, fever or flu-like symptoms, and minor burns or cuts. Some centers also have X-ray capabilities but generally have limited laboratory capabilities. Overall, the scope of services offered across UCCs varies. The most common diagnosis at UCCs is an upper respiratory infection.³ Additionally, the number of stand-alone care settings such as UCCs and retail health clinics continues to grow each year as patients look for and expect timely care and convenience. These settings are usually open daily, evenings, and weekends making them an attractive alternative to primary care physician offices for unplanned visits.

Proponents of UCCs emphasize their role in ensuring access to care for vulnerable populations and patients living in rural areas. However, only about 10 percent of clinics are in rural areas while 75 percent are in suburban areas, and 15 percent are in urban areas. Moreover, the payer mix of UCCs indicates that 55 percent of their patients are covered by private health insurance and 22 percent by either Medicare or Medicaid, 10 percent are paid with cash, and 7 percent are paid via workers' compensation.⁴ UCCs usually require upfront payment for services from uninsured patients creating a barrier to care for these patients.

In addition to requiring up-front payment, UCCs are in stark contrast with emergency departments (ED) because they do not have state or federal Emergency Medical Treatment and Labor Act obligations to see, treat, or stabilize patients without regard for the patient's ability to pay.⁵

URGENT CARE CENTER USE COMPARED TO EMERGENCY DEPARTMENT USE

In addition to convenience, proponents of UCCs state that the centers generate health care system cost-savings. UCCs may be classified as cost-effective if they are used as a substitute for an avoidable ED visit. However, it is estimated that only 3.9 percent of ED visits are considered non-urgent. An additional 24 percent of visits are classified as semi-urgent.⁶ Therefore, it seems that the utility of UCCs does not lie in their ability to provide substitutive care.

UCCs also have the potential to divert patients away from their usual source of care or patients might utilize UCCs as their usual source of care. Both situations have the potential to disrupt the patient-physician relationship. There are also worries, in an attempt to save money, insurers are encouraging customers to go to free-standing clinics for care, thereby exacerbating fragmentation. Further, UCCs have the potential to be used as additive, rather than substitutive, care, with a corresponding increase to the cost to the health care system. Accordingly, although UCCs have a role to play in the health care system, it is critical that this role is clearly defined and put into practice to avoid increased health care costs and care fragmentation.

URGENT CARE CENTER OWNERSHIP

Initially, when UCCs started to emerge in the early 2000s, they generally were opened by physicians, physician practices, and medical groups. However, more recently, the proliferation of UCCs has been driven by well-capitalized health systems and investor-owned companies. In 2008, 54 percent of UCCs were owned by physicians. Now, less than 40 percent are owned by physicians. Moreover, while hospitals owned less than 25 percent of UCCs in 2008, hospital ownership grew to 37 percent in 2014. At times, because of a UCC's connection to a hospital, it is effectively treated less as a separate extension of that hospital.⁷

UCC developers and health systems have also started partnering with private equity firms and payers.⁸ For example, UnitedHealth Group (UHG) and its Optum medical care services unit purchased MedExpress, a brand of UCCs, in 2015. Over the past five years, MedExpress UCC growth is up 70 percent, with more than 250 UCCs. According to UHG, its significant portfolio of clinics and UCCs will increasingly be “wired together” throughout the country.⁹

PHYSICIAN OVERSIGHT

According to the Urgent Care Center Association of America, about 80 percent of UCCs employ a combination of physicians, physician assistants, and nurse practitioners. The remaining 20 percent of centers employ only physicians. UCCs appear to be largely physician-led, with 94 percent of facilities employing at least one full-time physician.¹⁰ Of the physicians practicing in UCCs, about 48 percent are family medicine physicians, 30 percent are emergency medicine physicians, and 8 percent are internal medicine physicians.¹¹ Physician employment at UCCs tends to attract physicians wishing to work part-time hours and those looking to transition into retirement.¹² Staffing in UCCs contrasts with that in retail health clinics, which rely more heavily on nurse practitioners and physician assistants to provide the majority of care.

RELEVANT AMA POLICY

UCCs are consistent with long-standing AMA policy on pluralism (Policies H-165.920, H-160.975, H-165.944, and H-165.920). Most notably, the AMA supports free market competition among all modes of health care delivery and financing, with the growth of any one system determined by the number of people who prefer that mode of delivery, and not determined by preferential federal subsidy, regulations, or promotion (Policy H-165.985).

AMA Policy H-160.921, established with Council on Medical Service Reports 7-A-06, 5-A-07 and 7-A-17, outlines principles for retail health clinics. The policy proposes that an individual, company, or other entity establishing or operating a retail health clinic must have a well-defined and limited scope of clinical services; use standardized medical protocols derived from evidence-based practice guidelines; establish arrangements by which their health care practitioners have direct access to and supervision by MDs/DOs; establish protocols for ensuring continuity of care with practicing physicians within the local community; establish a referral system with physician practices or other facilities for appropriate treatment if the patient's conditions or symptoms are beyond the scope of services provided by the clinic; inform patients in advance of the qualifications of the health care practitioners who are providing care, as well as the limitation in the types of illnesses that can be diagnosed and treated; establish appropriate sanitation and hygienic guidelines and facilities to ensure the safety of patients; use electronic health records (EHRs) as a means of communicating patient information and facilitating continuity of care; and encourage patients to establish care with a primary care physician to ensure continuity of care. Additionally, Policy H-160.921 states that health insurers and other third-party payers should be prohibited from waiving or lowering copayments only for patients that receive services at retail health clinics.

[Council on Medical Service Report 7-A-17](#) further articulated AMA retail clinic policy (i.e., Policy H-160.921) by supporting that a retail health clinic must help patients who do not have a primary care physician or usual source of care to identify one in the community; must use EHRs to transfer a patient's medical records to his or her primary care physician and to other health care providers, with the patient's consent; must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information; should work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made; should use local physicians as medical directors or supervisors; clinics should neither expand their scope of services beyond minor acute illnesses nor expand their scope of services to include infusions or injections of biologics; and should have a well-defined and limited scope of services, provide a list of services provided by the clinic, provide the qualifications of the on-site

health care providers prior to services being rendered, and include in any marketing materials the qualifications of the onsite health care providers. Additionally, Policy H-160.921 supports that the AMA work with interested stakeholders to improve attribution methods such that a physician is not attributed the spending for services that a patient receives at a retail health clinic if the physician could not reasonably control or influence that spending.

The AMA also has established policy that addresses the patient-physician relationship, physician extenders, and continuity of care. The AMA encourages policy development and advocacy in preserving the patient-physician relationship (Policies H-100.971 and H-140.920). The AMA has extensive policy on guidelines for the integrated practice of physicians with physician assistants and nurse practitioners (Policies H-160.950, H-135.975, and H-360.987). Policy H-160.947 encourages physicians to be available for consultation with physician assistants and nurse practitioners at all times, either in person, by phone, or by other means. Policy H-425.997 encourages the development of policies and mechanisms that assure continuity and coordination of care for patients. Finally, the AMA believes that full and clear information regarding benefits and provisions of every health care system should be available to the consumer (Policy H-165.985).

The AMA has extensive policy related to the health care team. Several policies reinforce the concept of physicians bearing the ultimate responsibility for care and advocate that allied health professionals such as nurse practitioners and physician assistants function under the supervision of a physician (e.g., Policies H-35.970, H-45.973, H-35.989). Policy H-160.912 advocates that all members of a physician-led 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. Policy H-160.906 defines “physician-led” in the context of team-based health care as the consistent use by a physician of the leadership, knowledge, skill, and expertise necessary to identify, engage, and elicit from each team member the unique set of training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of those skills.

LEGISLATIVE ACTIVITY

Early in the emergence of UCCs, state regulation largely focused on defining “urgent care,” articulating services included within the definition, and accreditation standards. More recently, as the number of UCCs has increased, states are starting to pursue a more active role in urgent care regulatory oversight. For example, some states give state health agencies the authority to license UCCs.¹³

AMA ACTIVITY

With respect to scope of practice issues, the AMA has established the Scope of Practice Partnership with members of the Federation as a means of using legislative, regulatory, and judicial advocacy to oppose the expansion of scope of practice laws for allied health professionals that threaten the health and safety of patients.

DISCUSSION

The Council believes that UCCs can play a role in meeting the health care goals of high quality, efficient care. Nonetheless, striking a patient-centered balance between the use of UCCs and traditional physician visits, including the ED, requires coordination between the various health care settings. Coordination leads to better outcomes and protects against duplicative care. The Council believes that UCCs can serve as a health care access point when a patient’s usual source of care is unavailable. Therefore, in its recommendations, the Council emphasizes that the design and use of UCCs, just like retail clinics, should serve as a complement to, rather than a substitute for, the primary care physician or usual source of care. Accordingly, the Council recommends a set of principles to guide the use of UCCs similar to those on retail health clinics (Policy H-160.921).

The Council recommends that a UCC must help patients who do not have a primary care physician or usual source of care to identify one in the community. Given that it is critical that UCCs take responsibility for ensuring continuity of care, the Council further recommends that UCCs must transfer a patient’s medical records to his or her primary care physician or other health care providers, with the patient’s consent, including offering transfer in an electronic format if the receiving provider is capable of receiving it. Additionally, the Council recommends that UCCs must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information.

Moreover, it has been shown that policies that support patient-centered medical home activities in UCCs can help protect against fragmentation of care.¹⁴ Accordingly, the Council recommends that UCCs work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made. The Council also notes the importance of the patient-centered medical home (PCMH) and the fact that many physicians are expanding hours and scheduling to provide patients with enhanced access to care. To underscore the effectiveness of PCMHs and physicians' continued commitment to provide more comprehensive access to care, the Council recommends reaffirming Policy H-385.940 advocating for fair and equitable payment of services described by Current Procedural Terminology codes, including those that already exist for off-hours services. Physicians spend a significant amount of off-hours time messaging and otherwise communicating with patients, and they should be incentivized and supported to continue doing so.

Additionally, the Council is pleased that the vast majority of UCCs are physician-led, and recommends emphasizing the importance of physician-led care by not only reaffirming Policy D-35.985 advocating for the physician-led team, but also recommending that UCCs use local physicians as medical directors or supervisors. Similarly, the Council recommends reaffirming Policy H-385.926 supporting physicians' choice of practice and method of earning a living.

As previously stated, UCC capabilities range significantly. As such, the Council believes it is imperative that each center have a well-defined and limited scope of clinical services, provide a list of services provided by the center, provide the qualifications of the on-site providers prior to services being rendered, the degree of physician supervision of non-physician providers, and include in any marketing materials the qualifications of the onsite health care providers. Moreover, the Council believes that a physician should not be attributed to the spending for services that a patient receives at a UCC if the physician could not reasonably control or influence that spending.

The Council believes that UCCs can serve as a convenient way for patients to receive medical care that does not require life-saving interventions. However, it is critical that patients understand the limits of UCCs and not confuse them for an ED.¹⁵ Therefore, the Council recommends that UCCs be prohibited from using the word "emergency" or "ED" in their name, any of their advertisements, or as a way to describe the type of care provided. Further, the Council wholeheartedly supports patient education on the role of alternative sources of care such as UCCs. Patients should be notified if physicians are providing off-hours care and told what to do in urgent situations when their physician may be unavailable. Moreover, patients should be informed of the differences between a UCC and an ED. Additionally, the Council is interested in the volume of patient transfers to an ED after a UCC visit and will monitor this issue.

When health care is provided episodically, opportunities to develop or nurture the patient-physician relationship may be missed. Therefore, it is vital to ensure that there is care coordination between the UCC and a patient's usual source of care. Emphasizing the patient-physician relationship is critical to achieving the quadruple aim. To that end, the Council's recommendations aim to ensure that UCCs can be a modern component of patient-centered care.

