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REPORT 29 OF THE BOARD OF TRUSTEES (A-24)
Transparency and Accountability of Hospitals and Hospital Systems
Reference Committee G

EXECUTIVE SUMMARY

At the 2023 Annual Meeting of the House of Delegates, Policy D-200.971, "Transparency and Accountability of Hospitals and Hospital Systems" was adopted. This policy directed the American Medical Association (AMA) to (1) identify options for developing and implementing processes – including increased transparency of physicians complaints made to the Equal Employment Opportunity Commission (EEOC) and The Joint Commission – for tracking and monitoring physicians complaints against hospitals and hospital systems and (2) report back with recommendations for implementing such processes, including potential revisions to the Health Care Quality Improvement Act (HCQIA) of 1986 to include monetary penalties for institutions performing bad-faith peer reviews (Directive to Take Action).

This report provides detailed information about multiple systems in place for physicians to report concerns about their health system or hospital employer. Barriers persist that prevent physicians from reporting patient care concerns or seeking recourse if a bad-faith peer review process has been initiated against them based on what they believe are unfounded, unfair allegations.

To our knowledge, no systems are in place to track and publicly report malpractice information or complaints against hospitals or health systems. It is the AMA's position that malpractice payment information should not be made public. AMA policy requires state medical boards report disciplinary action to the AMA and Federation of State Medical Boards, but does not endorse the public reporting of such information. The AMA does not support efforts to require the AMA, FSMB, The Joint Commission or any state or federal entity to dedicate resources to providing this information to the public; however, the AMA does support transparency of physician complaints against hospitals and hospital systems through publicly accessible channels, such as the Joint Commission Quality Check reports.

Considering (1) that organizations found to have conducted bad-faith peer reviews are not granted immunity by the HCQIA, (2) the AMA has historically opposed attempts to amend the HCQIA and (3) monetary penalties at the state level have not resulted in increased reporting or reduced incident rates, the AMA does not recommend new attempts to amend the HCQIA for the purposes of adding such penalties for organizations involved in bad-faith peer reviews.

Finally, the AMA, despite having an abundance of policy on the matter, has not published many resources to help physicians navigate the tumultuous processes of reporting concerns or being the subject of a peer review. This report makes a recommendation for the AMA to enhance content offerings on this topic.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 29-A-24

Subject: Transparency and Accountability of Hospitals and Hospital Systems

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee G

INTRODUCTION

At the 2023 Annual Meeting, the House of Delegates (HOD) adopted Policy D-200.971, "Transparency and Accountability of Hospitals and Hospital Systems." This resolution asked that our American Medical Association (AMA) (1) identify options for developing and implementing processes – including increased transparency of physicians complaints made to the Equal Employment Opportunity Commission (EEOC) and The Joint Commission – for tracking and monitoring physician complaints against hospitals and hospital systems and (2) report back with recommendations for implementing such processes, including potential revisions to the Health Care Quality Improvement Act (HCQIA) of 1986 to include monetary penalties for institutions performing bad-faith peer reviews.

BACKGROUND

Key issues raised by the resolution that resulted in Policy D-200.971 were (1) the perceived limitations for physicians to safely, and without fear of retaliation, report patient care concerns due to the large influence and market dominance many health systems have; (2) mistreatment of or retaliation against physicians who report concerns, including through the conduct of bad-faith peer reviews; (3) the lack of publicly available information about complaints against hospitals and health systems; and (4) the potential amendment of the HCQIA to add monetary penalties for entities found to have conducted bad-faith peer reviews. Testimony in the Reference Committee hearing on this resolution also indicated that access to information about complaints filed on health systems would be valuable to physicians considering new employment. This report will address these items, in addition to brief background on peer reviews and the HCQIA, and make recommendations for further HOD action.

DISCUSSION

Whistleblower reports

Physicians or other medical professionals may have the unfortunate experience of witnessing unethical behavior, an incident where a patient was harmed or a colleague committing some type of wrongdoing. Upholding the ethical standards of the profession is among the duties of all health care professionals, and part of fulfilling that duty includes reporting concerns and issues when they happen. Hospitals and health systems, who depend on high quality ratings and safety scores, as well as low numbers of safety violations, do not always receive these reports well. Although

unlawful, since whistleblowers are protected by dozens of laws, people who report complaints or concerns, or "whistleblowers," may be ostracized, pressured to withdraw their report or threatened with counter allegations. Worse, a hospital may turn against the complainant and punish them through other means of retaliation such as a false or fabricated peer review. Given the potential negative consequences, many health care workers may avoid reporting ethical or patient safety concerns out of fear for their own livelihood, safety or reputation.[1]

Peer review

When a patient-safety or ethical violation is investigated, peer reviews are often the mechanism for evaluating the circumstances, conduct and outcomes of the incident. Peer review processes are long-established within organized medicine, intended to ensure patient safety but also to scrutinize professional conduct and protect hospitals from liability.[2] The responsibility to ensure quality care through physician monitoring has been delegated to committees composed mainly of medical staff that review physician credentials and applications for admission to the medical staff, as well as determine the privileges physicians have at a hospital.[3] Peer review is recognized and accepted as a means of promoting professionalism and maintaining trust. The peer review process is intended to balance physicians' right to exercise medical judgment freely with the obligation to do so wisely and temperately.[2]

The AMA defines peer review, in part, as: "… the task of self-monitoring and maintaining the administration of patient safety and quality of care, consistent with optimal standards of practice…" Peer review goes beyond individual review of instances or events; it is a mechanism for assuring the quality, safety and appropriateness of hospital services. The duties of peer review are addressing the standard of care, preventing patient harm, evaluating patient safety and quality of care and ensuring that the design of systems or settings of care support safety and high quality care (Policy H-375.962, "Legal Protections for Peer Review").[4]

This policy continues to discuss a "good faith peer review": a "peer review conducted with honest intentions that assess appropriateness and medical necessity to assure safe, high-quality medical care is good faith peer review. Misfeasance (i.e., abuse of authority during the peer review process to achieve a desired result other than improved patient care), or misuse of the peer review process, or peer review that is politically motivated, manipulated to achieve economic gains or due to personal vendetta is not considered a good faith peer review".[4]

Health Care Quality Improvement Act of 1986

The HCQIA of 1986 was introduced to provide protection from liability under federal and state laws for members of a professional review body and their staffs, and establish a national repository for reported information regarding medical malpractice payments and adverse actions involving physicians.[5]Since then, each state (and the District of Columbia) have passed their own laws requiring the peer review process to improve health care quality.[3]

In addition to establishing the National Practitioner Data Bank (NPDB) to monitor hospital- and state-level credentialing of physicians, the HCQIA also granted federal immunity protections to physicians that participate in good faith evaluation of their peers. To qualify for immunity protections under the Act, it is presumed that the actions of peer review committees meet four standards, unless their actions are rebutted by a "preponderance of the evidence", wherein the burden of proof is on the physician undergoing review.[3,6] First, there must be a reasonable belief that peer review action was taken to ensure quality care. Second, peer review action should only be taken after a reasonable effort to obtain the facts surrounding the case. Third, the physician

undergoing peer review must be afforded sufficient notice and hearing procedures or other fair protocols relevant to the circumstances of the case. Last, after reasonable efforts to obtain the facts of the case have been made, reasonable belief that peer review action was warranted by these facts is then also required.[3]

