AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (J-22)

Report of the Private Practice Physicians Section Reference Committee

Ronnie Dowling, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Resolution 0 – Joseph Heyman, MD, Memorial Resolution

RECOMMENDED FOR ADOPTION AS AMENDED

2. Resolution 1 – Advocacy of Private Practice Options for Healthcare Operations in Large Corporations
3. Resolution 2 – Maintaining an Open and Equitable Hospital Work Environment for Specialists
4. Resolution 3 – Prior Authorization – Patient Autonomy
5. Resolution 5 – Physician Payment Reform & Equity
6. Resolution 6 – Stakeholder Management in Medicare Administrative Contractor Policy Processes

RECOMMENDED FOR NOT ADOPTION

7. Resolution 4 – Outsourcing of Administrative and Clinical Work to Different Time Zones – An Issue of Equity, Diversity, and Inclusion

RECOMMENDED FOR ADOPTION

(1) RESOLUTION 0 – JOSEPH HEYMAN, MD, MEMORIAL RESOLUTION

RECOMMENDATION:

Resolution 0 be <u>adopted</u>.

RESOLVED, That our American Medical Association acknowledge with deep gratitude and sincere appreciation the lifelong work performed by Joseph Heyman, MD, in service of the practice of medicine; and be it further

RESOLVED, That our AMA extend its heartfelt condolences to the family of Joseph Heyman, MD, and adopt this resolution as an expression of deepest respect for our colleague and dear friend and our grief at his passing.

Your Reference Committee strongly supports adoption of Resolution 0 honoring the life and contributions of Dr. Joseph Heyman, a “founding father” of the Private Practice Physicians Section, an esteemed colleague, and a dear friend. Dr. Heyman’s contributions to the section are notable, not only in his tireless advocacy for private practice and the voice of private practice physicians within the AMA, but also for the award that bears his name and will serve as a mechanism for the PPPS to continue to honor his legacy. The Committee joins the Section as a whole in expressing its sympathy to Dr. Heyman’s family and it’s gratitude for his presence in the AMA.

RECOMMENDED FOR ADOPTION AS AMENDED

(2) RESOLUTION 1 – ADVOCACY OF PRIVATE PRACTICE OPTIONS FOR HEALTHCARE OPERATIONS IN LARGE CORPORATIONS

RECOMMENDATION A:

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

RESOLVED, That our American Medical Association study the best method to create pilot programs which advance the advocacy of private practice and small business medicine within the rapidly growing area of internal healthcare within Fortune 500 corporations in America with a report back at Annual 2022~~2~~3 (Directive to Take Action); and be it further

RECOMMENDATION B:

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

RESOLVED, that our AMA prioritize advocacy efforts that emphasize small private practice utilization within the investment and business efforts ~~that~~ of Fortune 500 corporations that are currently ~~undertaking~~ seeking to enter into the healthcare industry (Directive to Take Action)~~; and be it further~~.

RECOMMENDATION C:

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

RESOLVED, That our AMA use proposals for the advocacy of small business medicine and private practice models in healthcare as a pilot project in the development of advocacy programs within major leading corporations like Amazon and Walmart which are currently entering the healthcare service market with internalized models of healthcare in the complete absence of more diverse private practice (small business) options (Directive to Take Action)~~.~~; and be it further

RECOMMENDATION D:

The second and third resolves in Resolution 1 be amended to switch places so that the second resolve becomes the third resolve and the third resolve becomes the second resolve.

RECOMMENDATION E:

Resolution 1 be adopted as amended.

RESOLVED, That the AMA study the best method to create pilot programs which advance the advocacy of private practice and small business medicine within the rapidly growing area of internal healthcare within Fortune 500 corporations in American with a report back at Annual 2022 (Directive to Take Action); and be it further

RESOLVED, That our AMA prioritize advocacy efforts that emphasize small private practice utilization within the investment and business efforts that Fortune 500 corporations are currently undertaking into the healthcare industry (Directive to Take Action); and be it further

RESOLVED, That our AMA use proposals for the advocacy of small business medicine and private practice models in healthcare as a pilot project in the development of advocacy programs within major leading corporations like Amazon and Walmart which are currently entering the healthcare service market with internalized models of healthcare in the complete absence of more diverse private practice (small business) options (Directive to Take Action).