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) reaffirm Policy D-35.985 supporting the physician-led health care team.
2. That our AMA reaffirm Policy H-385.926 supporting physicians' choice of practice and method of earning a living.
3. That our AMA reaffirm Policy H-440.877 stating that if a vaccine is administered outside the medical home, all pertinent vaccine-related information should be transmitted to the patient's primary care physician and the administrator of the vaccine should enter the information into an immunization registry, when one exists.
4. That our AMA reaffirm Policy H-385.940 advocating for fair and equitable payment of services described by Current Procedural Terminology (CPT) codes, including those for off-hour services.
5. That our AMA supports that any individual, company, or other entity that establishes and/or operates urgent care centers (UCCs) adhere to the following principles:

- a. UCCs must help patients who do not have a primary care physician or usual source of care to identify one in the community;
 - b. UCCs must transfer a patient's medical records to his or her primary care physician and to other health care providers, with the patient's consent, including offering transfer in an electronic format if the receiving physician is capable of receiving it;
 - c. UCCs must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information;
 - d. UCCs should work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made;
 - e. UCCs should use local physicians as medical directors or supervisors, and they should be clearly identified and posted;
 - f. UCCs should have a well-defined scope of clinical services, communicate the scope of services to the patient prior to evaluation, provide a list of services provided by the center, provide the qualifications of the on-site health care providers prior to services being rendered, describe the degree of physician supervision of any non-physician practitioners, and include in any marketing materials the qualifications of the on-site health care providers; and
 - g. UCCs should be prohibited from using the word "emergency" or "ED" in their name, any of their advertisements, or to describe the type of care provided.
6. That our AMA work with interested stakeholders to improve attribution methods such that a physician is not attributed to spending for services that a patient receives at an UCC if the physician could not reasonably control or influence that spending.
 7. That our AMA support patient education including notifying patients if their physicians are providing extended hours care, including weekends, informing patients what to do in urgent situations when their physician may be unavailable, informing patients of the differences between an urgent care center and an emergency department, asking for their patients to notify their physician or usual source of care before seeking UCC services, and encourage patients to familiarize themselves with their anticipated out-of-pocket financial responsibility for UCC services.

REFERENCES

1. Cheryl Alkon, What's Behind the Growth of Urgent Care Center Clinics?, Medical Economics. Available at: <https://www.medicaleconomics.com/view/whats-behind-growth-urgent-care-clinics>
2. <https://www.benefitspro.com/2020/07/15/urgent-care-centers-poised-for-growth/>
3. 25 Things to Know about Urgent Care. Becker's Hospital Review. Available at: <https://www.beckershospitalreview.com/lists/25-things-to-know-about-urgent-care.html>
4. 25 Things to Know about Urgent Care. Becker's Hospital Review. Available at: <https://www.beckershospitalreview.com/lists/25-things-to-know-about-urgent-care.html>
5. Freestanding Emergency Departments and Urgent Care Centers. American College of Emergency Physicians. Available at: https://www.acep.org/globalassets/uploads/uploaded-files/acep/clinical-and-practice-management/resources/administration/fsed-and-ucs_info-paper_final_110215.pdf
6. National Hospital Ambulatory Medical Care Survey: 2017 Emergency Department Summary Tables. Available at: https://www.cdc.gov/nchs/data/nhamcs/web_tables/2017_ed_web_tables-508.pdf
7. 25 Things to Know about Urgent Care. Becker's Hospital Review. Available at: <https://www.beckershospitalreview.com/lists/25-things-to-know-about-urgent-care.html>
8. Anna Wilde Mathews, Physicians, Hospitals Meet Their New Competitor: Insurer-Owned Clinics. The Wall Street Journal. Available at: <https://www.wsj.com/articles/physicians-hospitals-meet-their-new-competitor-insurer-owned-clinics-11582473600?st=qr9q0q01lg4uqep>
9. Bruce Japsen, Urgent Care Centers Eclipse 9,200 Driven by Optum and Hospital Systems. Forbes. Available at: <https://www.forbes.com/sites/brucejapsen/2019/12/12/urgent-care-centers-eclipse-9200-thanks-to-optum-and-hospitals/#7288842d84c1>
10. Convenient Care: Growth and Staffing Trends in Urgent Care and Retail Medicine. Merritt Hawkins. Available at: <https://www.ihaconnect.org/About-IHA/Documents/Merritt%20Hawkins/mhawhitepaperconvenientcarePDF.pdf>

11. 25 Things to Know about Urgent Care. Becker's Hospital Review. Available at: <https://www.beckershospitalreview.com/lists/25-things-to-know-about-urgent-care.html>
12. Freestanding Emergency Departments and Urgent Care Centers. American College of Emergency Physicians. Available at: https://www.acep.org/globalassets/uploads/uploaded-files/acep/clinical-and-practice-management/resources/administration/fsed-and-ucs_info-paper_final_110215.pdf
13. Michael Ollove, States Forge Special Rules for Commercial Walk-In Health Clinics. Pew Trusts. Available at: <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/01/05/states-let-commercial-walk-in-health-clinics-grow-unregulated>
14. Michael Laff. Study: One in 15 FPs Spends Considerable Time in ER, Urgent Care. American Academy of Family Physicians. Available at: <https://www.aafp.org/news/practice-professional-issues/20140910rgc-eranalysis.html>
15. Policy Statement Urgent Care Centers. American College of Emergency Physicians. Available at: <https://www.acep.org/globalassets/new-pdfs/policy-statements/urgent.care.centers.pdf>

**7. ADDRESSING EQUITY IN TELEHEALTH
(RESOLVE 2, ITEMS A AND C OF ALTERNATE RESOLUTION 203-NOV-20)**

Reference committee hearing: see report of Reference Committee A.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLVE 2, ITEMS A AND C, RESOLUTION 203-NOV-20
REMAINDER OF REPORT FILED**

See Policies, H-478.980, H-480.937, D-385.957, D-480.963 and D-480.969

In reviewing American Medical Association (AMA) policy as well as telehealth initiatives on the local, state and federal levels, the Council believes that additional AMA policy is needed that advocates for solutions and infrastructure that facilitate equitable telehealth access. Policy D-480.963, newly adopted at the November 2020 Special Meeting of the House of Delegates, states that our AMA will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and supports the use of telehealth to reduce health disparities and promote access to health care. This new policy provides an essential foundation upon which additional policy addressing equity in telehealth can be developed and is consistent with the AMA's recent adoption of a new, eighth enterprise value embracing equity, which states: "We center the voices of the most marginalized in shaping policies and practices toward improving the health of the nation." Furthermore, AMA's vision statement for health equity states: "The AMA's vision for health equity is a nation where all people live in thriving communities where resources work well, systems are equitable and create no harm, everyone has the power to achieve optimal health, and all physicians are equipped with the consciousness, tools, and resources to confront inequities as well as embed and advance equity within and across all aspects of the health care system."

In addition, at the November 2020 Special Meeting of the House of Delegates, four potential additions to the second resolve of Alternate Resolution 203 were referred or referred for decision. The second resolve of Alternate Resolution 203-Nov-20, which is now Policy D-480.963[2] asked:

That our American Medical Association (AMA) advocate that the federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that:

1. provide equitable coverage that allows patients to access telehealth services wherever they are located; and
2. provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients.

The following additional elements were proposed for the second resolve. Items (a) and (b) were referred. Items (c) and (d) were referred for decision.

- a) promote continuity of care by preventing payers from using cost-sharing or other policies to prevent or disincentivize patients from receiving care via telehealth from the physician of the patient's choice.
- b) ensure qualifications of physicians duly licensed in the state where the patient is located to provide such services in a secure environment.
- c) provide equitable payment for telehealth services that are comparable to in-person services.
- d) promote continuity of care by allowing physicians to provide telehealth services, regardless of current location, to established patients with whom the physician has had previous face-to-face professional contact.

The Board of Trustees asked the Council on Medical Service to address Items (a)-(d) in reports back to the House of Delegates at the 2021 June Special Meeting. This report specifically responds to Items (a) and (c); Council on Medical Service Report 8, also being considered at this meeting, addresses Items (b) and (d).

This report provides background on barriers to and inequities in accessing telehealth; highlights programs and pathways to augment the ability of physicians to provide telehealth to historically marginalized and minoritized communities; summarizes relevant AMA policy; and presents policy recommendations.

BACKGROUND

The expansion of telehealth services as a result of the novel coronavirus (COVID-19) pandemic has positively impacted patients who now have the ability to utilize telecommunication technology to access their physicians without having to navigate public transportation in densely populated urban communities, take time off from work to commute to and from the appointment, or drive lengthy distances in rural areas to attend an outpatient office visit with a specialist. In addition, telehealth provides a mechanism to overcome other barriers affecting patients' ability to access in-person services, including functional impairments that make it difficult to get to a physician's office or require a family member, friend, or caregiver to accompany the patient, and the need to find care for children or grandchildren. Importantly, the increased use of telehealth provides another pathway for physicians to learn more about the social determinants of health that may influence a patient's health and access to health care, including one's living environment, economic stability and food security.

Overall, according to a recent survey, during the first six months of the COVID-19 pandemic, one-third of adults ages 18 to 64 reported having had a telehealth visit--defined in the survey as either audio-only or two-way audio-video. Adults with multiple chronic conditions as well as those in poorer health were much more likely to report using telehealth to access care than their counterparts. Black and Hispanic adults were more likely to use telehealth than White adults, and adults living in metropolitan areas were more likely to have used telehealth than adults living outside metropolitan areas. At the same time, patients reported going without a telehealth visit despite wanting one; adults in fair or poor health, those with chronic conditions, and Hispanic adults were more likely to report going without wanted telehealth care.¹ Of the Medicare fee-for-service population, more than 9 million beneficiaries received a telehealth service during the period ranging from mid-March through mid-June of 2020. More than 20 percent of Medicare beneficiaries residing in rural areas used telehealth services during that time, with 30 percent of beneficiaries in urban areas accessing telehealth services.²

Examining outpatient visits and telehealth use in a database of 16.7 million commercially insured and Medicare Advantage enrollees, a study showed that 30.1 percent of all visits from March 18, 2020, to June 16, 2020, were provided via telehealth. During this period, the weekly number of telehealth visits among the population studied increased to 397,977 visits per week, up from 16,540 visits per week during the period from January 1, 2020, to March 17, 2020. However, not all of these services were distributed evenly across different population groups. Notably, the percentage of total visits provided via telehealth was smallest among those ages 65 and older. In addition, health plan enrollees residing in counties with the lowest percentages of residents with incomes below the federal poverty level, and percentages of White residents had a greater proportion of total visits delivered via telehealth from March to June 2020 when compared with counties with higher percentages of these residents. In addition, a lower percentage of care was provided by telehealth in rural counties than in urban counties.³

Other studies also have reported inequitable access to telehealth services during the COVID-19 pandemic, as well as potential reliance on or preference for audio-only visits over two-way audio-video visits. For example, a cohort study of patients with appointments for primary care and specialty ambulatory telehealth visits during March through May of 2020 at a large academic health system showed that older adults, patients with limited English proficiency, Medicaid beneficiaries, and Asian patients had lower rates of telemedicine utilization. The study also found that Black, Hispanic,

lower-income, female and older patients had lower rates of two-way audio-video utilization.⁴ In addition, a claims-based analysis of approximately 7 million commercially insured patients found that, in the early stages of the pandemic in March and April of 2020, zip codes with 80 percent or more residents of historically minoritized racial/ethnic communities had smaller reductions in the use of in-person office visits, and smaller increases in the use of telehealth, than zip codes with 80 percent or more White residents.⁵ CMS has estimated that of the Medicare fee-for-service beneficiaries who accessed a telehealth service in the early months of the pandemic, 30 percent used audio-only telephone technology,⁶ with other studies showing higher rates of utilization of audio-only visits among low-income patients.⁷

BARRIERS TO TELEHEALTH ACCESS FOR PATIENTS

Telehealth has the potential to be an important tool for addressing long-standing health inequities among historically marginalized and minoritized communities that have been impacted disproportionately by the COVID-19 pandemic. However, far more emphasis needs to be placed on ensuring that telehealth solution functionality, content, user interface, and service access are designed in an equity-centric participatory fashion with and for historically minoritized and marginalized communities, including addressing culture, language, digital literacy ability, and broadband access. In addition to assessing how solutions are designed, it is also critical that an upstream lens is used to understand the root causes of barriers to optimal use of telehealth services within historically marginalized communities, namely systemic racism and inequitable resource allocation impacting infrastructure development and access to economic and education opportunities.

In 2019, 25 million individuals in the US did not have internet access at home, and 14 million did not have equipment capable of playing video--essential for two-way audio-video telehealth--such as a smartphone, tablet, computer or other connected device.⁸ Not all home internet services are equal; speed and bandwidth issues may continue to serve as obstacles to accessing telehealth services even for patients who have internet access at home. In addition, patients who only have a smartphone and solely rely on their phone's data plan and capacity for internet access may confront data and bandwidth challenges in accessing two-way audio-video telehealth visits.