Bad-faith peer review

Because peer review committees are typically not independent, and often comprise hospital-employed physicians who have agreed to make decisions on behalf of the organization, judgments made by these committees have the potential to be biased. A bad-faith, or "sham" peer review, may be politically motivated, manipulated to achieve economic gains or to avoid financial risks, conducted in a way that helps the organization avoid reputational damage or is facilitated to fulfill a personal vendetta against an individual. The peer review process may also be exploited to deem the whistleblower incompetent or disruptive, undermining the merits of their report. Such inappropriate peer reviews were the subject of AMA Board of Trustees Report 24-A-08, titled "Inappropriate Peer Reviews," which described several cases of improperly motivated peer review, including *Patrick v Burget* (1998), *Rosenblit v Superior Court (*1991), *Clark v Columbia/HCA Information Services* (2001), and *Poliner vs Presbyterian Hospital of Dallas* (2006).[7]

Victims of bad-faith peer reviews often share similar characteristics that cause them to be perceived as "easy targets." Such characteristics include independent physicians that lack the social and political support and other resources frequently enjoyed by physicians who are part of large health systems, physicians who are new on staff and haven't yet had the opportunity to develop strong connections and physicians that perform "new" or "different" procedures.[3]

Racial inequities in adverse action reports

Anecdotal evidence from the media and health law bar have reported a rise in racial inequities in adverse medical staff actions. This increase is believed to be due to racially motivated actions and more physicians of color challenging such actions. One example of this involved a Black physician who, over the course of 25 years, resided in a rural community, established a practice, and maintained an honorable career in her specialty. After identifying an unmet need of a patient population in her rural community that went unaddressed by local health systems, she established an outpatient facility that thrived. After she brought forward quality of care concerns regarding the danger to high-risk patients created by a gap in specialty coverage and quality nursing care at the hospital, a medical staff investigation was initiated against her by the hospital's peer review committee in response to retaliatory nursing staff claims. To avoid a potentially career-ending report to the NPDB, the physician was forced to invest time, money and energy toward participation in the demoralizing, retaliatory medical staff investigation.[6]

Adverse medical staff actions that cite subjective reasons such as "disruptive" behavior, competency concerns and/or unprofessional conduct have served to justify racism against Black physicians and other minoritized physicians. Racially motivated bad-faith peer reviews threaten the economic and mental well-being of physicians of color in addition to the health outcomes of the diverse patient populations they care for.[6]

Some hospital- and health system-level recommendations that have been proposed to prevent racial discrimination in the peer review process include hiring racially diverse leadership, as well as representation on peer review committees and reviewing and revising peer review protocols through an equity lens.[6]

Perceived barriers to reporting patient care concerns

The authors of AMA Policy D-200.971 raised concerns about perceived barriers for physicians to report patient care or other concerns without fear of retaliation due to the large influence and market dominance many health systems have. AMA Board of Trustees Report 5-I-17, "Effective Peer Review", discussed this issue, addressing physicians' concerns with the waning influence or control they have over their employment or patient care, as they are increasingly becoming employed by or affiliated with large hospital systems or health care organizations.[8] Despite BOT Report 5-I-17 having been published more than six years ago, the issues addressed within it remain relevant and thus appropriate to cite within this current report.

"In a large health system or hospital, peer review systems are integral to safeguarding patient safety and care. Because peer review can involve close scrutiny of all aspects of patient care and safety, both with respect to organization-wide patient care and safety issues and issues concerning individual physicians and health care practitioners, the peer review process may bring to light serious patient care and safety issues that are systemic to a hospital or other lay organization. Exposure of such issues could damage the hospital's or organization's reputation in its community or its other business interests. Consequently, a physician may be reluctant to participate in a peer review proceeding for fear of retaliation if the physician believes that the hospital or lay organization will take issue with the result of, or the physician's role in, that proceeding. This fear is exacerbated if the hospital or lay organization dominates the physician's community. Thus, to ensure effective peer review, physician peer review participants must be protected from the possibility of retaliation".[8]

Physician concerns about retaliation against physician peer review participants have grown as hospitals employ more physicians and hospital markets become more concentrated. Many communities in the United States are dominated by only a few hospitals, or even by a single hospital. As more physicians have become employed by, or affiliated with, dominant hospitals or other powerful lay organizations, some physicians increasingly fear retaliation for expressing patient safety or care concerns during a peer review proceeding, or otherwise participating in a peer review process, that the hospital or organization perceives as being contrary to its financial interests.[8]

Existing mechanisms for reporting complaints or concerns

To understand the issue of the perceived limitations for physicians to safely report patient care concerns due to the large influence and dominance of their health systems and/or seek recourse if they believe a peer review process has been initiated against them based on unfounded, unfair allegations, we evaluated the landscape of reporting mechanisms currently in place. Numerous systems exist for physicians to report complaints about a peer, patient safety concerns within their health system or other unethical or egregious practices they experience or observe within their place of practice. These systems are in place at multiple levels to promote patient safety and typically great efforts are made to ensure reports are confidential, so individuals feel safe and confident in reporting concerns without fear of retaliation.

The most appropriate organization for a physician to file a complaint against a health care system or hospital is their state medical board. Each state has at least one medical board that licenses allopathic or osteopathic doctors, investigates complaints, disciplines physicians, and refers physicians for evaluation and rehabilitation when appropriate.

Health care organizations should have in place reporting mechanisms through which physicians or other professionals can confidentially submit concerns or complaints without fear of recourse or retaliation. While this may be reasonable for expressing concerns about one's peer or colleague, due to concerns about privacy or fear of consequences many physicians may not feel comfortable bringing organization or system-level issues to their organization's leadership.

If physicians do not feel comfortable reporting concerns directly to their leadership or organization, they may report concerns or complaints about their health system or hospital to The Joint Commission if the organization is accredited or certified by The Joint Commission.[9] The Joint Commission's standards require leaders to provide and encourage the use of systems for blame-free reporting of a system or process failure. The Joint Commission encourages practices to engage frontline staff in internal reporting in a number of ways including (1) creating a nonpunitive approach to patient safety event reporting, (2) educating staff on and encouraging them to identify patient safety events that should be reported and (3) providing timely feedback regarding actions taken on reported patient safety events.[10]

The U.S. Department of Health & Human Services (HHS) provides a mechanism for physicians employed by HHS or one of its agencies, or whose employer receives HHS contract or grant funding, to have their whistleblower retaliation complaints processed by HHS-Office of the Inspector General. The actions of these physicians to expose unlawful activities such as abuse and mismanagement within an HHS agency, (sub)contractor or (sub)grantee organization are protected by HHS.[11] Individuals that submit a complaint can choose whether to provide identifying information or remain anonymous.[12]

Also at the federal level, if a physician has been unfairly subjected to a peer review due to underlying racial discrimination or denied compensation or benefits following a bad-faith peer review, for example, they can report such violations to the U.S. Department of Labor (DOL). The agency within the DOL that handles whistleblower retaliation allegations is the Occupational Safety and Health Administration (OSHA). OSHA enforces the retaliation protections of more than 20 federal laws.[13]

If a physician believes they have been subjected to a bad-faith peer review in retaliation for making complaints about discriminatory behavior, disclosing violations of the law, fraud, or abuse, refusing to obey an order believed to be discriminatory or participating in discrimination or whistleblower proceedings, one resource available to them for recourse is the EEOC.[14,15] A physician in this circumstance must provide evidence that (1) they participated in a protected activity, (2) their employer took materially adverse action and (3) retaliation was the driving force behind the employer's adverse action. Employer retaliatory action is any action that might deter a reasonable person from engaging in protected activity.[14]

Two additional resources that may be beneficial to physicians harmed by a bad-faith peer review are the Association of American Physicians and Surgeons (AAPS) Sham Peer Review Hotline and the Center for Peer Review Justice. Physicians can call or email the AAPS hotline for an attorney referral – a free resource for AAPS members.[16] The Center for Peer Review Justice offers complimentary second opinions, legal services, lectures and consultations regarding the NPDB.[17]

Lack of publicly available information about complaints against hospitals and health systems

There are no publicly available universal repositories that house information about U.S. physician or hospital misconduct, sanctions, malpractice incidents or other complaints. Some entities collect and track these elements, but none provide large-scale searchable tools for the public or for

physicians seeking information about health systems or hospitals. Most, if not all, states protect the confidentiality of peer review information, meaning that peer review information, documents and records cannot lawfully be disclosed to anyone except those conducting the peer review and any other specific individuals or entities identified in the peer review statute.[8] Here we describe the available resources and their respective access levels.

