AMERICAN MEDICAL ASSOCIATION PRIVATE PRACTICE PHYSICIAN SECTION

Resolution: 5
(JUN-22)

Introduced by: Private Practice Physicians Section

Subject: Physician Payment Reform & Equity

Referred to: PPPS Reference Committee

WHEREAS, Physicians in independent practice are running small businesses and employ tens of thousands of American workers; and

WHEREAS, According to the Medicare Economic Index, the cost of running a medical practice increased 39 percent from 2001 to 2021; and

WHEREAS, The U.S. economy has entered a new inflationary cycle and the cost of retaining staff for a physician's office continues to increase with inflation; and

WHEREAS, According to data from the Medicare Trustees, Medicare physician pay has increased just 11 percent over the last 20 years while Medicare hospital payments increased by 60 percent from 2011 to 2021; and

WHEREAS, Adjusted for inflation, Medicare physician pay declined 20 percent from 2011 to 2021, which hospital payment far surpassed inflation in this period; and

WHEREAS, Cost/price pressures have reduced the number of independent practice physicians and have threatened the viability of independent medical practice; and

WHEREAS, The loss of the private practice of medicine will have a profound impact on the availability of high-quality, cost-effective medical care for many patients across the nation; and

WHEREAS, Improved payments for physician work will aid all physicians, both independent and employed, as increased payment for physician services will also improve the value of RVUs that our employed physician colleagues depend on for their compensation; and

WHEREAS, Our AMA has long had policy on improving payments for physician work, but it has little to show in terms of concrete actions and results to accomplish said policy; therefore be it

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).

Fiscal Note: Not yet determined

Received: 5/9/2022

RELEVANT AMA POLICY

Payment for Physicians Services (H-385.989)

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

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

Physician Payment Reform (H-390.849)

1. Our AMA will advocate for the development and adoption of physician payment reforms that adhere to the following principles:
a) promote improved patient access to high-quality, cost-effective care;
b) be designed with input from the physician community;
c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions;
d) not require budget neutrality within Medicare Part B;
e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice;
f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process;
g) make participation options available for varying practice sizes, patient mixes, specialties, and locales;
h) use adequate risk adjustment methodologies;
i) incorporate incentives large enough to merit additional investments by physicians;
j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols;
k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization;
l) attribution processes should emphasize voluntary agreements between patients and

physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and
m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.

2. Our AMA opposes bundling of payments in ways that limit care or otherwise interfere with a physician's ability to provide high quality care to patients.

3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data.

4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.

5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

Citation: CMS Rep. 6, A-09; Reaffirmed: A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-12; Modified: CMS Rep. 6, A-13, Raffirmed: I-15; Reaffirmed: A-16; Reaffirmed in lieu of Res. 712, A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17; Reaffirmed: A-19; Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19; Reaffirmed: BOT action in response to referred for decision Res. 132, A-19; Reaffirmed: Res. 212, I-21.

Remuneration for Physician Services (H-385.951)

1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.

Citation: Sub. Res. 814, A-96; Reaffirmed: A-02; Reaffirmed: I-08; Reaffirmed: I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of: Res. 719, A-11; Reaffirmed in lieu of: Res. 721, A-11; Reaffirmed: A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of: Res. 711, A-14; Reaffirmed: Res. 811, I-19

Cuts in Medicare and Medicaid Reimbursement (H-330.932)

Our AMA: (1) continues to oppose payment cuts in the Medicare and Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients; (2) supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the Medicare population, and the cost of new technology; (3) aggressively encourages CMS to affirm the patient's and the physician's constitutional right to privately contract for medical services; (4) if the reimbursement is not improved, the AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee; and (5) supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases.

Citation: Sub Res. 101, A-97; Reaffirmed: A-99 and Reaffirmed: Res. 127, A-99; Reaffirmed: A-00; Reaffirmed: I-00; Reaffirmed: BOT Action in response to referred for decision Res. 215, I-00; Reaffirmed: A-01; Reaffirmed and Appended: Res. 113, A-02; Reaffirmed: A-05; Reaffirmed in lieu of Res. 210, A-13; Reaffirmed: Res. 212, I-21

Payment for Copying Medical Records (H-335.980)

It is the policy of the AMA to seek legislation under which Medicare will be required to reimburse physicians and hospitals for the reasonable cost of copying medical records which are required for the purpose of postpayment audit. A reasonable charge will be paid by the patient or requesting entity for each copy (in any form) of the medical record provided.

Citation: Res. 161, I-90; Appended by Res. 819, A-98; Reaffirmed: A-08; Reaffirmed in lieu of Res. 710, A-14