There are, notably, racial and ethnic inequities in access to the internet, with a larger percentage of Black and Hispanic individuals not having internet access at home. Individuals residing in rural areas are less likely to have access to the internet at home than those in urban areas. Age-related disparities also exist, with older individuals being less likely to have internet access at home. Significantly, Medicare and Medicaid beneficiaries make up two-thirds of those who lack internet access at home, and the uninsured make up 15 percent.⁹

In addition, the continued use and expansion of telehealth rely on equitable design to meet the need for varying levels of patient digital literacy, and how the availability of telehealth services is communicated to patients. Individuals without access to a computer or smartphone may be left out of telehealth service offerings. Even among patients with equitable access to devices and to the internet, there remain exclusionary and suboptimal design issues requiring patients to navigate email, fill out a form online or find a website--significant barriers to participating in a two-way audio-video telehealth visit. Requiring the use of a patient portal for accessing telehealth services can serve as another barrier for patients. Furthermore, the lack of transparency and equity in the design of privacy and security policies and practices in many telehealth solutions cause hesitancy among some patients as to the safety and security of telehealth visits with their physicians.

AUGMENTING THE ABILITY OF PHYSICIANS TO PROVIDE TELEHEALTH TO HISTORICALLY MARGINALIZED AND MINORITIZED POPULATIONS

To help close the digital divide in access to telehealth services, initiatives at the state and federal levels can serve as examples of, and first steps towards, what needs to be done to address some of the upstream barriers to equity in telehealth--including ensuring affordable access to needed technology to engage in two-way audio-video telehealth and investing in broadband capacity in underserved communities. Patient access to telehealth is inextricably linked to whether and how such services are covered by their health plans, including whether they can use telehealth to access care from their regular physician. Barriers to patients accessing telehealth can be overcome by fairly and equitably financing services in formats most accessible to and appropriate for patients, including two-way audio-video and audio-only.

Federal and State Initiatives Addressing Equity in Telehealth Service Delivery and Access

Increased investments in telehealth service delivery and access are essential to ensure patients can maintain needed access to health care regardless of where they are and augment the ability of physicians to provide telehealth to populations who cannot currently access telehealth services. Federal initiatives have recently been launched to assist health care providers in purchasing necessary services and equipment to provide telehealth services to underserved populations and in areas that have been disproportionately impacted by the COVID-19 pandemic. In addition, many states have leveraged available Medicaid authorities to provide technology and care coordination support to augment the ability of Medicaid beneficiaries to access telehealth services during the COVID-19 pandemic.

Connected Care Pilot

Under the auspices of the Federal Communications Commission (FCC), the Connected Care Pilot Program is a temporary program that will provide up to \$100 million over a three-year period to defray the costs faced by selected health care providers in providing connected care services, prioritizing providing these services to low-income or veteran patients. The Connected Care Pilot will cover 85 percent of the eligible costs incurred by selected pilot programs of patient broadband internet access services, health care provider broadband data connections, other connected care information services, and certain network equipment. Provider eligibility for the Connected Care Pilot Program is limited to public and nonprofit providers, including community health and mental health centers; local health departments; rural health clinics; skilled nursing facilities; not-for-profit hospitals; and other entities.¹⁰

COVID-19 Telehealth Program

The COVID-19 Telehealth Program was established by the FCC in response to the COVID-19 public health emergency to assist health care providers in providing connected care services to patients at their homes or mobile locations in response to the COVID-19 pandemic. The FCC adopted the Program in a report and order released in April 2020. Through this program, the FCC will distribute the \$200 million appropriated by Congress as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, providing immediate support to eligible health care providers--limited to public and nonprofit providers like the Connected Care Pilot--responding to the COVID-19 pandemic. The FCC has outlined the following examples under the auspices of the three main categories of eligible services related to the delivery of connected care that could be funded under the Program:

- Telecommunications Services and Broadband Connectivity Services: Voice services for health care providers or their patients.
- Information Services: Internet connectivity services for health care providers or their patients; remote patient monitoring platforms and services; patient reported outcome platforms; store and forward services, such as asynchronous transfer of patient images and data for interpretation by a physician; platforms and services to provide synchronous video consultation.
- Connected Devices/Equipment: Tablets, smart phones, or connected devices to receive connected care services at home (e.g., broadband-enabled blood pressure monitors; pulse oximetry monitors) for patient or health care provider use; or telemedicine kiosks/carts for health care provider sites.¹¹

Emergency Broadband Benefit Program

In February 2021, the FCC formally adopted a report and order to establish the Emergency Broadband Benefit Program, a program with \$3.2 billion in federal funding aimed at providing financial assistance to qualifying households to help cover the costs of broadband and device ownership. Broadband access and device ownership are critical building blocks to enable more equitable patient access to telehealth. Under the program, eligible households can receive discounts of up to \$50 per month for broadband service, up to \$75 if the household is on Tribal lands. Eligible households will also be eligible for a one-time discount of up to \$100 for the purchase of a computer or tablet. Households eligible for assistance under the Emergency Broadband Benefit Program include those that participate in an existing low-income or pandemic relief program offered by a broadband provider; Lifeline subscribers, including those who are Medicaid beneficiaries or receive Supplemental Nutrition Assistance Program (SNAP) benefits; households with children receiving free or reduced-price school meals; Pell grant recipients; and those who have lost jobs and experienced reductions in their income in the past year.¹²

Medicaid Appendix K Waivers

Medicaid Appendix K is a stand-alone appendix that states can use during emergencies, such as the COVID-19 pandemic, to request amendment to approved 1915(c) home and community-based waivers. During the COVID-19 pandemic, states have used Medicaid Appendix K authority to provide needed technology and care coordination support to targeted beneficiaries. For example, New Mexico was approved to provide up to \$500 to select Medicaid beneficiaries who do not currently have access to a computer, tablet or other device to purchase such a device to support their access to telehealth, including two-way audio-video as well as needed training.¹³ Kansas was approved under Medicaid Appendix K authority to provide remote monitoring technology and requisite training to beneficiaries with chronic diseases.¹⁴

Covering Telehealth Services by Patients' Physicians

Referred Item (a) proposed to be added to Alternate Resolution 203 from the November 2020 Special Meeting was to “promote continuity of care by preventing payors from using cost-sharing or other policies to prevent or disincentivize patients from receiving care via telehealth from the physician of the patient’s choice.” Patient access to telehealth is inextricably linked to whether telehealth services provided by their physicians--the physicians with whom they have a relationship--are covered by their health plan. The AMA has been highly active on the state and federal levels to ensure that health plans allow all contracted physicians to provide care via telehealth, and that cost-sharing is not used to incent care from other providers. Prior to the COVID-19 pandemic, many health plans established a separate network for telehealth or select telehealth providers, which did not always include contracted physicians who provide in-person services. As a result of the pandemic, adoption of telehealth has increased dramatically and is more likely to be available from an individual’s physician. AMA advocacy on the state and federal levels has underscored that the pre-pandemic separation of telehealth and in-person visits can no longer be justified based on low levels of adoption that no longer exist. In addition, the AMA has stressed that the perpetuation of separate networks is confusing for patients and threatens continuity of care and the patient-physician relationship.

For example, AMA model state legislation addressing this issue, the Telemedicine Reimbursement Act, states that “each carrier offering a health plan in this state shall provide coverage for the cost of health care services provided through telemedicine on the same basis and to the same extent that the carrier is responsible for coverage for the provision of the same service through in-person treatment or consultation. Coverage must not be limited only to services provided by select corporate telemedicine providers.” In addition, in an April 2020 comment letter in response to a proposed rule on the Medicare Advantage program, the AMA stated that “the rapid deployment of telehealth services by physicians in response to the COVID-19 pandemic is significantly changing the practice of medicine in ways that are likely to last long after the pandemic. Many patients are now having office visits with their regular physicians via telehealth. The AMA strongly encourages MA plans to cover telehealth visits and other services, at a minimum for those on the Medicare telehealth list, with their physicians. The AMA is aware that some plans contract with telehealth providers and encourage their enrollees to use these other services instead of covering telehealth services provided by the patients’ regular physicians. Patient advocates have made it very clear that what is most important to patients is for all members of the patient’s health care team to be involved in, and adhere to, the patient’s treatment plan. This continuity of care will not be possible if patients are directed to separately contracted telehealth providers even when the patients’ regular physicians are able to provide the services via telehealth themselves.”¹⁵

In addition, AMA advocacy has underscored that the cost-sharing for services provided via telehealth should not vary based on the telehealth provider. Reducing cost sharing for select telehealth providers who do not also provide in-person care inappropriately steers patients away from their current physicians, fragmenting the health care system and threatening patients’ continuity of care. Importantly, the AMA has stressed that health insurers should ensure transparency in coverage and patient cost-sharing of services provided via telehealth, and health care professionals should effectively communicate information about the scope of telehealth visits to patients.

Ensuring Fair and Equitable Payment for Two-Way Audio-Video and Audio-Only Visits

Relevant to Item (c) proposed to be added to Alternate Resolution 203 from the November 2020 Special Meeting, several states enacted Executive Orders early in 2020 requiring payers to provide equivalent payment for two-way audio-video visits, and sometimes audio-only visits, as compared to in-person visits. Through the end of the COVID-19 public health emergency, CMS will continue to pay for telehealth visits equivalent to in-person office visits. In the Final Rule for the 2021 Medicare Physician Payment Schedule, CMS stated that audio-only visits, described by CPT

codes 99441-99443, will not be payable after the conclusion of the COVID-19 public health emergency. CMS will allow payment, however, for brief communication technology-based services (e.g., virtual check-in), described by codes G2251 and G2252, at 2021 payment rates of \$15 and \$27 respectively.

During the COVID-19 public health emergency, two-way audio-video visits are reported with existing Current Procedural Terminology (CPT) codes for office visits. Prior to the COVID-19 public health emergency, payment for two-way audio-video telehealth visits was typically equivalent to an office visit provided in a facility setting (e.g., outpatient hospital clinic), where the physician is presumed to incur no direct costs (clinical staff, medical supplies and equipment). During the COVID-19 public health emergency, payment for two-way audio-video visits was paid equivalent to an office visit provided in a non-facility setting (e.g., physician's office). It is likely that the CPT Editorial Panel will receive an application to modernize the CPT codes describing audio-only services to address the CMS concerns and to align with the temporary G codes. After such an action, the AMA/Specialty Society RVS Update Committee would review the resources typically required to perform these services.

Relevant AMA Policy

Newly adopted at the November 2020 Special Meeting of the House of Delegates, Policy D-480.963 states that our AMA: (1) will continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post SARS-CoV-2; (2) will advocate that the federal government, including CMS and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that: (a) provide equitable coverage that allows patients to access telehealth services wherever they are located, and (b) provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients; (3) will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and (4) supports the use of telehealth to reduce health disparities and promote access to health care. Policy H-478.980 advocates for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services. Policy H-478.996 states that it is the policy of the AMA to support efforts to address the economic, literacy, and cultural barriers to patients utilizing information technology.

Relevant to referred-for-decision Item (c) proposed to be added to Alternate Resolution 203 from the November 2020 Special Meeting, Policy D-480.965 states our AMA will work with third-party payers, CMS, Congress and interested state medical associations to provide coverage and reimbursement for telehealth to ensure increased access and use of these services by patients and physicians. Established by Council Report 7-A-14, Policy H-480.946 outlines principles to guide the coverage and payment of telemedicine services. Regarding payment for audio-only visits, Policy H-390.889 states that our AMA supports and advocates with all payers the right of physicians to obtain payment for telephone calls not covered by payments for other services; and continues to work with CMS and the appropriate medical specialty societies to assure that the relative value units assigned to certain services adequately reflect the actual telephone work now performed incident to those services.

Relevant to referred Item (a) proposed to be added to Alternate Resolution 203 from the November 2020 Special Meeting, Policy H-480.946 states that patients seeking care delivered via telemedicine must have a choice of provider; and that telemedicine services must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities. Policy D-480.969 advocates for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers. 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 primarily based on cost of care factors. Policy D-155.987 advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information or other plan designs that may affect patient out-of-pocket costs.