The Joint Commission does not publish information about complaints, but its publicly available Quality Check reports provide an indication of accreditation and quality performance. These reports could be accessed by a physician looking to verify an organization's accreditation status and quality reports before considering employment. The Quality Check reports published by The Joint Commission could serve as a publicly accessible channel in which to publish final determinations of physician complaints against hospitals and hospital systems.

Complaints to the EEOC are confidential and maintained for record-keeping purposes, as well as to determine if the situation is covered by the EEOC, unless and until an individual files a discrimination charge. After a charge is filed, the individual's name and basic information surrounding the allegations are released to their employer. However, by law, this information is not available to the public. Different protocols apply to federal employees.[18]

Individuals seeking information about a hospital or health system's involvement in malpractice cases have the right to access public records through the federal, state or county court systems. Typically, the public-facing systems provide basic information about cases, and do not disclose information about proceedings or outcomes. More detailed court records may be accessible by the public for a fee. These systems only demonstrate legal actions involving individuals or businesses, however, and are not necessarily an indication of a hospital's quality or a physician's medical competence. It is not recommended public court records be used as a basis for making employment decisions.

State licensure and hospital credentialing entities require reporting of disciplinary investigations and related actions on applications and renewal forms, which may include peer review committee investigations. The NPDB collects and maintains information reported by the states and hospitals including adverse licensure, professional review actions, clinical privileges actions, and medical malpractice actions. It is the only federal database containing information about physician malpractice, but the lack of contextual information about individual cases makes it an incomplete and potentially misleading resource. The NPDB does not track and publish individual complaints about health care organizations, health systems or other health care employers. The NPDB provides access about individual practitioners only to authorized users, such as hospitals and medical boards, but not the general public.[19] Since its inception, there have been multiple attempts from members of Congress and other stakeholders to make the NPDB public.[20–22]

Of note, the AMA has historically maintained opposition of attempts to make the NPDB available to the public, instead supporting state-level efforts and the Federation of State Medical Boards (FSMB) Physician Data Center (Policy H-355.975, "Opposition to the National Practitioner Data Bank").[23]

The FSMB Physician Data Center collects information reported from state medical boards, government regulatory entities, and international licensing authorities. Hospitals and health care organizations, not the public, can search licensure history and past regulatory actions, including revocations, suspensions, loss of license, probation restrictions and licensure denials, for actively licensed physicians.[24]

State medical boards provide the public with access to information about physician licensure status. Many, if not most, also include general information about whether a physician has had disciplinary action against them. These systems do not publish information about health care organizations.

Amending the HCQIA to mandate monetary penalties for bad-faith peer reviews

Policy H-200.971 recommends amendments to the HCQIA to impose monetary penalties for institutions performing bad-faith peer reviews. Similarly, proposals for the imposition of monetary penalties against hospitals that fail to report adverse actions to the NPDB have been attempted but not adopted.[25] Some states impose financial penalties on hospitals for failure to report physician misconduct, but they are reportedly difficult to enforce due to lack of resources for investigations and a tendency for the state medical board to investigate the individual physician rather than the entity that failed to report the incident.[25,26]

Sham peer reviews are difficult to identify, prove, and track. The burden of proof lies with the complainant, and it is challenging to acquire tangible proof that a hospital acted maliciously in conducting a peer review. If an organization is found to have participated in or conducted a bad-faith peer review, it is no longer protected by the immunity the HCQIA otherwise offers these entities. It is thus subject to exposure to lawsuits, claims for damages and the risk of very costly rulings.

Your Board of Trustees does not at this time recommend pursuing a HCQIA amendment strategy because doing so could result in significant, negative unintended consequences, especially with respect to the NPDB. Opening the law for amendment to mandate monetary penalties for health care organizations could present opportunities for parties, whose interests are not aligned with those of organized medicine, to reintroduce changes that have in the past been attempted. For example, stakeholders outside organized medicine have strongly urged Congress to amend the HCQIA so that the information in the NPDB would be publicly available. AMA opposes such efforts. For example, AMA Policy H-355.976, "National Practitioner Data Bank" states in part: "Our AMA: (a) opposes all efforts to open the National Practitioner Data Bank to public access; (b) strongly opposes public access to medical malpractice payment information in the National Practitioner Data Bank; and (c) opposes the implementation by the National Practitioner Data Bank of a self-query user fee." The AMA has taken this position because information in the NPDB is often incomplete and inaccurate, not organized in a way that patients will understand and is thus highly likely to be misunderstood or misinterpreted by patients. For these reasons and those previously mentioned, the Board does not recommend attempting to amend HCQIA.

AMA POLICY

The AMA has numerous policies affirming its position supporting retaliation protections, including specifically in the context of peer review participation.

Our AMA: (1) opposes mandates from employers to supervise non-physician providers as a condition for physician employment and in physician employment contracts; and (2) supports whistleblower protections for physicians who report unsafe care provided by non-physicians to the appropriate regulatory board (Policy H-405.950, "Preserving the Practice of Medicine").

AMA policy states that physicians should be free to exercise their personal and professional judgment in advocating on any matter regarding patient care interests and that employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers for asserting these interests (Policy H-225.950, "Principles for Physician Employment";

Policy H-225.952, "The Physician's Right to Exercise Independent Judgement in All Organized Medical Staff Affairs").

Further, the AMA condemns any action taken by administrators or governing bodies of hospitals or other health care delivery systems who act in an administrative capacity to reduce or withdraw or otherwise prevent a physician from exercising professional privileges because of medical staff advocacy activities unrelated to professional competence, conduct or ethics (Policy H-230.965, "Immunity from Retaliation Against Medical Staff Representatives by Hospital Administrators").

Our AMA (1) supports whistleblower protections for health care professionals and parties who raise questions that include, but are not limited to, issues of quality, safety and efficacy of health care and are adversely treated by any health care organization or entity and (2) will advocate for protection in medical staff bylaws to minimize negative repercussions for physicians who report problems within their workplace (Policy H-435.942, "Fair Process for Employed Physicians").

AMA policy also states that entities and participants engaged in good faith peer review activities should be immune from civil damages, injunctive or equitable relief and criminal liability, and should be afforded all available protections from any retaliatory actions that might be taken against such entities or participants because of their involvement in peer review activities. This policy also defines a "good faith peer review", supports the confidentiality of peer review committee proceedings and opposes efforts to make these proceedings or any resulting decisions public or available via self-query (Policy H-375.962, "Legal Protections for Peer Review").

Moreover, the AMA monitors legal and regulatory challenges to peer review immunity and non discoverability of peer review records/proceedings and continues to advocate for adherence to AMA policy, reporting challenges to peer review protections to the HOD (Policy D-375.997, "Peer Reviewer Immunity").

Additional AMA policies call for fair and unbiased peer review procedures that enable due process for all participants.

In 2016, the AMA adopted policy directing it to study the current environment for effective peer review in order to update current policy to include strategies for promoting effective peer review by physicians and to consider a national strategy for protecting all physicians from retaliation as a result from participating in effective peer review (Policy D-375.987, "Effective Peer Review").

Additionally, the AMA published policy outlining appropriate peer review procedures that urge state medical associations to determine if additional state agency supervision of peer review is needed to meet the active state supervision requirement set forth by the Supreme Court, and that peer review procedures should, at a minimum, meet the HCQIA standards for federal immunity (Policy H-375.983, "Appropriate Peer Review Procedures").

