IPPS Governing Council Report A – November 2021 Special Meeting

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I: Items for Consideration by the Integrated Physician Practice Section

Item #	Ref Com	Title and Sponsor(s)	Proposed Policy	Governing Council Recommendation
1	CCB	CEJA 02 – Amendments to Opinions 1.2.11, "Ethical Innovation in Medical Practice"; 11.1.2, "Physician Stewardship of Health Care Resources"; 11.2.1, Professionalism in Health Care Systems"; and 1.1.6, "Quality"	RECOMMENDATION In light of the foregoing, the Council on Ethical and Judicial Affairs recommend that Opinion 1.2.11, "Ethically Sound Innovation in Medical Practice"; Opinion 11.2.1, "Professionalism in Health Care Systems"; Opinion 11.1.2, "Physician Stewardship of Health Care Resources"; and Opinion 1.1.6, "Quality," be amended as follows and the remainder of this report be filed: …. 2. Opinion 11.2.1, Professionalism in Health Care Systems Containing costs, promoting high-quality care for all patients, and sustaining physician professionalism are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships. Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient. Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future—can affect patients' choices, the patient-physician relationship, and physicians' relationships with fellow health care professionals.	Delegate instructed to: 1) Support the changes made to Opinion 11.2.1 2) Support the intent of Opinion 11.1.2, but propose that the opinion revert to the original language.

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			Formularies, clinical practice guidelines, decision support tools that rely on augmented intelligence, and other ~~tools~~ mechanisms intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented. Physicians in leadership positions within health care organizations and the profession should ~~ensure that practices for financing and organizing the delivery of care~~: (a) Ensure that decisions to implement practices or tools for organizing the delivery of care are transparent and reflect input from key stakeholders, including physicians and patients. ~~(b) Reflect input from key stakeholders, including physicians and patients.~~ (c) Recognize that over reliance on financial incentives or other tools to influence clinical decision making may undermine physician professionalism. (d) Ensure ethically acceptable incentives that all such tools: (i) are designed in keeping with sound principles and solid scientific evidence. a. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles. b. Practice guidelines, formularies, and ~~other~~ similar tools should be based on best available evidence and developed in keeping with ethics guidance. c. Clinical prediction models, decision support tools, and similar tools such as those that rely on AI technology must rest on the highest-quality data and be independently validated in relevantly similar populations of patients and care settings. (ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities; (iii) are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism;	

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			(iv) mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians. (e) Encourage, rather than discourage, physicians (and others) to: (i) provide care for patients with difficult to manage medical conditions; (ii) practice at their full capacity, but not beyond. (f) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients. (g) ~~Are~~ Ensure that the use of financial incentives and other tools is routinely monitored to: (i) identify and address adverse consequences; (ii) identify and encourage dissemination of positive outcomes. All physicians should: (h) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems. (i) Advocate for changes ~~in health care payment and delivery models~~ how the delivery of care is organized to promote access to high-quality care for all patients. 3. Opinion 11.1.2, Physician Stewardship of Health Care Resources Physicians' primary ethical obligation is to promote the well-being of individual patients. Physicians also have a long-recognized obligation to patients in general to promote public health and access to care. This obligation requires physicians to be prudent stewards of the shared societal resources with which they are entrusted. Managing health care resources responsibly for the benefit of all patients is compatible with physicians' primary obligation to serve the interests of individual patients. To fulfill their obligation to be prudent stewards of health care resources, physicians should:	

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			(a) Base recommendations and decisions on patients' medical needs. (b) Use scientifically grounded evidence to inform professional decisions when available. (c) Help patients articulate their health care goals and help patients and their families form realistic expectations about whether a particular intervention is likely to achieve those goals. (d) Endorse recommendations that offer reasonable likelihood of achieving the patient's health care goals. (e) Use technologies that have been demonstrated to meaningfully improve clinical outcomes to ~~C~~choose the course of action that requires fewer resources when alternative courses of action offer similar likelihood and degree of anticipated benefit compared to anticipated harm for the individual patient but require different levels of resources. (f) Be transparent about alternatives, including disclosing when resource constraints play a role in decision making. (g) Participate in efforts to resolve persistent disagreement about whether a costly intervention is worthwhile, which may include consulting other physicians, an ethics committee, or other appropriate resource. Physicians are in a unique position to affect health care spending. But individual physicians alone cannot and should not be expected to address the systemic challenges of wisely managing health care resources. Medicine as a profession must create conditions for practice that make it feasible for individual physicians to be prudent stewards by: (h) Encouraging health care administrators and organizations to make cost data transparent (including cost accounting methodologies) so that physicians can exercise well-informed 8 stewardship. (i) Advocating that health care organizations make available well-validated technologies to enhance diagnosis, treatment planning, and prognosis and support equitable, prudent use of health care resources. (j) Ensuring that physicians have the training they need to be informed about health care costs and how their decisions affect resource utilization and overall health care spending.	