DISCUSSION

While the AMA has foundational policy pertaining to the coverage and payment for telehealth, Policy D-490.963, adopted at the November 2020 Special Meeting, serves as an essential step forward in developing policy specific to addressing equity in telehealth. The new policy, as well as Policy H-478.980, recognizes that historically marginalized and minoritized populations cannot optimally access telehealth services without the basics: a connected device that has video capabilities, and access to the internet. The Council notes that ownership of devices and access to the internet are beneficial for telehealth only if patients know how to use the devices and if those solutions are designed for patients with varying digital literacy levels to participate in two-way audio-video telehealth. In addition, telehealth technologies need to be designed upfront to meet the needs of older adults, individuals with vision impairment, and individuals with disabilities. Furthermore, telehealth solutions must be designed with and for patients with limited English proficiency, ensuring all cultures and languages represented in a patient population are centered in the creation of communications promoting telehealth services and supporting engagement in a telehealth visit. As such, the Council recommends reaffirmation of Policy D-385.957, which advocates for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services.

Ultimately, for patients to access and engage in telehealth, they must be aware of the telehealth services available to them and be comfortable with accessing care via telehealth. Hospitals, health systems and health plans need to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth.

In addition, it is essential for physicians to serve as leading partners in efforts to improve the access of historically marginalized and minoritized communities to telehealth services. The Council welcomes initiatives to assist health care providers in purchasing necessary services and equipment to provide telehealth services to underserved populations and in areas that have been disproportionately impacted by the COVID-19 pandemic. However, eligibility of physician practices for these programs remains quite limited, and the Council sees tremendous potential in expanding eligibility for these programs so that physicians are able to help their patients engage with and access telehealth services.

To ensure that physicians are able to provide care to their patients via telehealth, health plans need to allow all contracted physicians to provide care via telehealth. Policy D-480.969 provided a policy foundation in this regard, advocating for telemedicine parity laws that do not limit coverage only to services provided by select corporate telemedicine providers, relevant to the emergence of companies including Amazon expanding in the telehealth space. The Council is concerned that physicians are being prevented from, or facing barriers to, providing covered services via telehealth to their patients. In addition, cost-sharing should not be used to require or incentivize the use of telehealth or in-person care, or to incentivize care from a separate or preferred telehealth network. Such incentives could also include creating separate cost-sharing requirements or structures for in-person care and care provided via telehealth.

The Council believes that barriers to patients accessing telehealth can be overcome by fairly and equitably financing services in formats most accessible to and appropriate for patients, including two-way audio-video and audio-only. The expanded use of audio-video telehealth services during the COVID-19 pandemic has made it clear that requiring the use of video limits the number of patients who can benefit from telecommunications-supported services, particularly lower-income patients and those in rural and other areas with limited internet access. In addition, some patients, even those who own the technology needed for two-way real-time audio-video communication, do not know how to employ it or for other reasons are not comfortable communicating with their physician in this manner. Ultimately, physician payments should consider the resource costs required to provide all physician visits and should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person. Fair and equitable payments will help ensure that patients are able to receive the right care, via the most appropriate and accessible modality, at the right time.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolve 2, Items (a) and (c) of Alternate Resolution 203-Nov-2020, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policy D-480.963, which advocates for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients.
2. That our AMA reaffirm Policy H-478.980, which advocates for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States.
3. That our AMA encourage initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations.
4. That our AMA encourage telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations.
5. That our AMA support efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities.
6. That our AMA reaffirm Policy D-385.957, which advocates for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services.
7. That our AMA encourage hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth.
8. That our AMA support expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations.
9. That our AMA reaffirm Policy D-480.969, which advocates for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers.
10. That our AMA support efforts to ensure payers allow all contracted physicians to provide care via telehealth.
11. That our AMA oppose 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.
12. That our AMA advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.
13. That our AMA recognize access to broadband internet as a social determinant of health.

REFERENCES

1. Smith L and Blavin F. One in Three Adults Used Telehealth during the First Six Months of the Pandemic, but Unmet Needs for Care Persisted. Robert Wood Johnson Foundation/Urban Institute. January 2021. Available at: https://www.urban.org/sites/default/files/publication/103457/one-in-three-adults-used-telehealth-during-the-first-six-months-of-the-pandemic-but-unmet-needs-for-care-persisted_1.pdf.
2. Verma, S. Early Impact Of CMS Expansion Of Medicare Telehealth During COVID-19. Health Affairs Blog. July 15 2020. Available at: <https://www.healthaffairs.org/doi/10.1377/hblog20200715.454789/full/>.

3. Patel S, Mehrotra A, Huskamp H, Uscher-Pines L, Ganguli G, and Barnett M. Variation In Telemedicine Use And Outpatient Care During The COVID-19 Pandemic In The United States. *Health Affairs*. 40(2): 349-358. February 2021. Available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.01786>.
4. Eberly LA et al. Patient Characteristics Associated With Telemedicine Access for Primary and Specialty Ambulatory Care During the COVID-19 Pandemic. *JAMA Network Open*. 2020; 3(12). December 29, 2020. Available at: <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774488?resultClick=3>.
5. Whaley C, Pera M, Cantor J, et al. Changes in Health Services Use Among Commercially Insured US Populations During the COVID-19 Pandemic. *JAMA Netw Open*. 2020;3(11):e2024984. Available at: <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2772537>.
6. Verma, *supra* note 2.
7. Uscher-Pines L, Sousa J, Jones M, et al. Telehealth Use Among Safety-Net Organizations in California During the COVID-19 Pandemic. *JAMA*. Published online February 02, 2021. Available at: <https://jamanetwork.com/journals/jama/fullarticle/2776166>.
8. Amin K, Rae M, Ramirez G, and Cox C. How Might Internet Connectivity Affect Health Care Access? Peterson-KFF Health System Tracker. December 14, 2020. Available at: <https://www.healthsystemtracker.org/chart-collection/how-might-internet-connectivity-affect-health-care-access/>.
9. *Ibid*.
10. Federal Communications Commission. Connected Care Pilot Program Frequently Asked Questions (FAQs). Available at: <https://www.fcc.gov/connected-care-pilot-program-frequently-asked-questions-faqs>.
11. Federal Communications Commission. COVID-19 Telehealth Program - Frequently Asked Questions (FAQs). Available at: <https://www.fcc.gov/covid-19-telehealth-program-frequently-asked-questions-faqs>.
12. Federal Communications Commission. FCC Adopts Report and Order to Implement Emergency Broadband Benefit Program. February 25, 2021. Available at: <https://www.fcc.gov/document/fcc-adopts-report-and-order-emergency-broadband-benefit-program>.
13. New Mexico Appendix: Emergency Preparedness and Response and COVID-19 Addendum. Developmental Disabilities Waiver, Mi Via ICF/IDD Waiver, Medically Fragile Waiver. January 27, 2020. Available at: <https://www.medicaid.gov/state-resource-center/downloads/nm-combined-appendix-k-appvl.pdf>.
14. Kansas Appendix: Emergency Preparedness and Response and COVID-19 Addendum. Autism; Brain Injury, Frail Elderly, Intellectual & Developmental Disability; Physical Disability; Serious Emotional Disturbance; Technology Assisted. January 27, 2020. Available at: <https://www.medicaid.gov/state-resource-center/downloads/ks-combined-appendix-k-appvl.pdf>.
15. Comment Letter to CMS Administrator Seema Verma in response to the Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly Proposed Rule (Proposed Rule). April 6, 2020. Available at: <https://searchf.ama-assn.org/letter/documentDownload?url=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-4-6-Letter-to-Verma-re-MA-and-Part-D-NPRM.pdf>.

8. LICENSURE AND TELEHEALTH (RESOLVE 2, ITEMS B AND D OF ALTERNATE RESOLUTION 203-NOV-20)

Reference committee hearing: see report of Reference Committee A.

**HOUSE ACTION: RECOMMENDATION 1 REFERRED FOR DECISION
RECOMMENDATIONS 2-5 ADOPTED
IN LIEU OF RESOLVE 2, ITEMS B AND D, RESOLUTION 203-NOV-20
REMAINDER OF REPORT FILED
*See Policies H-480.946, H-480.969 and D-480.964***

At the November 2020 Special Meeting of the House of Delegates, four potential additions to the second Resolve of Alternate Resolution 203 were referred or referred for decision. The second Resolve of Alternate Resolution 203-I-20, which is now Policy D-480.963[2] asked:

That our American Medical Association (AMA) advocate that the federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that (1) provide equitable coverage that allows patients to access telehealth services wherever they are located; and (2) provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients.

The following additional elements were proposed for the second Resolve. Paragraphs a and b were referred. Paragraphs c and d were referred for decision.

- a) promote continuity of care by preventing payors from using cost-sharing or other policies to prevent or disincentivize patients from receiving care via telehealth from the physician of the patient's choice.
- b) ensure qualifications of physicians duly licensed in the state where the patient is located to provide such services in a secure environment.
- c) provide equitable payment for telehealth services that are comparable to in-person services.
- d) promote continuity of care by allowing physicians to provide telehealth services, regardless of current location, to established patients with whom the physician has had previous face-to-face professional contact.

The Board of Trustees asked the Council on Medical Service to address Paragraphs (a)-(d) in reports back to the House of Delegates at the 2021 June Special Meeting. This report is specifically responding to Paragraphs (b) and (d); Council on Medical Service Report 7, also being considered at this meeting, is addressing Paragraphs (a) and (c).

This report provides an overview of physician licensure and telehealth, describes exceptions to licensing laws authorized by states before and during the novel coronavirus (COVID-19) pandemic, summarizes relevant AMA policy, and makes policy recommendations. For the purposes of this report, the term "telehealth" refers to digital health solutions that connect patients and clinicians through real-time audio and video technology.

BACKGROUND

In response to the spread of COVID-19, widespread stay-at-home orders, and federal and state policy changes instituted last spring, the use of telehealth by physicians and other health professionals expanded exponentially. Swift adoption of telehealth across most practices and settings enabled physicians to provide uninterrupted continuity of care while adhering to social distancing that protected patients and health professionals from exposure to the virus. The surge in telehealth is reflected in data from recent biennial AMA Physician Practice Benchmark Surveys, which are nationally representative samples of non-federal physicians who provide care to patients at least 20 hours per week. Benchmark Survey data show a substantial increase in the use of telehealth between 2018 and 2020, with 79 percent of physicians reporting use of telehealth in their practice in 2020, up from 25 percent in 2018.¹ Additionally, last summer more than 75 percent of respondents to the Telehealth Impact Physician Survey said that telehealth enabled them to provide quality care for COVID-19-related care, acute care, chronic disease management, hospital or emergency department follow-up, care coordination, preventive care, and mental or behavioral health.² Sixty percent of physicians reported that telehealth has improved the health of their patients, while 55 percent indicated that telehealth has improved their work satisfaction.³ Payment (73 percent) and technology challenges for patients (64 percent) were cited by a majority of physicians as barriers to maintaining telehealth after the pandemic, while 18 percent of physicians cited licensure as a barrier.⁴

The Council anticipates that many physicians who increased their use of telehealth during the pandemic will want to continue the practice after COVID-19 is under control, not as a replacement for in-person care but as part of a hybrid model in which physicians utilize both in-person and telehealth visits to support optimal care. The AMA continues to study telehealth use to better understand the needs of patients and physicians as well as the overall impact of telehealth on care quality and patient outcomes. At the same time, the AMA engages in robust federal and state advocacy on telehealth, weighing in on a range of policy proposals including the temporary flexibilities put in place during the public health emergency as well as proposals that will shape the practice of telehealth post-pandemic.

Interstate licensure and telehealth were addressed in [Council Report 1-I-19, Established Patient Relationships and Telemedicine](#), which highlighted concerns raised by physicians that the nation's state-based licensure system has impeded growth in telehealth use by medical homes and other physician practices, including those wishing to provide telehealth services to their regular patients when those patients travel to another state. In adopting the Council's 2019 report, the House of Delegates reaffirmed long-standing AMA policy maintaining that physicians delivering telemedicine services must be licensed in the state where the patient receives services (Policies H-480.946 and H-480.969). Additionally, by adopting the recommendations in the report, the House established Policy D-480.964, which directs the AMA to work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact (IMLC) to consider joining; advocate for reduced application and state licensure(s) fees processed through the IMLC; and work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services.