The AMA also adopted guidelines for obtaining outside reviewers when a fair review cannot be conducted by hospital medical staff (Policy H-375.960, "Protection Against External Peer Review Abuses").

AMA policy encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care. services. The AMA supports this use of physician data when it is used in conjunction with program(s) designed to improve or maintain the quality of, and access to, medical care for all

patients and is used to provide accurate physician performance assessments (Policy H-406.991, "Work of the Task Force on the Release of Physician Data").

However, the AMA opposes the requirement that peer review organizations and private accreditation entities report any negative action or finding to the NPDB (Policy H-355.975, "Opposition to the National Practitioner Data Bank"), advocates for amendments to the Freedom of Information Act to exempt confidential peer review information from disclosure under the Act, and supports appropriate efforts to prohibit discovery of information obtained in the course of peer review proceedings (Policy D-375.999, "Confidentiality of Physician Peer Review").

Finally, the AMA Code of Medical Ethics includes opinions related to physicians' right to report concerns about their peers or organizations, the peer review process, and protections against retaliation.

The AMA believes that physicians have mutual obligations to hold one another to the ethical standards of their profession. Peer review, by the ethics committees of medical societies, hospital credentials and utilization committees, or other bodies, has long been established by organized medicine to scrutinize professional conduct. Peer review is recognized and accepted as a means of promoting professionalism and maintaining trust. The peer review process is intended to balance physicians' right to exercise medical judgment freely with the obligation to do so wisely and temperately (Opinion 9.4.1 Peer Review & Due Process).

The AMA also believes that physicians who become aware of or strongly suspect that conduct threatens patient welfare or otherwise appears to violate ethical or legal standards should:

a) Report the conduct to appropriate clinical authorities in the first instance so that the possible impact on patient welfare can be assessed and remedial action taken;
b) Report directly to the state licensing board when the conduct in question poses an immediate threat to the health and safety of patients or violates state licensing provisions.
(c) Report to a higher authority if the conduct continues unchanged despite initial reporting.
(d) Protect the privacy of any patients who may be involved to the greatest extent possible, consistent with due process.
(e) Report the suspected violation to appropriate authorities (Opinion 9.4.2 Reporting Incompetent or Unethical Behavior by Colleagues).

AMA RESOURCES

The AMA, despite having an abundance of policy on the matter, has not published a significant number of resources to help physicians navigate the tumultuous processes of reporting concerns or being the subject of a peer review. Existing resources include the following.

The AMA's Principles for Physician Employment include principles for peer review and performance evaluations and state that employed physicians should be accorded due-process protections, including a fair and objective hearing, in all peer review proceedings.
For medical staff leadership, the AMA Credentialing Services offers a webinar entitled, "Medical Group Peer Review: Legal Issues and Possible Protections", that provides information about the importance of ensuring fair peer review proceedings to mitigate liability.

Finally, physicians can submit concerns or complaints about another physician or health professional to the AMA, although the AMA Code of Medical Ethics states that grievances against a medical professional who is believed to be acting unethically or not providing a certain standard

of care should be directed to the state medical licensing board. The AMA will not investigate any complaints of misconduct or unethical behavior by physicians or health care organizations, nor does the AMA have legal authority or the proper resources to investigate individual cases.

CONCLUSION

The key issues underpinning Policy H-200.971 are the (1) perceived limitations for physicians to safely, and without fear of retaliation, report patient care concerns due to the large influence and market dominance many health systems have; (2) the conduct of bad-faith peer reviews or other mistreatment or retaliation against physicians that have reported concerns; (3) lack of publicly available information about complaints against hospitals and health systems; and (4) the potential amendment of the HCQIA to add monetary penalties for entities found to have conducted bad-faith peer reviews.

This report provides detailed information about multiple systems in place for physicians to report concerns about their health system or hospital employer. Despite the attempts to make these systems safe and confidential, and the fact that employed physicians are protected from retaliation by state and federal laws, there are often still barriers that prevent physicians from reporting concerns without fear of retaliation in some form and/or seeking adequate recourse if a bad-faith peer review process is initiated against them.

Peer reviews in medicine will continue to be a mainstay in ensuring safe and ethical patient care is provided by competent physicians. When conducted appropriately and according to acceptable standards, peer reviews are a valuable tool for the health care system. The conduct of bad-faith peer reviews, however, is morally, ethically and professionally abhorrent, and runs counter to everything that physicians and the practice of medicine stand for.

Also highlighted in this report are several entities that collect and publish data on physician licensure, malpractice payments, and disciplinary actions. None of the systems that house this data make it available to the public. To our knowledge, no systems are in place to track and publicly report malpractice information or complaints against hospitals or health systems. It has long been the position of the AMA that malpractice payment information should not be made public. And while AMA policy requires state medical boards report disciplinary action to the AMA and FSMB, it does not call for or endorse the public reporting of such information. Physicians have numerous other options for locating organization-related information when seeking new employment, and the AMA does not support efforts to require the AMA, FSMB, The Joint Commission or any state or federal entity to dedicate resources to providing this information to the public for the purposes of aiding job seekers in their employment decisions. It is also the AMA's position that providing the public with access to incomplete information devoid of context would invite more issues than it would resolve. The AMA does, however, support transparent reporting of final determinations of physician complaints against hospitals and health systems through publicly accessible channels such as The Joint Commission Quality Check reports.

Finally, we address the request for the AMA to recommend amendments to the HCQIA to impose monetary penalties on perpetrators of bad-faith peer reviews. The HCQIA provides protection for hospitals and peer review committees, so long as their peer reviews are conducted in a manner consistent with the law. They are no longer entitled to such immunity if it is found they participated in or led a bad-faith peer review. In the U.S., the justice system is in the position to facilitate the appropriate penalization of organizations faced with lawsuits and damages brought on by their participation in bad-faith peer reviews. Considering (1) that protection under the HCQIA is not

provided to organizations failing to meet the HCQIA's four standards of professional review; (2) the AMA has historically opposed attempts to amend the HCQIA; and (3) monetary penalties at the state level have not resulted in increased reporting or reduced incident rates, the AMA does not recommend new attempts to amend the HCQIA for the purposes of adding such penalties for organizations involved in bad-faith peer reviews.[25,27,28]

RECOMMENDATIONS

The Board of Trustees recommends:

1. The following policies be reaffirmed:
    a. Policy H-405.950, "Preserving the Practice of Medicine"
    b. Policy H-225.950, "Principles for Physician Employment"
    c. Policy H-225.952, "The Physician's Right to Exercise Independent Judgement in All Organized Medical Staff Affairs"
    d. Policy H-230.965, "Immunity from Retaliation Against Medical Staff Representatives by Hospital Administrators"
    e. Policy H-435.942, "Fair Process for Employed Physicians"
    f. Policy H-375.962, "Legal Protections for Peer Review
    g. Policy D-375.987, "Effective Peer Review"
    h. Policy H-375.960, "Protection Against External Peer Review Abuses" (Reaffirm HOD policy); and

2. That the following policy statement be adopted to supersede Policy H-200.971, "Transparency and Accountability of Hospitals and Hospital Systems,":
    a. The AMA supports transparent reporting of final determinations of physician complaints against hospitals and health systems through publicly accessible channels such as the Joint Commission Quality Check reports (New HOD Policy).
    b. The AMA will develop educational materials on the peer review process, including information about what constitutes a bad-faith peer review and what options physicians may have in navigating the peer review process (Directive to Take Action).