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			(k) Advocating for policy changes, such as medical liability reform, that promote professional judgment and address systemic barriers that impede responsible stewardship.	
2	F	CMS 04 – Financing of Home and Community-Based Services	RECOMMENDATIONS The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed: 1. That our American Medical Association (AMA) support federal funding for payment rates that promote access and greater utilization of home and community-based services (HCBS). (New 31 HOD Policy) 2. That our AMA support policies that help train, retain, and develop an adequate HCBS workforce (New HOD Policy) 3. That our AMA support efforts to simplify state plan amendments and Medicaid waivers to allow additional state flexibility to offer HCBS. (New HOD Policy) 4. That our AMA support that Medicaid's Money Follows the Person demonstration program be extended or made permanent. (New HOD Policy) 5. That our AMA support cross-agency and federal-state strategies that can help improve coordination] among HCBS programs and streamline funding and the provision of services. (New HOD Policy) 6. That our AMA support HCBS programs tracking protocols and outcomes to make meaningful comparisons across states and identify best practices. (New HOD Policy) 7. That our AMA support that the Centers for Medicare & Medicaid Services and private insurers ~~offer~~ extend flexibility to implement hospital at home programs ~~for the subset of patients who meet the criteria used by hospital at home programs~~ ~~beyond the public health emergency~~. (New HOD Policy)	Delegate instructed to support with amendment to #7 as drafted by the Governing Council and further amended by IPPS Staff.

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			8. That our AMA reaffirm Policy H-280.945, which provides a comprehensive set of principles to improve the financing of long-term services and supports and supports incentivizing states to expand the availability of and access to HCBS and permitting Medigap and Medicare Advantage plans to offer a respite care benefit. (Reaffirm HOD Policy) 9. That our AMA reaffirm Policy H-290.958 which supports increases in states' Federal Medical Assistance Percentages or other funding during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment. (Reaffirm HOD Policy)	

II: The Integrated Physician Practice Section Governing Council proposes the following items all be supported by the adoption of a consent calendar. Items below may be extracted by an IPPS member during the IPPS Business Meeting for discussion and debate:

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3	A	CMS 05 – Integrating Care for Individuals Dually Eligible for Medicare and Medicaid	RECOMMENDATIONS The Council on Medical Service recommends that the following recommendations be adopted and the remainder of the report be filed: 1. That our American Medical Association (AMA) support integrated care for individuals dually eligible for Medicare and Medicaid that aligns with AMA policy and meets the following criteria: a. Care is grounded in the diversity of dually eligible enrollees and services are tailored to individuals' needs and preferences. b. Coverage of medical, behavioral health, and long-term services and supports is aligned. c. Medicare and Medicaid eligibility and enrollment processes are simplified, with enrollment assistance made available as needed. d. Enrollee choice of plan and physician is honored, allowing existing patient physician relationships to be maintained. e. Services are easy to navigate and access, including in rural areas.