Council Report 1-I-19 highlighted the rationale behind state oversight of the practice of medicine and the licensure of physicians to practice within a state's borders. State authority to protect the health, safety and general welfare of its citizens was granted in 1791 under the 10th Amendment of the US Constitution, with formal licensing of physicians through state medical boards dating back to the 1800s.⁵ The primary goals of state medical boards are to protect patients, ensure quality health care, and foster the professional practice of medicine. In addition to issuing licenses, state medical boards are authorized to investigate complaints and take disciplinary action against the licenses of those who violate state law. States also license a range of other health professionals, including physician assistants and nurses, and establish scope of practice parameters within the state to safeguard the practice of medicine.

The prevailing standard for medical licensure found in the medical practice acts of each state affirms that the practice of medicine is determined to occur where the patient is located. This standard enables states to ensure that health professionals adhere to that state's laws and regulations (e.g., licensing requirements and scope of practice parameters) and to protect the public from the unprofessional and improper practice of medicine. Because the standards and scope of telehealth services should be consistent with related in-person services (consistent with Policy H-480.946), most states similarly require physicians utilizing telehealth to be licensed in all jurisdictions where patients receive care. Licensure requirements established by state medical boards may vary but, according to the Federation of State Medical Boards (FSMB), 49 state boards—as well as the medical boards of the District of Columbia, Puerto Rico, and the Virgin Islands—require physicians practicing telehealth to be licensed in the state in which the patient is located.⁶

INTERSTATE LICENSURE

Recognizing the costs and burdens associated with obtaining physician licenses to practice medicine in multiple states, the AMA has long supported making it easier to obtain licenses to practice across state lines, and addressing the cost, time and administrative burdens while preserving the ability of states to oversee the care provided to patients within their borders. Advances in telehealth, and the potential to increase access to virtual care among people in rural and underserved communities, increasingly motivated stakeholders to seek solutions that would streamline licensure processes across state lines. Ultimately, these efforts culminated in the development of the IMLC.

Interstate Medical Licensure Compact

In 2017, the IMLC became operational establishing a new expedited pathway to licensure for qualifying physicians seeking to practice in multiple states. From the beginning, the AMA strongly supported the IMLC as a means of facilitating expedited licensure while ensuring that states retain the authority to regulate the practice of medicine and protect patient welfare. The IMLC adopts the prevailing standard that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter. A physician practicing under a license facilitated by the IMLC is thus bound to comply with the statutes, rules, and regulations of each state wherein he/she chooses to practice medicine.

At the time this report was written, the IMLC was an agreement among the following 30 states, the District of Columbia and the Territory of Guam: Alabama, Arizona, Colorado, Georgia, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, North Dakota, Oklahoma, Pennsylvania, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin, and Wyoming.⁷ Compact authorizing legislation has been introduced in Missouri, New Jersey, New York, North Carolina, Ohio, Oregon, Rhode Island and Texas, with other states expected to introduce legislation during 2021 legislative sessions.⁸

Over 17,000 licenses have been issued by IMLC,⁹ and the IMLC Commission estimates that 80 percent of physicians in Compact states meet the criteria for licensure.¹⁰ However, physicians practicing in several heavily populated states—e.g., California, Florida, Massachusetts, New York and Texas—are unable to apply for expedited licenses through the IMLC since those states have not passed authorizing legislation to join the Compact. Physicians practicing in Compact states are similarly unable to use the IMLC to obtain expedite licenses in these non-Compact states.

Costs associated with Compact licenses/renewals remain an additional barrier to increased licensing via the IMLC, since physicians who want to apply must pay an initial \$700 fee plus cover the costs and renewal fees of the license(s) in Compact state(s) where the physician wants to practice.¹¹ Licensing fees in Compact states range from \$75 in Alabama and Wisconsin to \$790 in Maryland, with most states charging several hundred dollars. These costs may be beyond the budgets of many physician practices—particularly small practices—that continue to face COVID-19-

related financial pressures. A nationwide physician survey conducted by the AMA in July-August 2020 found that practice revenue had dropped by a third, on average, and spending on personal protective equipment (PPE) had increased 57 percent.¹² Despite an increase in telehealth use, almost 70 percent of physicians were still providing fewer total visits (in-person plus telehealth) at the time of the survey than before the pandemic.¹³

Exceptions to State Licensing Laws Pre-COVID-19

Prior to the pandemic, physicians licensed by states that had not joined the IMLC or who wanted to practice in a non-Compact state were generally required to go through that state's traditional, often lengthy, licensure application process. Allowances for circumstances under which out-of-state physicians may practice in a state without being licensed vary by state and were predominantly limited pre-pandemic to physicians consulting with in-state physicians and physicians practicing in emergencies or responding to natural disasters. Although licensing requirements across states share many commonalities, each state has its own rules and exceptions to those rules. Colorado's Medical Practice Act [§ 12-240-107(3)(b)], for example, uniquely permits physicians licensed and lawfully practicing medicine in another state to provide "occasional services" in Colorado, provided they do not have a regular practice in Colorado and maintain malpractice insurance.¹⁴

Some states had licensure policies specific to interstate telehealth in place before the pandemic. According to FSMB, 12 state medical boards issue a special purpose license, telemedicine license or certificate, or license to practice medicine across state lines, while six state boards require physicians to register if they wish to practice across states.¹⁵ Florida is an example of the latter. Despite opposition from the Florida Medical Association and other health providers, Florida enacted a law in 2019 allowing out-of-state health professionals to provide telehealth services in the state without a Florida license if they register with the state medical board.

The Uniform Emergency Volunteer Health Practitioners Act (UEVHP) allows properly registered out-of-state volunteer health professionals providing disaster relief in a state to provide services without having to seek a license in the state that has declared an emergency; however, participation is limited to the 18 states plus the District of Columbia that have enacted the Act.¹⁶ Some states have enacted universal licensure recognition laws to allow people holding certain out-of-state occupational licenses to practice in that state, although these laws have generally been limited to emergencies and accommodations for military spouses.¹⁷

Physicians and other health professionals employed by the US Veterans Administration, the Indian Health Service and the US Department of Defense are generally permitted by these health systems to practice—including via telehealth—outside of the state where they are licensed. States also recognize the licenses of National Disaster Medical System physician team members. The Sports Medicine Licensure Clarity Act, passed by Congress in 2018, enabled sports medicine professionals to provide medical care to athletes and team members while traveling with an athletic team in a state in which they are not licensed. Under this law, services provided by a sports medicine professional are deemed to have occurred in the professional's primary state of licensure. The law further extends medical professional liability insurance to cover the professional with respect to medical care provided while out of state with the team.¹⁸

Liability concerns are integral to licensure discussions because liability insurance policies vary in terms of coverage for care across state lines. Most insurers provide coverage for actions undertaken in any state, although the intent is to ensure coverage for one-off situations where a physician provides a limited amount of care outside the jurisdiction where they are licensed. Accordingly, it is important for physicians to speak to their insurers if they intend to treat patients in other states on a regular basis so the insurer can verify whether their coverage extends to those states.

Licensing Waivers in Response to COVID-19

COVID-19 led to a slew of federal and state temporary waivers of telehealth coverage and payment regulations intended to expand the scale and reach of telehealth, thereby meeting the increased demand for virtual medical care. Federal and state licensure requirements were also waived, enabling health care professionals to work across state lines and provide care in areas hardest hit by the pandemic without having to seek licenses in those states. After the President and US Department of Health and Human Services Secretary declared a public health emergency in March 2020, CMS used its 1135 waiver authority to temporarily waive requirements that out-of-state physicians and other health professionals be licensed in the state where they are providing services when they are licensed in another state. Licensing requirements were waived for physicians and other health professionals participating in the Medicare, Medicaid and Children's Health Insurance Program programs and meeting the following four conditions: 1) must be

enrolled as such in the Medicare program; 2) must possess a valid license to practice in the state; 3) is furnishing services—whether in person or via telehealth—in a state in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity; and 4) is not affirmatively excluded from practice in the state or any other state that is part of the emergency area.¹⁹

CMS' actions did not waive state or local licensure requirements, which remain in effect unless also waived. Accordingly, for a physician or other health professional to avail him- or herself of the CMS waiver under the conditions described above, the state would also have to have modified its licensure requirements. Many states did so by implementing temporary changes that to varying degrees permit physicians licensed in other states to provide medical services during the public health emergency. Some states issued broad reciprocity waivers permitting physicians and other health professionals possessing an active license in good standing in another state to provide care without obtaining a license, temporary or otherwise, in that state. Other states required registration with or approval by the state medical board. Some waivers were more targeted, presumably based on a state's needs, and several states established emergency temporary licensure or certification processes that out-of-state providers must go through to seek permission to practice. A few states specified that telehealth could be used by out-of-state physicians to provide continuity of care to patients in that state, or by physicians in contiguous states that have existing patient relationships with state residents. At the time this report was written, a few states had already rescinded their temporary licensure waivers while Idaho's Governor, via executive order, had declared that all the state's waivers, including the change allowing out-of-state physicians to provide telehealth services to Idaho residents, be made permanent. [States modifying licensure requirements for physicians in response to COVID-19](#), and [states waiving telehealth licensure requirements](#), are tracked by FSMB.

The AMA has supported the need for flexibilities to effectively respond to COVID-19 but does not currently support extending the CMS licensure waiver beyond the end of the public health emergency. To protect patients, the AMA has long advocated that physicians and other health professionals providing care via telehealth must be licensed or otherwise authorized to practice in the state where the patient is receiving care to ensure that state medical practice acts, informed consent, and scope of practice laws apply, and that the state has oversight of medical practice.

Providing telehealth services in a "secure environment"

Aside from licensure, the referred item (b) also specifies that telehealth services should be provided in a secure environment, which may be relevant to temporary changes to Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules. To help physicians and other health professionals quickly adopt telehealth, the Office for Civil Rights (OCR) announced early in the pandemic that it would exercise discretion in enforcing violations of HIPAA privacy and security rules for physicians and hospitals who, in good faith, utilized telemedicine platforms and applications to connect with their patients. This policy allows health professionals and patients to use technologies that may not meet all HIPAA requirements, such as Skype, FaceTime and Google Hangouts, to provide care. The AMA supported this policy because it helped physicians quickly adopt telehealth without needing to first implement contracts and security reviews that are often complex and time-consuming. However, while HIPAA compliance may seem onerous and burdensome, it is a necessary ingredient to the successful use of telehealth over the long term.

HIPAA's requirements are intended to ensure that both health professionals and their business associates are accountable for the privacy and security of patient information, thereby fortifying the trust that is central to the patient-physician relationship. Accordingly, when the public health emergency ends, the AMA has urged OCR to not continue its enforcement discretion policy, but rather to establish a glide path to compliance with HIPAA obligations. This would mean that, if the emergency ends on September 30, rather than requiring physicians to be fully in compliance on October 1, OCR should instead allow providers to begin taking steps toward compliance (e.g., engage their vendors in discussions about business associate agreements and initiate or implement their security risk analysis of a new telehealth platform). Additionally, the AMA has advocated that OCR should ensure that physicians and other health professionals are held harmless for actions taken in good faith during the public health emergency.

RELEVANT AMA POLICY

A key safeguard included in Policy H-480.946, which was established through [Council Report 7-A-14, Coverage and Payment for Telemedicine](#), stipulates that physicians and other health practitioners must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by the state's medical board. In addition, this policy requires physicians to abide by state licensure laws, state medical practice acts and other

requirements in the state where the patient receives services and maintains that the delivery of telemedicine must be consistent with scope of practice laws. The full text of Policy H-480.946 and other relevant policies is appended.

Long-standing AMA policy maintains that state and territorial medical boards should require a full and unrestricted license in the state for the practice of telemedicine unless there are other appropriate state-based licensing methods (Policy H-480.969). This policy also delineates exemptions from such licensure requirements for “curbside consultations” that are provided without expectation of compensation, and in the event of emergent or urgent circumstances.