Your Reference Committee heard testimony in strong support of Resolution 1 in the Online Forum and agreed with comments there that the advocacy encouraged in the resolution is work that is appropriate for the AMA to be engaging in. Understanding that this resolution was originally offered in November of 2022, the Committee updated the report back timeline to keep the resolution feasible. It also recommends shifting the second and third resolves to more clearly tie the proposals mentioned in resolve three with the study mentioned in resolve one, which the Committee believes reflects the intent of the author. The Committee proposes minor changes to grammar in the second resolve to clarify intent.

(3) RESOLUTION 2 – MAINTAINING AN OPEN AND EQUITABLE HOSPITAL WORK ENVIRONMENT FOR SPECIALISTS

RECOMMENDATION A:

The first resolve in Resolution 2 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~takes the position that there should be~~ support equal promotion of, and access to inpatient consults for, credentialed and privileged community /independent specialty physicians ~~as for~~ on par with hospital-employed specialty physicians (New HOD Policy); and be it further

RECOMMENDATION B:

The second resolve in Resolution 2 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate that hospitals ~~engage~~ support having community/independent and employed specialty physicians if credentialled available ~~on the medical staff~~ for observation, inpatient, and emergency department coverage ~~and that the parties negotiate mutually satisfactory payment terms and service agreements for such service~~ thus ensuring that physician referrals and consults be based on physician and patient choice (Directive to Take Action).

RECOMMENDATION C:

Resolution 2 be adopted as amended.

RESOLVED, That our American Medical Association takes the position that there should be equal promotion of, and access to inpatient consults for, credentialed and privileged community /independent specialty physicians as for hospital-employed specialty physicians (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that hospitals engage community/independent specialty physicians available on the medical staff for observation, inpatient, and emergency department coverage and that the parties negotiate mutually satisfactory payment terms and service agreements for such service (Directive to Take Action).

Your Reference Committee heard supportive testimony of Resolution 2 with respondents agreeing with the need for AMA action. Several respondents in the Online Forum experienced the situations Resolution 2 outlines personally; members of the Committee did as well. The Committee considered proposals for additional resolve clauses, but believed that keeping the two that existed was the best method for keeping to authorial intent. The Committee did believe, however, that additional consideration was needed to ensure that closed health systems would be able to comply with the policy should the AMA enact it. To this end, your Reference Committee proposes the recommendations above which are designed to keep to the spirit of the resolution but make allowances for health systems which must draw from a closed pool of physicians, including credentialled independent physicians and credentialled employed ones.

(4) RESOLUTION 3 – PRIOR AUTHORIZATION – PATIENT AUTONOMY

RECOMMENDATION A:

The resolve in Resolution 3 be <u>amended by deletion</u> to read as follows:

RESOLVED, That our American Medical Association will advocate that patients should be given access to an electronic prior authorization system by their health plans with the ability to ~~initiate and~~ monitor the electronic prior authorization process in any model legislation and as a basis for all advocacy for prior authorization reforms (Directive to Take Action).

RECOMMENDATION B:

Resolution 3 be <u>adopted as amended</u>.

RESOLVED, That our American Medical Association will advocate that patients should be given access to an electronic prior authorization system by their health plans with the ability to initiate and monitor the electronic prior authorization process in any model legislation and as a basis for all advocacy for prior authorization reforms (Directive to Take Action).

Your Reference Committee heard uniformly supportive testimony of Resolution 3, with several respondents voicing approval for the innovative approach to managing prior authorizations. The Committee had no disagreement with respondents or with the resolution. However it did debate how patients would initiate prior authorization processes given that a course of treatment should be determined by the physician, thus making the physician ultimately responsible for initiating the authorization. The Committee remained supportive of the notion that patients should have the ability to monitor the progress of their prior authorization status, however. To that end, the Committee proposes removing language that patients initiate electronic prior authorization while maintaining the ability to monitor the authorization to clarify responsibility for the process.