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			f. Care coordination is prioritized, with quality case management available as appropriate. g. Barriers to access, including inadequate networks of physicians and other providers and prior authorizations, are minimized. h. Administrative burdens on patients, physicians and other providers are minimized. i. Educational materials are easy to read and emphasize that the ability and power to opt in or out of integrated care resides solely with the patient. j. Physician participation in Medicare or Medicaid is not mandated nor are eligible physicians denied participation. (New HOD Policy) 2. That our AMA reaffirm Policy H-290.967, which establishes principles on the delivery of care and financing reform for Medicare and Medicaid dually eligible patients. (Reaffirm HOD Policy) 3. That our AMA reaffirm Policy D-290.978, which calls on the Centers for Medicare & Medicaid Services to require all states to develop processes to facilitate opting out of managed care programs by dual eligible individuals. (Reaffirm HOD Policy) 4. That our AMA reaffirm Policy H-165.822, which encourages new and continued partnerships to address non-medical health needs and the underlying social determinants of health; supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs; and encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health. (Reaffirm HOD Policy) That our AMA reaffirm Policy H-180.944, which states that health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health services, research and data collection; promoting equity in care; increasing health workforce diversity; influencing social determinants of health; and voicing and modeling commitment to health equity. (Reaffirm HOD Policy)
4	A	Res. 101 – Standardized Coding for Telehealth Services (Virginia)	RESOLVED, That our American Medical Association advocate by regulation and/or legislation that telehealth services are uniformly identified by using place of service (02) without any additional requirements, such as modifiers imposed by third party payors, for claim submission and reimbursement. (Directive to Take Action)
5	A	Res. 113 – Supporting Medicare Drug Price Negotiation	RESOLVED, That our American Medical Association aggressively advocate for passage of legislation that authorizes Medicare to negotiate drug prices with pharmaceutical companies to bring down the cost of prescription drugs for our patients (Directive to Take Action); and be it further

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		(California)	RESOLVED, That our AMA amend Policy H-110.980, "Additional Mechanisms to Address High and Escalating Pharmaceutical Prices" to support indexing Medicare Part D drug prices to a reasonable percentage of the prices paid in other large western industrialized nations by addition and deletion to read as follows: H-110.980 - Additional Mechanisms to Address High and Escalating Pharmaceutical Prices 2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles: ~~a. Any international drug price index or average should exclude countries that have single-payer health systems and use price controls;~~ ~~b. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;~~ a. Any international drug price index used to determine Medicare Part D drug prices should be based on a reasonable percentage of the drug's volume weighted net average price in at least six large western industrialized nations; ~~c.~~b. The use of any international drug price index or average should preserve patient access to necessary medications; ~~d.~~c. The use of any international drug price index or average should limit burdens on physician practices; and ~~e.~~d. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly.; and e. Any international drug price index used to determine Medicare Part D drug prices should ensure that American taxpayers are not unnecessarily subsidizing drug costs in other large western industrialized nations. (Modify Current HOD 27 Policy); and be it further RESOLVED, That our AMA support legislation that limits Medicare annual drug price increases to the rate of inflation (New HOD Policy); and be it further RESOLVED, That our AMA support legislation that reinvests a portion of any savings from Medicare drug price negotiation into the Medicare physician fee schedule and other Medicare physician value-based payments. (New HOD Policy)
6	B	BOT 10 – Physician Access to Their Medical and Billing Records	RECOMMENDATIONS In light of these considerations, the Board recommends that the following be adopted in lieu of Resolution 226-A-19 and the remainder of this report be filed:

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			1. That our AMA advocate that licensed physicians have unrestricted access to all their patients' billing records and associated medical records during employment or while under contract to provide medical or health care items or services. The records should also include any billing records submitted under the physician's name, regardless of whether the physician directly provided the item or service. (Directive to Take Action) 2. That our AMA advocate that, where physician possession of all his or her billing records is not already required by state law, the employment or other contractual arrangement between a physician and entity submitting claims on behalf of the physician should specify that the physician is entitled to copies of his or her billing records subsequent to the termination of employment or contractual arrangement, when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician. (Directive 37 to Take Action) That our AMA advocate for legislation or regulation to eliminate contractual language that bars or limits the treating physician's access to his or her billing records and associated medical records, such as treating these records as trade secrets or proprietary. (Directive to Take Action)
7	C	CME 01 – Guiding Principles and Appropriate Criteria for Assessing the Competency of Late Career Physicians	The Council on Medical Education therefore recommends that the following recommendations be adopted and that the remainder of the report be filed. 1. That our American Medical Association (AMA) support the following Guiding Principles on the Assessment of Late Career Physicians: a) Evidence-based: Guidelines for assessing and screening late career physicians should be 16 based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. Some physicians may suffer from declines in practice performance with advancing age. Research also suggests that the effect of age on an individual physician's competency can be highly variable; and since wide variations are seen in cognitive performance with aging, age alone should not be a precipitating factor. b) Ethical: Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines/standards for monitoring and assessing both their own and their colleagues' competency. c) Relevant: Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians' ability to perform the tasks specifically required in their practice environment.