3. That the title of Policy H-200.971, "Transparency and Accountability of Hospitals and Hospital Systems," be changed to:
    a. "Transparent Reporting of Physician Complaints Against Hospitals and Health Systems"

4. That the remainder of this report be filed.

Fiscal note: Minimal

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 30-A-24

Subject: Proper Use of Overseas Virtual Assistants in Medical Practice

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee G

At the 2023 Annual Meeting of the House of Delegates (HOD), Policy H-200.947, "Proper Use of Virtual Assistants in Medical Practice", was adopted. This policy directed the American Medical Association (AMA) to (1) support the concept that properly trained overseas virtual assistants are an acceptable way to staff administrative roles in medical practice (New HOD Policy), and (2) study and offer formal guidance for physicians on how best to utilize overseas virtual assistants in such a way as to ensure protections for physicians, practices, patient outcomes, and overseas medical staff (Directive to Take Action).

This report details guidance, considerations (e.g., equity, diversity and inclusion, business and compliance), opportunities and challenges regarding the appropriate use of overseas virtual assistants by medical practices. Additionally, relevant AMA policy is discussed. Based on this information, AMA identified the need for the creation and publication of educational materials for medical practices that provide guidance on how best to utilize overseas virtual assistants in a manner that protects physicians, practices, patients, and overseas medical staff.

BACKGROUND

Over the last two decades, health care organizations have increasingly outsourced administrative and certain clinical work – such as revenue cycle management, coding and billing, IT support and prior authorization tasks – to entities or individuals that reside in different time zones. Outsourcing, a business agreement in which an organization contracts out the procurement of products or services to an external firm, became widely used in health care during the early 2000s. Organizations pursue these arrangements with the goals of lowering administrative costs, raising productivity, and addressing workforce shortages. In 2017 alone, health care industry outsourcing grew by 36%.[1]

In addition to outsourcing, health care organizations also began using remote employees for administrative positions. Remote work is the practice of working from one's home or another space separate from the office. Medical practices adopted remote work for employees for several reasons, including office closures during the COVID-19 pandemic, limited working space within the medical practice, employee retention and satisfaction and decreased practice overhead costs.[1]

In recent years, there has been an evolution from remote employees to virtual assistants. While remote employees are employed by the practice directly, a virtual assistant is an independent contractor who provides administrative services to clients while operating outside of the client's office. As such, the individual can be located anywhere in the world, broadening the candidate options for companies. Virtual assistants can also include artificial intelligence in software used by

medical practices. As this resolution is specific to human virtual assistants, this report does not consider artificial intelligence virtual assistants.[1]

The primary benefit of using virtual assistants in medical practice is to offload administrative duties to decrease physician workload and allow more time for patient care. Properly informed medical practices can successfully utilize overseas or domestic virtual assistants for nonclinical, administrative tasks, including but not limited to appointment scheduling and reminders, sending and receiving patient medical records, visit note dictation, prior authorization requests, charge entry, claim submission, claim control, and follow-up. Additionally, the use of overseas virtual assistants can have economic benefits for medical practices. For instance, virtual assistants can be hired for a set number of hours or tasks each week instead of hiring a full-time employee, lowering staffing costs for the practice. They also typically have a lower hourly rate than those in the U.S. largely due to a lower cost of living in the countries they live.[2]

Medical practices seeking virtual assistants outside of the U.S. can utilize online job boards specific to the geographical area they would like to search. One example is OnlineJobs.ph, a job board that connects companies to virtual assistants located in the Philippines.[3] These online job boards facilitate the initial communication and interview process and provide employers with best practices for training virtual assistants located within the U.S. or overseas.

Business and Compliance Considerations

There are several business and compliance considerations that medical practices should review before hiring a virtual assistant, including employee classification, global labor protections, and HIPAA compliance standards. Virtual assistants classified as independent contractors are required to report their income for taxes and social contributions within their country on their own. In contrast, remote direct hires are employed by the practice and may require additional tax liabilities, withholdings and employee benefits depending on local labor laws where the individual lives. Medical practices should consult an accountant for any reporting requirements the practice has for virtual assistants classified as independent contractors.[4]

Securing private and confidential data is of the utmost importance, especially when working remotely. To protect sensitive data, health care organizations and medical practices that utilize virtual assistants should establish data protection protocols and obtain the appropriate consents from users.[5] The AMA has created several resources to guide medical practices through the process of securing patient health information, including guidance on Implementing a Work-From-Home Program, a tip sheet for Working from home during COVID-19 pandemic, a checklist for protecting office computers in medical practices against cyberattacks and technology considerations for working remotely. However, medical practices employing virtual assistants should still consult with their IT vendor to ensure the security of patient health information.

Equity, Diversity, and Inclusion Considerations

When considering using overseas virtual assistants, medical practices and health care organizations should prioritize equity, diversity, and inclusion. For example, it is important that practices and organizations verify the U.S. Dollar conversion to the currency used by the virtual assistant or employee to ensure fair and reasonable compensation.

Other considerations include the virtual assistant work schedule if there is a large time difference between in-office staff within the country the organization operates in and the country in which overseas virtual assistants live. This is essential to promote a healthy work environment.[1] For

example, some medical practices and health care organizations outsource the entirety of their customer service operations overseas and also supply these services for 24-hours. Time zone compatibility between the medical practice and virtual assistant can impact employee health and quality of life. Night shift workers experience an incompatibility with family leisure time and the unavailability of services during nighttime hours.[6] These workers are prevented from recovering from a long day of work in the way that day shift workers can. Rather, when their shift ends, they must still function in a world operating on a completely different schedule. Studies have examined the social ramifications to this work. For instance, night shift workers have been demonstrated to experience divorce rates as high as 30 percent.[7] Health risks among night shift workers have also been analyzed. In a study of night shift employees working at international call centers in the National Capital Region (NCR) of Delhi, 77.6 percent of participants had some suspicion of insomnia or suspected insomnia. In addition to sleep quality issues, 44.3 percent of participants were cigarette smokers and 37 percent reported physical ailments.[8] Further, a Circadian Technologies study reported that night shift workers were 20 percent more likely to experience severe accidents.[7] Additionally, research shows that these workers may be at greater risk of cardiovascular disease, gastrointestinal disease, psychological disorders, cancers, diabetes, obesity and adverse reproductive outcomes.[7,9]

However, instances also exist where time zone differences can benefit both U.S. and overseas staff. For example, some organizations and practices outsource their operations overseas part-time so that work is performed by overseas staff during their local day-time hours after which their workday concludes and the work they performed is available to U.S. staff who then begin working their day-time schedule.

Training for Overseas Virtual Assistants in Medical Practice

Medical practices would benefit from the adoption of in-house training programs for virtual assistants that includes general knowledge of health care administration and compliance, as well as processes and procedures specific to the practice. Training on the general knowledge of health care administration is available for little or no cost from professional organizations, such as the AMA's Navigating Practice Series and AMA STEPS Forward® Private Practice playbook. Several resources also exist from the Medical Group Management Association. Before implementing any virtual assistant or employee, the medical practice or health care organization would benefit from a clear strategic plan that outlines and addresses the risks previously mentioned.

AMA POLICY

The AMA has several policies related to the appropriate use of overseas virtual assistants for administrative functions within medical practices.

The AMA will work towards its goal of health equity, defined as optimal health for all, by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity (Policy H-180.944, "Plan for Continued Progress Toward Health Equity").

The AMA will also explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens (Policy D-320.982, "Prior Authorization Reform").

Additionally, the AMA:

a. Supports the need for developing and implementing technologies to reduce glare from vehicle headlamps and roadway lighting schemes, and developing lighting technologies at home and at work that minimize circadian disruption, while maintaining visual efficiency.
b. Recognizes that exposure to excessive light at night, including extended use of various electronic media, can disrupt sleep or exacerbate sleep disorders, especially in children and adolescents. This effect can be minimized by using dim red lighting in the nighttime bedroom environment.

c. Supports the need for further multidisciplinary research on the risks and benefits of occupational and environmental exposure to light-at-night.

d. Encourages work environments that operate in a 24/7 hour fashion to have an employee fatigue risk management plan in place (Policy H-135.932, "Light Pollution: Adverse Health Effects of Nighttime Lighting").