(5) RESOLUTION 5 – PHYSICAN PAYMENT REFORM & EQUITY

RECOMMENDATION A:

The second resolve in Resolution 5 be <u>amended by deletion</u> to read as follows:

RESOLVED, That our AMA place Physician Payment Reform & Equity as the ~~single highest~~ advocacy priority of our organization (Directive to Take Action); and be it further

RECOMMENDATION B:

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

RESOLVED, That our AMA use ~~every~~ multiple resources ~~at its disposal~~, including but not limited to elective, legislative, regulatory, and lobbying efforts, to advocate for an immediate increase in Medicare physician payments to help cover the expense of office practices (Directive to Take Action); and be it further

RECOMMENDATION C:

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

RESOLVED, That ~~in addition to an immediate increase in Medicare physician payments,~~ our AMA advocate for a statutory annual update in such payments that would equal or exceed the Medicare Economic Index or the Consumer Price Index, whichever is most advantageous in covering the continuously inflating costs of running an office practice (Directive to Take Action); and be it further

RECOMMENDATION D:

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

RESOLVED, That our AMA establish a Task Force appointed by the Board of Trustees to outline a specific set of steps that are needed to accomplish the goals of Physician Payment Reform & Equity and ~~report back to the HOD at Interim 2022 regarding that plan (Directive to Take Action); and be it further~~ report back to the HOD at each subsequent Annual meeting regarding their progress on meeting the goals of Physician Payment Reform & Equity until PPR&E is accomplished (Directive to Take Action).

RECOMMENDATION E:

The sixth resolve in Resolution 5 be deleted.

~~RESOLVED, That our AMA Board of Trustees report back to the HOD at each subsequent meeting regarding their progress on meeting the goals of Physician Payment Reform & Equity until PPR & E is accomplished (Directive to Take Action).~~

RECOMMENDATION F:

Resolution 5 be adopted as amended.

RESOLVED, That our American Medical Association define Physician Payment Reform and Equity (PPR & E) as "improvement in physician payment be Medicare and other third-party payers so that physician reimbursement covers current office practice expenses at rates that are fair and equitable, and that said equity include annual updates in payment rates" (New HOD Policy); and be it further

RESOLVED, That our AMA place Physician Payment Reform & Equity as the single highest advocacy priority of our organization (Directive to Take Action); and be it further

RESOLVED, That our AMA use every resource at its disposal, including but not limited to elective, legislative, regulatory, and lobbying efforts, to advocate for an immediate increase in Medicare physician payments to help cover the expense of office practices (Directive to Take Action); and be it further

RESOLVED, That in addition to an immediate increase in Medicare physician payments, our AMA advocate for a statutory annual update in such payments that would equal or exceed the Medicare Economic Index or the Consumer Price Index, whichever is most advantageous in covering the continuously inflating costs of running an office practice (Directive to Take Action); and be it further

RESOLVED, That our AMA establish a Task Force appointed by the Board of Trustees to outline a specific set of steps that are needed to accomplish the goals of Physician Payment Reform & Equity and report back to the HOD at Interim 2022 regarding that plan (Directive to Take Action); and be it further

RESOLVED, That our AMA Board of Trustees report back to the HOD at each subsequent meeting regarding their progress on meeting the goals of Physician Payment Reform & Equity until PPR & E is accomplished (Directive to Take Action).

Your Reference Committee heard supportive testimony in favor of Resolution 5. The Committee also supported the intent of the resolution, however believed that mandating that payment reform be the "single highest advocacy" priority of the AMA was potentially problematic. Singling out one issue for sole priority could have unintended consequences in times of emergency or crisis. Additionally, designating an issue as the single highest priority could potentially put aside other advocacy activities that could generate real "wins" for physicians. The Committee felt similarly about requiring "every available resource" to achieve these goals. While the Committee agreed that physician payment absolutely should be a high priority for the AMA, it proposes minor changes to these directives to allow for other high priorities to co-exist alongside them.

Additionally, The Committee believed that six months to form a task force that would meet, engage in activity, and generate a report back is an unrealistic timeline. The Committee instead proposes a merging of the final two resolutions to allow one year for creation and engagement with continual reports at each year's Annual meeting instead. The Committee believes this timeline will yield better and more robust results.

(6) RESOLUTION 6 – STAKEHOLDER ENGAGEMENT IN MEDICARE ADMINISTRATIVE CONTRACTOR POLICY PROCESSES

RECOMMENDATION A:

The fourth resolve in Resolution 6 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate that Congress and the Department of Health and Human Services consider clarifying ~~legislative~~ language that reinstates a role for local Carrier Advisory Committees in review processes going forward, addressing unintended outcomes of changes in the 21st Century Cures Act that allowed local CACs to be left without a voice or purpose (Directive to Take Action).