Policy D-480.999 opposes a single national federalized system of medical licensure. Policy H-480.974 states that our AMA will work with FSMB and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries. Policy D-480.969 states that our AMA will work with the FSMB to draft model state legislation to ensure telemedicine is appropriately defined in each state’s medical practice statutes and its regulation falls under the jurisdiction of the state medical board. Policy D-275.994 supports the IMLC. Policies H-275.978 and H-275.955 urge licensing jurisdictions to adopt laws and regulations facilitating the movement of licensed physicians between states. Policy D-480.963 directs the AMA to continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post-pandemic.

Policy H-130.941 encourages physicians who are interested in volunteering during a disaster to register with their state’s Emergency System for Advance Registration of Volunteer Health Professionals program, local Medical Reserve Corps unit, or similar registration systems capable of verifying that practitioners are licensed and in good standing at the time of deployment; and supports the Uniform Emergency Volunteer Health Practitioners Act. Policy H-275.922 encourages FSMB to develop model policy for state licensure boards to streamline and standardize the process by which a physician who holds an unrestricted license in one state may participate in physician volunteerism in another state.

The AMA has substantial scope of practice policy, including Policies D-160.995, H-270.958, and H-160.949. Principles for the supervision of nonphysician providers when telemedicine is used are outlined in Policy H-160.937. Code of Medical Ethics Opinion 1.2.12 states that physicians who provide clinical services through telemedicine must uphold the standards of professionalism expected in in-person interactions, follow appropriate ethical guidelines of relevant specialty societies and adhere to applicable law governing the practice of telemedicine. HIPAA is addressed by Policies H-478.997, D-190.983, and H-315.964.

AMA RESOURCES AND ADVOCACY

Consistent with AMA policy, AMA model state legislation provides a framework for a modern state medical practice act that facilitates physician adoption of telemedicine. The Telemedicine Act clarifies licensure requirements for physicians treating patients via telemedicine, ensuring that, with certain exceptions (e.g., curbside consultations, volunteer emergency medical care), physicians and other health professionals practicing telemedicine are licensed in the state where the patient receives services or are providing these services as otherwise authorized by that state’s medical board. The model bill also outlines steps through which a physician can establish a relationship with a new patient via telemedicine and addresses informed consent and privacy.

The AMA has created numerous resources to help guide physician practices through the successful implementation of telehealth, including a [Telemedicine Quick Guide](#), [Telehealth Implementation Playbook](#), and [Continuing Medical Education \(CME\) modules](#) available on the AMA Ed Hub. The AMA has also developed [HIPAA privacy and security resources](#) to help walk physicians through what is needed to comply with the required HIPAA privacy and security rules. The [AMA Physician Profile Service](#) is used extensively by organizations that verify physician credentials directly (e.g., licensing boards, hospitals, group practices, managed care organizations and physician recruiters).

At the beginning of the pandemic, the AMA also made available a [COVID-19 State Policy Guidance on Telemedicine](#), which outlined AMA policy recommendations for telemedicine on a range of issues, including licensure, in response to COVID-19. As noted previously, the AMA engages in robust federal and state telehealth advocacy and routinely weighs in on a range of telehealth policy proposals related to licensure, payment, coverage, technology and equity. Federal legislation addressing licensure includes the Temporary Reciprocity to Ensure Access to Treatment Act or the TREAT Act (S 168/HR 708), which would provide nationwide temporary licensing reciprocity for telehealth and in-person care during the public health emergency and for 180 days thereafter. The AMA is neutral on this legislation

because it specifies that health professionals providing care across state lines will be subject to the jurisdiction of the state in which the patient is located. The Equal Access to Care Act (S 155/HR 688) would allow health professionals in one state to provide telemedicine in states where they are not licensed during the public health emergency and for 180 days thereafter. The site of care in this legislation is considered to be the state where the health professional is located. More broadly, in response to the COVID-19 pandemic the AMA has:

- sought and secured broad telehealth coverage expansion and improved payments at the federal and state levels to increase access to care and provide patients with a safer way to receive care;
- secured introduction of legislation to make key telehealth policy changes permanent; and
- obtained permanent ability to use smart phones for Medicare telehealth services.

DISCUSSION

Once the COVID-19 pandemic was declared a public health emergency, many states quickly waived licensure requirements so that physicians licensed in one state could provide medical care—including via telehealth—to patients in another state. Scores of executive orders and regulatory actions that expanded coverage for and payment of telehealth led to a substantial surge in virtual services, enabling physicians to provide uninterrupted continuity of care amidst stay-at-home orders and helping to ease physician shortages in areas hardest hit by COVID-19. The AMA continues to hear success stories from patients and physicians who view the expansion of telehealth positively and are more comfortable with telehealth than ever before. The Council encourages continued assessment of the experiences of physicians who have used licensing flexibilities to provide telehealth across state lines as well as the impact of virtual services on care quality and patient outcomes. The Council also understands the challenges facing physician practices trying to compete with corporate telehealth entities—including those contracting with payers to provide telehealth—and how these challenges may increase post-pandemic.

The Council is mindful that physicians hold strong, divergent opinions about interstate telehealth and whether the licensure flexibilities put in place during the public health emergency should be made permanent. Some proponents want to abandon the prevailing standard that physicians must be licensed in the state where the patient is located and move toward national licensure and/or federal oversight of interstate telehealth. Other physicians prefer to uphold the state-based licensing structure—which dates to the 1800s and is embedded in state authority granted by the 10th Amendment—and continue treating the location of the patient (originating site) as the site of service. The Council continues to believe that patient safety should remain the primary consideration and that licensure of physicians and other health professionals should remain within the purview of each state. Proposals to change which state is responsible for overseeing the physician from the state where the patient is located to the physician's home state would likewise change which state's medical practice and scope laws apply to the care rendered. Such proposals would interfere with states' investigative and disciplinary authorities and also raise enforcement concerns since states are generally unable to investigate incidents that happen in another state.²⁰ Similarly, states cannot take action against the license of a physician in another state.

Considering the differing views among physicians and the issues raised in paragraphs (b) and (d) of the second Resolve of Alternate Resolution 203-Nov-20, the Council focused its deliberations on helping physicians, practices and patients by allowing physicians to treat existing patients wherever they are, thereby preserving those patient relationships, ensuring continuity of care, and permitting specialist care for complex patients and the seriously ill. Consistent with Policy H-480.969, the Council affirmed in its 2019 report that, where there is an established patient relationship, a physician should be able to use telemedicine to provide quality emergent or urgent care for a patient's existing condition when that patient is traveling in another state. In this report, the Council suggests broadening the scope of that statement and address a frustration common among physicians—that they are prohibited by most states from using telehealth to provide longitudinal care to existing patients whom they have seen in the office but who may live across a state border, attend college in another state, or travel for work or seasonally. The Council believes that multiple pathways are available to states to facilitate interstate telehealth for continuity of care purposes, including exceptions to state licensing laws, reciprocity agreements, or possibly other solutions not yet proffered. Accordingly, the Council recommends that the AMA work with FSMB, state medical associations and other stakeholders to encourage states to allow an out-of-state physician to use telehealth to provide continuity of care to an existing patient if certain conditions are met. The Council further recommends amending Policy H-480.969 by addition to codify the previous recommendation in AMA telehealth licensure policy. Because Policy H-480.969 currently prohibits the use of telehealth to provide medical opinions and e-consults between physicians in different states, the Council recommends additional amendments by deletion to update this policy to reflect current practice.

The Council believes these recommendations will increase physician and patient satisfaction with health care, reduce physician licensure-related costs and administrative burdens, help sustain physician practices as they continue to recover from the economic impacts of COVID-19, and address the needs of individuals with disabilities or complex health conditions who lack access to specialty care locally and would benefit from virtual visits with out-of-state specialist physicians. Additionally, as discussed in Council on Medical Service Report 7-JUN-21, these recommendations have the potential to address long-standing health inequities among marginalized and minoritized communities.

The Council is aware of efforts at the state level to streamline or otherwise facilitate interstate licensure through reciprocity or other means. To ensure that our AMA can support such efforts if they align with existing policy, the Council recommends continued support for state efforts to expand physician licensure recognition across state lines in accordance with the standards and safeguards outlined in Policy H-480.946. The Council continues to support the IMLC as an important licensure solution and hopes that the states that have not joined the Compact elect to do so. Accordingly, the Council recommends that Policy H-480.946 be reaffirmed. Finally, the Council recommends reaffirmation of Policy H-480.946, which delineates standards and safeguards that should be met for the coverage and payment of telemedicine.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolve 2, Items (b) and (d) of Alternate Resolution 203-Nov-20, and that the remainder of the report be filed.

[Editor's note: Recommendation 1 referred for decision.]

1. That our American Medical Association (AMA) work with the Federation of State Medical Boards, state medical associations and other stakeholders to encourage states to allow an out-of-state physician to use telehealth to provide continuity of care to an existing patient in the state without penalty if the following conditions are met:
 - a) The physician has an active license to practice medicine in a state or US territory and has not been subjected to disciplinary action.
 - b) There is a pre-existing and ongoing physician-patient relationship.
 - c) The physician has had an in-person visit(s) with the patient.
 - d) The telehealth services are incident to an existing care plan or one that is being modified.
 - e) The physician maintains liability coverage for telehealth services provided to patients in states other than the state where the physician is licensed.
 - f) Telehealth use complies with Health Insurance Portability and Accountability Act privacy and security rules.

[Editor's note: Recommendations 2 to 5 adopted.]

2. That our AMA amend Policy H-480.969[1] by addition and deletion as follows:

The Promotion of Quality Telemedicine H-480.969

(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:

~~(a) application to situations where there is a telemedical transmission of individual patient data from the patient's state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board's state;~~

~~(ba) exemption from such a licensure requirement for traditional informal physician-to-physician consultations ("curbside consultations") that are provided without expectation of compensation;~~

~~(eb) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and~~

~~(c) allowances, by exemption or other means, for out-of-state physicians providing continuity of care to a patient, where there is an established ongoing relationship and previous in-person visits, for services incident to an ongoing care plan or one that is being modified.~~

(d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices.

3. That our AMA continue to support state efforts to expand physician licensure recognition across state lines in accordance with the standards and safeguards outlined in Policy H-480.946, Coverage and Payment for Telemedicine.
4. That our AMA reaffirm Policy D-480.964, which directs the AMA to work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact to consider joining the Compact; advocate for reduced application and state licensure(s) fees processed through the Interstate Medical Licensure Compact; and work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services.
5. That our AMA reaffirm Policy H-480.946, which delineates standards and safeguards that should be met for the coverage and payment of telemedicine, including that physicians and other health practitioners must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by the state's medical board.

REFERENCES

1. Kane, C. Key Findings from the AMA 2012-2020 Physician Practice Benchmark Surveys.
2. COVID-19 Healthcare Coalition. Telehealth Impact: Physician Survey Analysis. Last updated Nov. 2020. Available online at: <https://c19hcc.org/static/catalog-resources/telehealth-physician-survey-analysis-c19hcc.pdf>.
3. *Ibid.*
4. *Ibid.*
5. Federation of State Medical Boards. Understanding Medical Regulation in the United States. Available online at: <https://www.fsmb.org/siteassets/education/pdf/best-module-text-intro-to-medical-regulation.pdf>.
6. Federation of State Medical Boards. Telemedicine Policies: Board by Board Overview. July 2020. Available online at: https://www.fsmb.org/siteassets/advocacy/key-issues/telemedicine_policies_by_state.pdf.
7. The Interstate Medical Licensure Compact website: <https://imlcc.org/>.
8. *Ibid.*
9. Federation of State Medical Boards. Advocacy Network News. April 1, 2020.
10. The Interstate Medical Licensure Compact website: <https://www.imlcc.org/information-for-states/>
11. The Interstate Medical Licensure Compact website: <https://www.imlcc.org/what-does-it-cost/>
12. American Medical Association. COVID-19 Physician practice financial impact survey. 2020. Available online at: <https://www.ama-assn.org/system/files/2020-10/covid-19-physician-practice-financial-impact-survey-results.pdf>
13. *Ibid.*
14. Colorado's Medical Practice Act [§ 12-240-107(3)(b)]
15. Federation of State Medical Boards. Telemedicine Policies: Board by Board Overview. July 2020. Available online at: https://www.fsmb.org/siteassets/advocacy/key-issues/telemedicine_policies_by_state.pdf.
16. Uniform Law Commission. Emergency Volunteer Health Practitioners Act. Available online at: <https://www.uniformlaws.org/committees/community-home?CommunityKey=565933ce-965f-4d3c-9c90-b00246f30f2d>
17. National Conference of State Legislatures. Universal Licensure Recognition. March 2, 2021. Available online at: <https://www.ncsl.org/research/labor-and-employment/universal-licensure-recognition.aspx>
18. Sports Medicine Licensure Clarity Act of 2018. Available online at: <https://www.congress.gov/bill/115th-congress/house-bill/302?q=%7B%22search%22%3A%5B%22Sports+Medicine+Licensure+Clarity+Act%22%5D%7D&r=1>
19. Centers for Medicare & Medicaid Services. COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers. Available online at: <https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf>
20. Mehrotra A, Nimgaonkar BA and Richman B. Telemedicine and Medical Licensure — Potential Paths for Reform. *New England Journal of Medicine*, Feb. 25, 2021. Available online at: <https://www.nejm.org/doi/full/10.1056/NEJMp2031608?query=TOC>

Appendix: Relevant AMA Policy

Policy H-480.946, "Coverage of and Payment for Telemedicine"

1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles:

- a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:
 - A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or
 - A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or
 - Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.

Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.

- b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.
- c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.
- d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.
- e) The delivery of telemedicine services must be consistent with state scope of practice laws.
- f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.
- g) The standards and scope of telemedicine services should be consistent with related in-person services.
- h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.
- i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.
- j) The patient's medical history must be collected as part of the provision of any telemedicine service.
- k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.
- l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.
- m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.

2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information.

3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine.

4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine.

5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models.

6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.

7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines. (CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed in lieu of Res. 815, I-15; Reaffirmed: CME Rep. 06, A-16; Reaffirmed: CMS Rep. 06, I-16; Reaffirmed: Res. 111, A-17; Reaffirmation: A-18; Reaffirmed: CMS Rep. 1, I-19)

Policy D-480.964, "Established Patient Relationships and Telemedicine"

Our AMA will: (1) work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact to consider joining the Compact as a means of enhancing patient access to and proper regulation of telemedicine services; (2) advocate to the Interstate Medical Licensure Compact Commission and Federation of State Medical Boards for reduced application fees and secondary state licensure(s) fees processed through the Interstate Medical Licensure Compact; and (3) work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services, in accordance with AMA Policy H-480.946, "Coverage of and Payment for Telemedicine." (CMS Rep. 1, I-19)

Policy H-480.969, "The Promotion of Quality Telemedicine"

(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:

(a) application to situations where there is a telemedical transmission of individual patient data from the patient's state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board's state;

(b) exemption from such a licensure requirement for traditional informal physician-to-physician consultations ("curbside consultations") that are provided without expectation of compensation;

(c) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and

(d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices.

(2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the interstate telemedicine approach adopted must accommodate these essential quality-related functions.

(3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as “educational tools”); Policy 410.987 (which identifies practice parameters as “strategies for patient management that are designed to assist physicians in clinical decision making,” and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties). (CME/CMS Rep., A-96; Amended: CME Rep. 7, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 6, A-10; Reaffirmed: CME Rep. 6, A-12; Reaffirmed in lieu of Res. 805, I-12; Reaffirmed: BOT Rep. 22, A-13; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed: CMS Rep. 1, I-19)

Policy D-480.969, “Insurance Coverage Parity for Telemedicine Service”

1. Our AMA will advocate for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers.

2. Our AMA will develop model legislation to support states’ efforts to achieve parity in telemedicine coverage policies.

3. Our AMA will work with the Federation of State Medical Boards to draft model state legislation to ensure telemedicine is appropriately defined in each state’s medical practice statutes and its regulation falls under the jurisdiction of the state medical board. (Res. 233, A-16; Reaffirmed: CMS Rep. 1, I-19)

Policy H-480.974, “Evolving Impact of Telemedicine”

Our AMA:

(1) will evaluate relevant federal legislation related to telemedicine;

(2) urges CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;

(3) urges professional organizations that serve medical specialties involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine;

(4) encourages professional organizations that serve medical specialties involved in telemedicine to develop appropriate educational resources for physicians for telemedicine practice;

(5) encourages development of a code change application for CPT codes or modifiers for telemedical services, to be submitted pursuant to CPT processes;

(6) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;

(7) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician’s Recognition Award, for educational consultations using telemedicine;

(8) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries; and

(9) will leverage existing expert guidance on telemedicine by collaborating with the American Telemedicine Association (www.americantelemed.org) to develop physician and patient specific content on the use of telemedicine services--encrypted and unencrypted. (CMS/CME Rep., A-94; Reaffirmation A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of Res. 805, I-12; Appended: BOT Rep. 26, A-13; Modified: BOT Rep. 22, A-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: CME Rep. 06, A-16; Reaffirmation: A-18)

State Authority and Flexibility in Medical Licensure for Telemedicine D-480.999

Our AMA will continue its opposition to a single national federalized system of medical licensure. (CME Rep. 7, A-99; Reaffirmed and Modified: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: BOT Rep. 3, I-14)

Policy D-275.994, “Facilitating Credentialing for State Licensure”

Our AMA: (1) encourages the Federation of State Medical Boards to urge its Portability Committee to complete its work on developing mechanisms for greater reciprocity between state licensing jurisdictions as soon as possible; (2) will work with the Federation of State Medical Boards (FSMB) and the Association of State Medical Board Executive Directors to encourage the increased standardization of credentials requirements for licensure, and to increase the number of reciprocal relationships among all licensing jurisdictions; (3) encourages the Federation of State Medical Boards and its licensing jurisdictions to widely disseminate information about the Federation’s Credentials Verification Service, especially when physicians apply for a new medical license; and (4) supports the FSMB Interstate Compact for Medical Licensure and will work with interested medical associations, the FSMB and other interested stakeholders to ensure expeditious adoption by the states of the Interstate Compact for

Medical Licensure and creation of the Interstate Medical Licensure Compact Commission. (Res. 302, A-01; Reaffirmed: CME Rep. 2, A-11; Reaffirmed: CME Rep. 6, A-12; Appended: BOT Rep. 3, I-14)

9. ADDRESSING PAYMENT AND DELIVERY IN RURAL HOSPITALS

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS REMAINDER OF REPORT FILED

See Policies H-290.976, D-290.979 and D-465.998

Despite legislative advances such as the Affordable Care Act (ACA) and Medicaid expansion bringing insurance coverage and health care accessibility to millions of Americans, rural Americans and the health care system intended to serve them continue to face a health care crisis. By most measures, the health of the residents of rural areas is significantly worse than the health of those in urban areas.¹ Though the American Medical Association (AMA) has policy on stabilizing and strengthening rural health, it does not have policy specifically addressing changes to payment and delivery for rural providers and hospitals to address the growing rural health crisis.

This report, initiated by the Council, provides background on the unique obstacles facing rural hospitals including financial challenges, the rural hospital payer mix, the costs of delivering services in the rural setting, and quality measurement and risk adjustment challenges. The report also details relevant AMA policy and provides recommendations to improve the rural hospital payment and delivery systems.

BACKGROUND

Sixty million Americans, almost one-fifth of the US population, live in a rural area. On average, rural residents are older, sicker, and less likely to have health insurance. They stay uninsured for longer and are less likely than their urban and suburban counterparts to seek preventive services. Moreover, they are more likely than urban and suburban residents to encounter possibly preventable deaths from heart disease, cancer, unintentional injuries, chronic lower respiratory disease, and stroke. Disparities in health outcomes continue to increase for this population compared to those living in urban and suburban areas. Rural residents tend to have higher rates of smoking, hypertension, and obesity. They also report less physical activity and have higher rates of poverty. Rural residents are also more likely to be Medicare or Medicaid beneficiaries. For example, Medicare and Medicaid make up over half of rural hospitals' net revenue.^{2,3} Additionally, 45 percent of children in rural areas are enrolled in Medicaid or Children's Health Insurance Program compared to 38 percent of children in urban areas.⁴

Those living in rural areas often must travel long distances to access the emergency department (ED) and physician offices, a barrier to care that can lead to delayed or forgone care, which can worsen their health status and increase the cost of care when they do receive it. They are more likely than urban and suburban residents to say that access to good doctors is a major problem in their community.⁵ Rural residents live an average of 10.5 miles from the nearest hospital compared with 5.6 miles and 4.4 miles for those in suburban and urban areas respectively.

From 2018 to 2020, 50 rural hospitals closed, a more than 30 percent increase in the number of closures compared to the 3 years prior.⁶ The closure of hospitals was generally preceded by financial losses caused by a combination of decreasing rural population and inadequate payments from health insurers. There are more than 2,000 rural hospitals across the country, and more than 800 (40 percent) of them are estimated to be at risk of closing. Most of the hospitals at risk of closing are small rural hospitals serving isolated rural communities.

These hospitals are frequently the principal or sole source of health care in their communities, including primary care as well as hospital services. The closure of these rural hospitals could cause the vulnerable populations they serve to lose access to health care and worsen health disparities.⁷ Rural hospitals also have more difficulty attracting physicians of varying specialties, which are essential to providing care to rural populations. Often, when a rural hospital closes, recruiting and retaining physicians in the local community becomes increasingly difficult, and the result is decreased access to care for the surrounding population.⁸ In addition, rural hospitals often serve as economic anchors in their communities, providing both direct and indirect employment opportunities and supporting the local economy.⁹ Rural hospitals are hubs of employment, public health, and community outreach initiatives.¹⁰ Their closure puts the already

vulnerable populations they serve at increased risk of losing access to health care, worsening health disparities, and negatively impacting the economy of the local area.¹¹

Meanwhile, the novel coronavirus (COVID-19) pandemic has highlighted the fragility of the rural health system and increased the financial threat to an unstable system. All hospitals experienced lower revenue due to canceled elective procedures and some routine care, while simultaneously facing higher expenses due to supplies, equipment, and staff to care for COVID-19 patients. Unlike large urban hospitals, small rural hospitals do not have financial reserves that they can use to cover these higher costs and revenue losses. Rural patients are also more likely to experience more severe impacts from COVID-19 because they are more likely to be obese and have chronic conditions such as diabetes and hypertension.¹² Temporary federal assistance during the pandemic helped many rural hospitals avoid closure during 2020, but the underlying financial problems may cause an increase in closures after the public health emergency ends. The financial impact of the pandemic on individuals living in rural areas has been significant, as many may have experienced unemployment or under employment on hourly jobs with limited benefits.

IMPACT OF PAYER MIX

A higher proportion of patients at rural hospitals are insured by Medicare and Medicaid than at urban hospitals.¹³ While having a high proportion of Medicare patients would be viewed as financially problematic at large hospitals, for many small rural hospitals, Medicare is their “best” payer because Medicare explicitly pays more to cover the higher costs of care in small rural hospitals.

About 75 percent of rural hospitals are classified as Critical Access Hospitals (CAHs), which provides cost-based payment for services provided to Medicare beneficiaries. To be designated as a CAH, a hospital must meet a set of criteria including but not limited to being located either more than 35 miles from the nearest hospitals (or CAH) or more than 15 miles in areas with mountainous terrain; maintain no more than 25 inpatient beds; furnish 24-hour emergency care 7 days a week; and operate a psychiatric or rehabilitation unit of up to 10 beds.¹⁴ It is important to note, however, that CAH payments apply only to beneficiaries with traditional Medicare, not those with private Medicare Advantage (MA) plans.

Most small rural hospitals lose money on Medicaid patients, but in some states, small rural hospitals also receive cost-based payments for Medicaid patients, and some states provide special subsidies to offset losses on Medicaid and uninsured patients.

For many small rural hospitals, the leading cause of negative margins is insufficient payment from private health insurance plans and MA plans. Many private health insurance plans pay less than the cost to deliver essential services in small rural hospitals, whereas private plan payments at most large hospitals are higher than the cost of delivering services.¹⁵ Although most hospitals lose money on Medicaid and care to the uninsured, larger hospitals can use profits on privately insured patients to cover those losses. In contrast, many small rural hospitals cannot cover losses on Medicaid and uninsured patients because the payments from private payers do not generate significant profits or may not even cover the costs of providing services to the privately insured patients.