DISCUSSION

Opportunities for Overseas Virtual Assistants in Medical Practice

U.S. companies have struggled with staffing shortages since 2021, known as "The Great Resignation".[10] Health care is no exception, and the industry has arguably struggled more with staffing shortages due to higher levels of burnout post-COVID-19 pandemic, higher levels of administrative burden, diminished reimbursement and a decline in overall annual revenue.[11–14]

The ability to quickly find and hire experienced individuals is crucial for the success of medical practices. When practices are short-staffed, physicians take on the extra workload, decreasing time spent with patients and contributing to burnout. Overseas virtual assistants, when successfully integrated into practice operations, can enable medical practices to expand their talent search beyond U.S. borders to choose among an expansive talent pool to quickly hire an experienced workforce at a much lower cost than those based in the U.S. Additionally, virtual assistants do not require physical space to work in the office, thus lowering the physical infrastructure cost for medical practices.

Risks Associated with Utilizing Overseas Virtual Assistants in Medical Practice

Despite expectations, studies show that outsourcing any health care role contains risks such as the loss of control over work quality, exposure of patient health information and other secure data, the lack of provision of anticipated financial benefits and jeopardization of the organization's culture and reputation.[1]

CONCLUSION

Medical practices struggling to fill vacant positions may turn to virtual assistants within the U.S. or overseas. While virtual assistants can offer cost-saving and efficiency benefits to medical practices, it is imperative that practices have a clear strategic plan before hiring a virtual assistant. This plan should include the security of patient information, in-house training/onboarding for the employee, fair pay and working hours, and management of the virtual employee's work quality and engagement with the rest of the practice. The creation of a strategic plan will allow the medical practice to consider all variables and determine how best to utilize a virtual assistant within their

practice. With an informed approach, the use of properly trained overseas virtual assistants is an option for medical practices.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted, and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm the following policies:
    a. H-385.951- Remuneration for Physician Services
    b. H-180.944 - Plan for Continued Progress Toward Health Equity
    c. H-135.932 - Light Pollution: Adverse Health Effects of Nighttime Lighting; (Reaffirm HOD Policy) and

2. That Policy H-200.947 be amended to read as follows: "Our AMA: (1) supports the concept that properly trained ~~overseas~~ virtual assistants, in the U.S. or overseas, are an acceptable way to staff administrative roles in medical practices; and (2) will ~~study and offer formal guidance for physicians on how best to utilize overseas virtual assistants to ensure protection of patients, physicians, practices, and equitable employment in communities served, in a manner consistent with appropriate compliance standards~~ create and publish educational materials for medical practices that offer formal guidance on how best to utilize virtual assistants to ensure protection of patients, physicians, virtual assistants and practices." (Modify Current HOD Policy).

Fiscal Note: Moderate

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-A-24

Subject: Council on Medical Service Sunset Review of 2014 House Policies

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee G

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; or (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 10-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

APPENDIX – Recommended Actions

POLICY #	Title	Text	Recommendation
D-110.993	Reducing Prescription Drug Prices	Our AMA will (1) continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and (2) encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to contact the National Conference of State Legislatures, which maintains a comprehensive database on all such programs and legislation.	Rescind. Superseded by Policy H-110.987. **Pharmaceutical Costs** **H-110.987** 1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives. 2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition. 3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry. 4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system. 5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies. 6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.

POLICY #	Title	Text	Recommendation
			7. Our AMA supports legislation to shorten the exclusivity period for biologics. 8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens. 9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients. 10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by ten percent or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of ten percent or more each year or per course of treatment. 11. Our AMA advocates for policies that prohibit price gouging on prescription

POLICY #	Title	Text	Recommendation
			medications when there are no justifiable factors or data to support the price increase. 12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts adhdressing drug price and cost transparency. 13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations. 14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation.
D-120.943	Review of Straddle Drug Pricing Rules for Medicare Part D Participants	Our AMA: (1) urges the Centers for Medicare and Medicaid Services (CMS) to examine how Medicare Part D plans are applying the straddle drug pricing rules and determine whether costs are being inappropriately shifted to beneficiaries whose drug spending totals span multiple coverage phases; and (2) will prepare a report explaining the straddle drug pricing rules and their potential impact on patients, incorporating information that is available from CMS regarding implementation by Part D plans.	Retain.
D-160.929	Patient Education Regarding the Medicare Chronic Care Management Fee	Our AMA will create a model letter that its members may use to explain the Medicare chronic care management fee to their patients.	Retain.
D-160.931	CMS Two Midnight Policy	Our AMA encourages the Centers for Medicare & Medicaid Services to educate the public and develop tools for physicians and patients that outline the financial impact of the two midnight policy.	Retain.
D-160.932	Medicare's Two-Midnight Rule	Our AMA will petition the Centers for Medicare & Medicaid Services to repeal the August 19 rules	Retain.

POLICY #	Title	Text	Recommendation
		regarding Hospital Inpatient Admission Order and Certification.	
D-160.990	Identification of Health Care Providers	Our AMA will encourage all medical facilities to provide reliable identification of health care providers.	Retain.
D-165.937	Health System Reform Resources	Our AMA will continue to develop resources to help physician practices address the ongoing and emerging issues associated with expanding health insurance coverage under the Affordable Care Act.	Retain.
D-165.981	Transitional Issues in Moving Toward a System of Individually Selected and Owned Health Insurance	(1) Our AMA will inform individual physicians and group practice administrators why self-paying patients (e.g., those who have MSA-type coverage or are uninsured) may be at a significant price disadvantage in purchasing health care services.	Retain.
D-180.994	Rescinding Provisions Requiring Physicians to Have Hospital Admitting Privileges	Our AMA will work with the American Association of Health Plans, Health Insurance Association of America, and other appropriate organizations to rescind provisions requiring physicians to have hospital medical staff privileges in order to participate in health plans.	Retain.
D-185.995	Health Plan Coverage of Prescription Drugs	Our AMA will: (1) advocate AMA policies related to health plan coverage of prescription drugs to pharmacy benefit managers, as well at to public and private sector payers; and (2) advocate for the enactment of legislation consistent with AMA policies related to health plan coverage of prescription drugs.	Retain.
D-230.986	Opposition to Proposed Revision of CMS Conditions of Participation that Limit the Autonomy, Self Governance and Quality Oversight of the Organized Medical Staff	1. Our AMA through appropriate means, including but not limited to a formal response during the current comment period for the proposed regulation on conditions of participation (CoP) or necessary legal action, including injunctive relief, will actively oppose any Centers for Medicare & Medicaid Services (CMS) policy that would bypass or remove the clinical quality and safety oversight, and credentialing and privileging responsibilities of the physician	Retain.

POLICY #	Title	Text	Recommendation
		members of the Organized Medical Staff, or that would allow a practitioner to practice at a hospital without being a member of the medical staff. 2. Our AMA will actively educate our AMA physician members of the proposed revisions to the CoP by CMS, and the potential adverse effects of such proposals on the quality and safety of patient care, and encourage them to respond individually during the CMS comment period. 3. In the name of quality care and patient safety, our AMA will vigorously engage its members, the public, and interested stakeholders to advocate against the proposed revisions to the Medicare CoPs that would bypass or remove the clinical quality and safety oversight, and credentialing and privileging responsibilities of the physician members of the Organized Medical Staff, or that would allow a practitioner to practice at a hospital without being a member of the medical staff. 4. (a) Our AMA will update model hospital staff bylaws to address the problem of requiring board recertification to remain on staff; (b) once our AMA develops these model hospital staff bylaw changes with regards to board recertification, they shall be made public in our AMA publications so physicians will recognize this problem of losing staff privileges that may be upon us in the near future; and (c) our AMA representatives to The Joint Commission will convey AMA Policies H-230.986 and H-230.997, which address board certification/recertification and hospital/health plan network privileges, to The Joint Commission.	
D-230.989	Reappointments to the Medical Staff	Our AMA will work with The Joint Commission to change the requirement for reappointments to medical staffs to every four years.	Retain.