RECOMMENDATION B:

Resolution 7 be adopted as amended.

RESOLVED, That our American Medical Association opposes Medicare Administrative Contractors (MACs) using Local Coverage Articles (LCAs) that could have the effect of restricting coverage or access without providing data and evidentiary review or without issuing associated Local Coverage Determinations (LCDs) and following required stakeholder processes (New HOD Policy); and be it further

RESOLVED, That our AMA advocate and work with the Centers for Medicare and Medicaid Services (CMS) to ensure no LCAs that could have the effect of restricting coverage or access are issued by MACs without the MAC providing public data, decision criteria, and evidentiary review and allowing comment, or without an associated LCD and the required LCD stakeholder review and input process, through the modernization requirement of the 21st Century Cures Act (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate to CMS that the agency immediately invalidate any LCAs that are identified as potentially restricting coverage or access and that were issued without the MACs providing public data, decision criteria, and evidentiary review, or that were issues without an associated LCD and the required stakeholder processes, and that CMS require MACs to restart those processes taking any such proposed changes through CLDs and associated requirements for stakeholder engagement, public data, and evidentiary review (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that Congress consider clarifying legislative language that reinstates a role for local Carrier Advisory Committees in review processes going forward, addressing unintended outcomes of changes in the 21st Century Cures Act that allowed local CACs to be left without a voice or purpose (Directive to Take Action).

Your Reference Committee heard generally supportive testimony in favor of Resolution 6. The Committee did question if the resolution may end up with a reaffirmation given the

volume of existing policy the AMA already has on the subject. After a review of existing AMA policy, the Committee determined that Resolution 6 likely articulated enough new policy and directive action to warrant serious consideration.

The Committee next considered that the final resolve was possibly too limiting in its construction, particularly because the action required to achieve the resolution's aims is unlikely to be accomplished by legislative action and the U.S. Congress alone. The Committee believed adding in the Department of Health and Human Services allows greater leeway for the AMA to advocate for regulatory action through the executive branch, effectively giving the resolution a better chance for success.

RECOMMENDED FOR NOT ADOPTION

(7) RESOLUTION 4 – OUTSOURING OF ADMINISTRATIVE AND CLINICAL WORK TO DIFFERENT TIME ZONES – AN ISSUE OF EQUITY, DIVERSITY, AND INCLUSION

RECOMMENDATION:

Resolution 4 be <u>not adopted</u>.

RESOLVED, That our American Medical Association support the policy and advocates for national legislature that health plans implement 12-hour availability for their support services staffed by outsources employees to allow local day shift work schedules for their own outsourced employees in different time zones and provider employees located in similar time zones (Directive to Take Action); and be it further

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

Your Reference Committee gave significant consideration to Resolution 4, appreciating the intent but grappling with the possible side effects that such a policy could have on patients. The Committee primarily is concerned that delays in prior authorizations or other approvals that have traditionally been outsourced to call centers or similar operations outside of the United States could result in adverse consequences for patients in need. The Committee considered amending Resolution 4 to call for a study to examine the potential effects of such a policy, but ultimately was not convinced that a study would be in the best interest of the AMA.

Your Reference Committee also considered that it is the responsibility of the Committee, and the PPPS at large, to only promote policies and actions that are a benefit to private practice, particularly small private practices. The Committee therefore was unable to recommend a policy that could reasonably be predicted to create delays in private practice operations and make it more difficult for private practice physicians to serve the needs of their patients and efficiently run their business.

Doctor Speaker, this concludes the report of the Private Practice Physicians Section Reference Committee. Each Committee member is pleased to present this report on behalf of the Private Practice Physicians Section and does not speak for our respective delegations or medical societies. I would like to thank Drs. Lynn Jeffers, Charles Rainey, Sheila Rege, and all those who testified before the Committee.

Ronnie Dowling, MD
Chair, Arizona Delegation

Lynn Jeffers, MD
Delegate, California Medical Association

Charles Rainey, MD, JD
Delegate, Wisconsin Medical Society

Sheila Rege, MD
Delegate, Washington State Medical Association