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			d) Accountable: The ethical obligation of the profession to the health of the public and patient safety should be the primary driver for establishing guidelines and informing decision making about physician screening and assessment results. e) Fair and equitable: The goal of screening and assessment is to optimize physician competency and performance through education, remediation, and modifications to a physician's practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care. f) Transparent: Guidelines, procedures, or methods of screening and assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations, and standards against which performance will be judged and the possible outcomes of the screening or assessment. g) Supportive: Education and/or remediation practices that result from screening and /or assessment procedures should be supportive of physician wellness, ongoing, and proactive. h) Cost conscious: Procedures and screening mechanisms that are distinctly different from "for cause" assessments should not result in undue cost or burden to late career physicians providing patient care. Hospitals and health care systems should provide easily accessible screening assessments for their employed late career physicians. Similar procedures and screening mechanisms should be available to late career physicians who are not employed by hospitals and health care systems. (Directive to Take Action) 2. That our AMA encourage the Council of Medical Specialty Societies and other interested organizations to develop educational materials on the effects of age on physician practice. (Directive to Take Action) 3. That Policy D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians," be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)
8	C	CME 03 – Rural Health Physician Workforce Disparities	The Council on Medical Education therefore recommends that the following recommendation be adopted and the remainder of this report be filed: 1. That our AMA amend Policy H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage," by addition and deletion to read as follows: ~~Our AMA will undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies (such as telehealth) to alleviate rural physician workforce shortages. (4)~~ Our AMA will encourage ACGME review committees to consider adding exposure to rural medicine as appropriate, to encourage the development of rural program tracks in training programs and increase physician

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			awareness of the conditions that pose challenges and lack of resources in rural areas. (5) Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs. (Modify Current HOD Policy) 2. That our AMA monitor the status and outcomes of the 2020 Census to assess the impact of physician supply and patient demand in rural communities. (Directive to Take Action) 3. That our AMA amend Policy H-200.954, "US Physician Shortage," by addition to read as follows: "(13) will monitor the impact of initiatives to address rural physician workforce 3 shortages." (Modify Current HOD Policy) That our AMA reaffirm Policy H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage," which states, in part "(1.a) Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents. (1.b) Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians." (Reaffirm HOD Policy).
9	F	CLRPD 01 – Minority Affair Section Five-Year Review	RECOMMENDATION The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Minority Affairs Section through 2026 with the next review no later than the 2026 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)
10	F	CLRPD 02 – Integrated Physician Practice Section Five-Year Review	RECOMMENDATION The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Integrated Physician Practice Section through 2026 with the next review no later than the 2026 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)
11	G	Res. 701 – Coverage of Pregnancy-Associated Healthcare for 12 Months Postpartum for Uninsured Patients Ineligible for Medicaid (Medical Student Section)	RESOLVED, That our American Medical Association amend Policy H-290.974, "Extending Medicaid Coverage for One Year Postpartum," by addition as follows to read as follows: Extending Medicaid Coverage for One Year Postpartum D-290.974 1. Our AMA will work with relevant stakeholders to support extension of Medicaid coverage to 12 months postpartum.; and 2. Our AMA will work with relevant stakeholders to expand Medicaid eligibility for pregnant and postpartum non-citizen immigrants. (Modify Current HOD Policy); and be it further

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			RESOLVED, That our AMA amend Policy H-165.828, "Health Insurance Affordability," by addition as follows: H-165.828 – HEALTH INSURANCE AFFORDABILITY 1. Our AMA supports modifying the eligibility criteria for premium credits and cost sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to that which applies to the exemption from the individual mandate of the Affordable Care Act (ACA). 2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the affordability of employer-sponsored coverage with respect to the cost of family-based or employee-only coverage. 3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy. 4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible. 5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services. 6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges. 7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA. <u>Our AMA supports the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace.</u> (Modify Current HOD Policy)