POLICY #	Title	Text	Recommendation
D-240.993	Verbal Admission Order Signatures	Our AMA will work with the Centers for Medicare & Medicaid Services to allow authentication of verbal admission orders within 30 days, rather than prior to discharge.	Retain.
D-280.987	Analysis of Place-of-Service Code for Observation Services	Our AMA will advocate with the Centers for Medicare & Medicaid Services that the status of any observation patient who remains confined at a hospital for more than 24 hours be changed automatically to inpatient, and if they had spent a midnight in observation status, that midnight would be counted toward the three-day prior hospitalization requirement for Medicare coverage of skilled nursing facility care.	Retain.
D-280.989	Inclusion of Observation Status in Mandatory Three Day Inpatient Stay	1. Our AMA will continue to monitor problems with patient readmissions to hospitals and skilled nursing facilities and recoding of inpatient admissions as observation care and advocate for appropriate regulatory and legislative action to address these problems. 2. Our AMA will continue to advocate that the Centers for Medicare & Medicaid Services explore payment solutions to reduce the inappropriate use of hospital observation status.	Retain.
D-285.977	Excessive Telephone Wait Times for Physician Appeals of Managed Care Decisions on Patient Care	Our AMA advocates that managed care organizations be required to staff physician contact phone numbers concerning appeals for denied care sufficiently to maintain no more than a five minute average wait time.	Retain.
D-330.911	Generic Changes in Medicare (Part D) Plans	1. Our AMA will investigate the incidence and reasoning behind the conversion of one generic drug to another generic drug of the same class in Medicare Advantage drug plans. 2. Our AMA will request the Centers for Medicare & Medicaid Services to ensure that pharmaceutical vendors, when they do ask for generic transitions of drugs, list the drugs they believe are more cost effective along with	Retain-in-part. Rescind (1); accomplished with AMA participation in monthly CMS Medicare Part D Workgroup meetings.

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		their tier price and alternative drug names.	
D-330.921	Hospital Systems' Practices of Reclassification of Place of Service, Opting Not to Bill Medicare for Hospital and Aggressive Denial of Hospital Days in Reaction to Recovery Audits	1. Our American Medical Association will work with the Centers for Medicare & Medicaid Services, the Government Accountability Office, and other stakeholders to ensure that: (a) when hospitals make reclassifications based on screening criteria in proprietary databases, both the admitting physicians and the patient is immediately notified; (b) Recovery Audit Contractors, are precluded from making recoupments associated with "inappropriate admissions" and/or discrepancies between the hospital and physician's site of service; (c) physicians are intimately involved in the development of the data being used by proprietary databases; (d) a process is put in place whereby physicians can substitute their medical judgment for that of the software programs, and carriers and auditors will ensure that that judgment is considered and evaluated by physicians in the same state and specialty; and (e) the evidence underlying data programs and the processes being employed are completely transparent. 2. Our AMA will work with CMS to remove the requirement of linkage of Part A and Part B place of service so that admission or consultation documents that were done prior to a determination or reclassification of a place of service be recognized and not result in a rejection in claim for services.	Retain.
D-330.933	Restoring High Quality Care to the Medicare Part D Prescription Drug Program	Our AMA will: a. work to eliminate prior authorizations under the Medicare Part D Prescription Drug Program which undermine a physician's best medical judgment; b. work with the Centers for Medicare and Medicaid Services (CMS) to enforce the Medicare Part D Prescription Drug Program statutory requirement that all Part	Retain.

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		D plans include at least two drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients; c. work with CMS to place reasonable copays in the Medicare Part D Prescription Drug Program; d. work with other interested parties to simplify the CMS prior authorization process such that a diagnosis or reason written on the prescription should be accepted as documentation for non-formulary request; and e. work with CMS to develop a one-page form for physicians and patients to utilize in appealing a prescription coverage denial.	
D-330.964	Update to Ambulatory Surgery Procedure List	Our American Medical Association urge the Centers for Medicare and Medicaid Services to immediately update the ambulatory surgery center list of covered procedures.	Rescind. The list of approved ASC procedures is now updated annually.
D-35.988	The Joint Commission Primary Care Home Initiative	1. Our AMA Commissioners to The Joint Commission will strongly advocate that the requirements for any primary care home or medical home initiative of The Joint Commission strictly meet the requirements of the *Joint Principles of the Patient-Centered Medical Home* and more specifically that (1) each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care and (2) that a personal physician lead a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients. The *Joint Principles of the Patient-Centered Medical Home* were developed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association and approved by the AMA. 2. Our AMA will continue to support the concept of physician-	Rescind. Superseded by Policy H-160.919. **Principles of the Patient-Centered Medical Home H-160.919** 1. Our AMA adopts the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association "Joint Principles of the Patient-Centered Medical Home" as follows: Principles Personal Physician - Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care. Physician Directed Medical Practice - The personal physician leads a team of

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		led teams within the patient centered medical home (PCMH) as outlined in the Joint Principles of the Patient-Centered Medical Home. 3. Our AMA will respond to The Joint Commission's interpretation of its primary care medical home certification standards addressing non-physician-led PCMHs. 4. Our AMA will oppose any interpretation by The Joint Commission, or any other entity, of primary care medical home or patient centered medical home (PCMH) as being anything other than MD/DO physician led.	individuals at the practice level who collectively take responsibility for the ongoing care of patients. Whole Person Orientation - The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care. Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. Quality and safety are hallmarks of the medical home: Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family. Evidence-based medicine and clinical decision-support tools guide decision making.

POLICY #	Title	Text	Recommendation
			Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement. Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met. Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication. Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model. Patients and families participate in quality improvement activities at the practice level. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff. Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework: It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.

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			It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources. It should support adoption and use of health information technology for quality improvement. It should support the provision of enhanced communication access such as secure e-mail and telephone consultation. It should recognize the value of physician work associated with remote monitoring of clinical data using technology. It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits). It should recognize case mix differences in the patient population being treated within the practice. It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting. It should allow for additional payments for achieving measurable and continuous quality improvements. 2. Our AMA supports the patient-centered medical home (as defined in Policy H-160.919) as a way to provide care to

POLICY #	Title	Text	Recommendation
			patients without restricting access to specialty care. 3. It is the policy of our AMA that medical home participation criteria allow any physician practice to qualify as a medical home, provided it can fulfill the principles of a patient-centered medical home. 4. Our AMA will work with The Joint Commission (TJC) to examine the structures of TJC-accredited medical homes and determine whether differences exist in patient satisfaction, quality, value, and patient safety, as reflected by morbidity and mortality outcomes, between physician-led (MD/DO) and non-physician-led medical homes. 5. Our AMA supports the physician-led patient-centered medical home and advocate for the public reporting/notification of the professional status (education, training, experience) of the primary care clinician who leads the primary care medical home.
D-390.954	Hospital-Based Physicians and the Value-Based Payment Modifier	Our AMA will continue to advocate that the Value-Based Payment Modifier program be repealed or significantly modified.	Rescind. The Merit-based Incentive Payment System (MIPS) under the Quality Payment Program replaced the Physician Feedback/Value-Based Payment Modifier program on January 1, 2019.
D-390.981	Medicare Payment for Services to Skilled Nursing Facility Residents in Physicians' Offices	Our AMA will: (1) inform the Centers for Medicare and Medicaid Services of the problems physicians and their patients experience as a result of the inclusion of the technical component of physicians' office-based services in the consolidated billing protocol for Medicare Skilled Nursing Facility residents; (2) urge the Centers for Medicare and Medicaid Services (CMS) to provide greater oversight of Medicare Skilled Nursing Facilities	Retain.