COST OF DELIVERING SERVICES IN RURAL HOSPITALS AND CLINICS

Low patient volume represents a persistent challenge to the financial viability of rural hospitals. There is a minimum level of cost needed to maintain the staff and equipment required to provide a particular type of service, whether it be an ED, a laboratory, or a primary care clinic. As a result, the average cost per service will be higher at a hospital that has fewer patients. In addition, the hospital will need to incur a minimum level of overhead costs that include accounting and billing, human resources, medical records, information systems, and maintenance. These costs are allocated to each hospital service line, so the fewer services the hospital offers, the higher the cost for each service.¹⁶

The mix of fixed costs paired with low volumes can result in instances where the current fee-for-service payments are often not large enough to cover the cost of delivering services in small rural communities. For example, a hospital ED must be staffed by at least one physician around the clock regardless of how many patients visit the ED. Generally, a small rural hospital will have fewer ED visits, but the standby capacity cost remains fixed, which means the average cost per visit will be higher. Therefore, a payment per visit that is high enough to cover the average cost per service at a larger hospital will fail to cover the costs of the same services at a smaller rural hospital. Exacerbating this issue

is that some private plans pay small rural hospitals less than they pay larger hospitals for delivering the same services even though the cost per service at the rural hospital is intrinsically higher.¹⁷

Due to the low population density in rural areas, it is impossible for many rural hospitals to have enough patients to use the full minimum capacity of services such as an ED. Medicare explicitly pays small rural hospitals more to compensate for the higher average costs, but most other payers do not, which is why small rural hospitals have greater financial problems.

QUALITY MEASUREMENT CHALLENGES IN RURAL HOSPITALS

Current quality measurement systems are problematic for small rural hospitals. Many commonly used quality measures cannot be used in small rural hospitals because there are too few patients to reliably measure performance, and some measures are not relevant at all for small rural hospitals because they do not deliver the services being measured.¹⁸

Rural hospital volume varies significantly for several reasons including the population of the community, the age and health status of the population, the availability of other primary care options, and the accessibility of the hospital. Many currently used quality measures are not applicable to numerous types of patients and aspects of care, and many focus on a specific condition or service. Accordingly, many rural hospitals cannot achieve a meaningful sample size because they do not have enough patients with that specific condition. Moreover, rural hospitals often face challenges reporting quality measurement data due to limited staff, time, and infrastructure.

The typical value-based payment system of bonuses and penalties often penalizes rural providers and hospitals. Again, the small patient panels inherent in rural care mean that providers can easily be penalized for random variation over which they have no control.¹⁹

RISK ADJUSTMENT CHALLENGES IN RURAL HOSPITALS

In addition to the reliability problems in measurement caused by small populations, the differences between rural and urban populations with respect to age, health status, and ability to access services makes risk adjustment of quality and spending measures essential. Random variation and outlier patients make risk adjustment scores less accurate at small hospitals than at hospitals with large patient populations.²⁰ The greater statistical variation at rural hospitals often leads to quality incentive payments going to higher volume hospitals that can achieve lower standard deviations but are not necessarily delivering higher quality care.

Moreover, risk adjustment is based on diagnosis codes recorded on claims forms. Since payments to CAHs do not depend on what diagnoses a patient has, diagnosis codes tend to be underreported by rural hospitals.²¹ Also, the use of diagnosis codes can fail to capture risk appropriately including the lack of a comorbid condition diagnosis due to barriers to care such as distance from the health care setting and lack of support services in the community. As a result, rural hospitals and clinics can appear to have healthier patients or worse outcomes than they really do. Risk adjustment can also make spending in rural communities appear higher than it is. For example, MA risk adjustment scores fail to accurately measure the true differences in patient health because the hierarchical condition category coding used in MA payments are retrospective based on past chronic conditions, not acute or new chronic conditions. Therefore, there is no risk adjustment for patients with injuries, acute conditions, or those newly diagnosed with cancer or diabetes, among other conditions. Likewise, the higher barriers for rural patients to obtain preventive care can cause a more severe presentation of diseases once finally diagnosed, requiring higher costs of care and poorer absolute outcomes.

RELEVANT AMA POLICY

The AMA has significant policy on rural health. Policy H-465.994 supports the AMA's continued and intensified efforts to develop and implement proposals for improving rural health care. AMA policy specific to rural hospitals includes Policy H-165.888 stating that any national legislation for health system reform should include sufficient and continuing financial support for rural hospitals. Policy H-465.990 encourages legislation to reduce the financial constraints on small rural hospitals to improve access to care. Policy H-465.999 asks for a more realistic and humanitarian approach toward certification of small, rural hospitals. Policy H-465.979 recognizes that economically viable small rural hospitals are critical to preserving patient access to high-quality care and provider sustainability in

rural communities. Policy D-465.999 calls on the Centers for Medicare & Medicaid Services to support individual states in their development of rural health networks; oppose the elimination of the state-designated CAH “necessary provider” designation; and pursue steps to require the federal government to fully fund its obligations under the Medicare Rural Hospital Flexibility Program.

Policy H-385.913 discusses payment and delivery reform in the context of the shift away from volume to value. The policy states that alternative payment models (APMs) must provide flexibility to physicians to deliver the care their patients need. Policy H-385.913 also calls for APMs to be feasible for physicians in every specialty and for practices of every size to participate in. Importantly, Policy D-385.952 directs the AMA to continue encouraging the development and implementation of APMs that provide services to improve the health of vulnerable and high-risk populations, including those in rural areas.

Finally, the AMA has long-standing policy in support of reasonable and adequate Medicaid payments. Policy H-290.976 advocates that Medicaid payments to medical providers be at least 100 percent of Medicare payment rates. Policy H-290.997 promotes greater equity in the Medicaid program through adequate payment rates that assure broad access to care. Further, Policy D-290.979 supports state efforts to expand Medicaid eligibility as authorized by the ACA.

DISCUSSION

Long-term solutions are needed to effectively address the health needs of the rural population. Preventing the closure of rural hospitals that provide essential services is a first step. Rural hospitals must be paid adequately to support the costs of delivering essential services, and they should have the flexibility to tailor available services to the needs of their local populations.

To begin accomplishing its goal of providing adequate payment for rural hospital services, the Council recommends reaffirming Policy D-290.979 directing our AMA to support state efforts to expand Medicaid eligibility, and reaffirming Policy H-290.976 stating that Medicaid payments be at least 100 percent of Medicare payment rates. Medicaid eligibility and enrollment are evidence-based factors strengthening the viability of rural hospitals. Medicaid expansion, particularly if it is accompanied by adequate payments, will improve hospital financial performance and sustainability, and lower the likelihood of closure, especially in those rural markets with large numbers of uninsured patients. For example, since 2010, of the eight states with the highest levels of rural hospital closures, none are Medicaid expansion states. A key cause of financial losses at most rural hospitals is the volume of care provided to uninsured patients, so a key component of any strategy for sustaining rural health care services is increasing the number of insured residents.

The Council identified the need for better and more reliable payment for rural hospitals that support their sustainability and recommends that a series of policies be adopted to ensure that payment to rural hospitals is adequate and appropriate. Since small rural hospitals need to sustain essential services even with low volumes of services, the Council recommends that health insurance plans provide such hospitals with a capacity payment to support the minimum fixed costs of essential services, including surge capacity, acknowledging that a small rural hospital requires a baseline of staffing and expenses to remain open regardless of volume. It is also recommended that payers provide adequate service-based payments to cover the costs of services delivered in small communities. The Council also recommends that the capacity payment provide adequate support for physician standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner. Regarding quality measurement, the Council recommends only using quality measures that are relevant for rural hospitals and setting minimum volume thresholds for measures to ensure statistical reliability and avoiding financial penalties that might occur from failing to have met specific quality metrics due to lower volumes. To help effect these changes, the Council recommends encouraging employers and rural residents to choose health plans that adequately and appropriately pay the rural hospitals.

The Council notes that taking these steps to ensure adequate and reliable payment for rural hospitals is critical to addressing the barriers to procedural service lines. A small patient population and declining revenue stifles the ability of rural hospitals to add new service lines that not only attract needed specialists to underserved areas but also aid in the financial sustainability of a rural hospital. The Council believes that addressing payment issues for rural hospitals will help give those hospitals the flexibility to offer more complex services. In turn, those services will boost financial viability, allow small rural hospitals to hire and retain subspecialists, and ultimately increase patient access to care.

The Council also reiterates the need to address payment for primary care services at rural facilities. The Council recommends voluntary monthly payments for primary care providers so that physicians have the flexibility to deliver services in the most effective manner, particularly for those patients for whom travel is a significant barrier to care. Importantly, such monthly payments should include an allowance and expectation that some services would be provided via telehealth or telephone.

Additionally, the Council recommends policy that encourages transparency among rural hospitals regarding their costs and quality outcomes. It will be essential that rural hospitals publicly demonstrate that higher payments are needed to support the cost of delivering high quality care.

The challenges facing the rural health system are varied and complex. Although many steps are needed to ensure access to care and quality outcomes for the rural population, the Council offers these recommendations as a pragmatic step forward to address the needs of rural populations.

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 reaffirm Policy D-290.979 directing our AMA to support state efforts to expand Medicaid eligibility as authorized by the Affordable Care Act.
2. That our AMA reaffirm Policy H-290.976 stating that Medicaid payments to medical providers be at least 100 percent of Medicare payment rates.
3. That our AMA advocate that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate:
 - a. Create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume;
 - b. Provide adequate service-based payments to cover the costs of services delivered in small communities;
 - c. Adequately compensate physicians for standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner;
 - d. Use only relevant quality measures for rural hospitals and set minimum volume thresholds for measures to ensure statistical reliability;
 - e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability; and
 - f. Create voluntary monthly payments for primary care that would give physicians the flexibility to deliver services in the most effective manner with an expectation that some services will be provided via telehealth or telephone.
4. That our AMA encourages transparency among rural hospitals regarding their costs and quality outcomes.
5. That our AMA support better coordination of care between rural hospitals and networks of providers where services are not able to be appropriately provided at a particular rural hospital.
6. That our AMA encourage employers and rural residents to choose health plans that adequately and appropriately reimburse rural hospitals and physicians.

REFERENCES

1. Ollove, M. Rural America's Health Crisis Seizes States' Attention. Pew Trusts. Available at: <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2020/01/31/rural-americas-health-crisis-seizes-states-attention>
2. Rural and Urban Health. Georgetown University Health Policy Institute. Available at: <https://hpi.georgetown.edu/rural/>
3. Rural Hospital Closures: Number and Characteristics of Affected Hospitals and Contributing Factors. United States Government Accountability Office. Available at: <https://www.gao.gov/assets/700/694125.pdf>

4. Medicaid Works for People in Rural Communities. Center on Budget and Policy Priorities. Available at: <https://www.cbpp.org/research/health/medicaid-works-for-people-in-rural-communities>
5. Lam, O. et al. How Far Americans Live from the Closest Hospital Differs by Community Type. Pew Research Center. Available at: <https://www.pewresearch.org/fact-tank/2018/12/12/how-far-americans-live-from-the-closest-hospital-differs-by-community-type/>
6. *Supra* note 3.
7. Barker, A. et al. Can the Market Deliver Affordable Health Insurance Options in Rural Areas? Health Affairs Blog. Available at: <https://www.healthaffairs.org/doi/10.1377/hblog20190104.599904/full/>
8. Wishner, J, et al. A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies. Kaiser Family Foundation. Available at: <https://www.kff.org/report-section/a-look-at-rural-hospital-closures-and-implications-for-access-to-care-three-case-studies-issue-brief/>
9. *Supra* note 7.
10. *Id.*
11. Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-Quality, Affordable Care. American Hospital Association. Available at: <https://www.aha.org/system/files/2019-02/rural-report-2019.pdf>
12. Thomas, S. et al. Alternatives to Hospital Closure: Findings from a National Survey of CAH Executives. North Carolina Rural Health Research Program. Available at: <https://www.shepscenter.unc.edu/download/22075/>
13. *Supra* note 10.
14. Critical Access Hospitals. Centers for Medicare & Medicaid Services. Available at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/CAHs>
15. Miller, H. Saving Rural Hospitals and Sustaining Rural Healthcare. Center for Healthcare Quality & Payment Reform. Available at: https://www.chqpr.org/downloads/Saving_Rural_Hospitals.pdf
16. *Id.*
17. *Id.*
18. *Id.*
19. *Id.*
20. *Supra* note 7.
21. *Supra* note 14.