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		(SNFs) in meeting their obligations to pay physicians for the technical component of services those physicians provide in their offices to Medicare SNF residents; (3) advocate to Congress that it exclude from Medicare's Skilled Nursing Facility (SNF) consolidated billing protocol the technical component of medical services provided in physicians' offices to Medicare SNF residents, because of concern with the negative impact on care that could potentially occur; (4) urge the Centers for Medicare and Medicaid Services to require SNFs to clearly identify those patients who fall under the Medicare SNF consolidated billing program, as opposed to non-skilled extended care facility (ECF) patients, prior to sending patients to physicians' offices for care; and (5) communicate to physicians that in order to assure payment whenever a SNF resident receives a service that is subject to SNF consolidated billing, the SNF and the physician are required to enter into an arrangement prior to providing services and the physician must look to the SNF for payment.	
D-390.984	Payment by Health Insurance Plans of Medicare Deductibles and Copayments	Our AMA will: (1) seek legislation to compel all insurers paying secondary to Medicare to be required to pay the deductibles and coinsurance owed after the Medicare payment is made; and (2) seek federal legislation to require that a secondary plan not manage the primary Medicare benefit by imposing limits as if it were primary.	Retain.
D-40.991	Acceptance of TRICARE Health Insurance	Our AMA: 1. Encourages state medical associations and national medical specialty societies to educate their members regarding TRICARE, including changes and improvements made to its operation, contracting processes and mechanisms for dispute	Retain.

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		resolution. 2. Encourages the TRICARE Management Activity to improve its physician education programs, including those focused on non-network physicians, to facilitate increased civilian physician participation and improved coordination of care and transfer of clinical information in the program. 3. Encourages the TRICARE Management Activity and its contractors to continue and strengthen their efforts to recruit and retain mental health and addiction service providers in TRICARE networks, which should include providing adequate reimbursement for mental health and addiction services. 4. Strongly urges the TRICARE Management Activity to implement significant increases in physician payment rates to ensure all TRICARE beneficiaries, including service members and their families, have adequate access to and choice of physicians. 5. Strongly urges the TRICARE Management Activity to alter its payment formula for vaccines for routine childhood immunizations, so that payments for vaccines reflect the published CDC retail list price for vaccines. 6. Continues to encourage state medical associations and national medical specialty societies to respond to requests for information regarding potential TRICARE access issues so that this information can be shared with TRICARE representatives as they develop their annual access survey. 7. Continues to advocate for changes in TRICARE payment policies that will remove barriers to physician participation and support new, more effective care delivery models, including: (a) establishing a process to allow midlevel providers to receive 100 percent of the TRICARE allowable cost for services rendered while practicing	

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		as part of a physician-led health care team, consistent with state law; and (b) paying for transitional care management services, including payment of copays for services provided to TRICARE for Life beneficiaries receiving primary coverage through Medicare. 8. Continues to advocate for improvements in the communication and implementation of TRICARE coverage policies to ensure continued patient access to necessary services, including: (a) consistently approving full payment for services rendered for the diagnosis and treatment of common mental health conditions, regardless of the specialty of the treating physician; and (b) clarifying policies with respect to coverage for age appropriate doses of vaccines that have been recommended and adopted by the Advisory Committee on Immunization Practices.	
D-400.988	PLI-RVU Component of RBRVS Medicare Fee Schedule	Our AMA will: (1) continue its current activities to seek correction of the inadequate professional liability insurance component in the Resource-Based Relative Value Scale Formula; (2) continue its current activities to seek action from the Centers for Medicare & Medicaid Services to update the Professional Liability Insurance Relative Value Units (PLI-RVU) component of the RBRVS to correctly account for the current relative cost of professional liability insurance and its funding; and (3) support federal legislation to provide additional funds for this correction and update of the PLI-RVU component of the RBRVS, rather than simply making adjustments in a budget-neutral fashion.	Retain.
D-450.961	Hospital-Based Physicians and the Value-Based	Our AMA encourages national medical specialty societies to pursue the development of relevant performance measures that	Rescind. The Merit-based Incentive Payment System (MIPS) under the Quality Payment Program replaced the

POLICY #	Title	Text	Recommendation
	Payment Modifier	demonstrate improved quality and lower costs, and work with the Centers for Medicare & Medicaid Services to have those measures incorporated into the Value-Based Payment Modifier program and other quality measurement and improvement programs.	Physician Feedback/Value-Based Payment Modifier program on January 1, 2019.
D-465.999	Critical Access Hospital Necessary Provider Designation	Our AMA: (1) will call on the Centers for Medicare & Medicaid Services to support individual states in their development of rural health networks; (2) opposes the elimination of the state-designated Critical Access Hospital (CAH) "necessary provider" designation; and (3) will pursue steps to require the federal government to fully fund its obligations under the Medicare Rural Hospital Flexibility Program.	Retain.
D-480.991	Access to Medical Care	Our AMA shall work with the Centers for Medicare and Medicaid Services to maximize access to the devices and procedures available to Medicare patients by ensuring reimbursement at least covers the cost of said device or procedure.	Retain.
D-70.965	Membership on RVS Update Committee (RUC) and CPT Coding Committee	Our AMA will request that representative societies send delegates or alternate delegates to the American Medical Association/Specialty Society Relative Value Scale Update Committee and the AMA Current Procedural Terminology Editorial Panel and Physician Advisory Committee who are currently engaged for a substantial portion of their professional activities with the practice of medicine either in active patient care or closely related activities.	Retain.
H-130.990	Freestanding Emergency Medical Care	(1) The AMA is concerned that the use of the term "emergency" in the title or description of a medical practice or a hospital center without maintaining specific emergency capabilities is not in the public interest since needed critical emergency service may be delayed. (2) The AMA firmly believes that the optimal provision of emergency	Retain.

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		care requires prompt physical access to the immediate resources of the hospital and that a freestanding emergency center without such access may delay definitive care of critical emergencies. (3) The AMA endorses the following criteria to aid in determining if a full range of emergency services is being offered: hours of operation, staffing and medical direction, relationship to the local emergency medical services system, ancillary service and equipment, protocols, private physician referrals, medical records, and payment for services.	
H-160.944	Defining "Observation Care"	1. The AMA will work with third party payers to establish a uniform definition of “observation care,” including the following: (a) The patient should be designated as under “observation care” if the physician's intent for hospital stay is less than 24 hours. If the physician's intent and expectation is for a hospital stay of greater than 24 hours, then the stay should be considered inpatient. The use of 24 hours as a threshold for observation is a guideline. It is not unusual for observation to extend to a few hours beyond 24 hours or for patients to be admitted to inpatient status before 24 hours. (b) Patients classified as under “observation care” require hospital level-of-care. (c) The patient should be registered as under “observation care” after initial physician evaluation of the patient’s signs and symptoms and appropriate testing. Post day surgical patients should be registered as under “observation care” if, after a normal recovery period, they continue to require hospital level-of-care as determined by a physician. 2. The AMA will establish policy on “observation care” and develop model legislation to ensure that: (a) After initial approval of inpatient admission by insurers, there should be no retrospective reassignment to	Retain.

POLICY #	Title	Text	Recommendation
		"observation care" status by insurers unless the original information given to insurers is incorrect. (b) Insurers should provide 60 days prior notice to providers of changes to "observation care" criteria or the application of those criteria with opportunity for comment. There should be no implementation of criteria or changes without first following these protocols. (c) Insurers' "observation care" policies should include an administrative appeal process to deal with all utilization and technical denials within a 60-day time frame for final resolution. An expedited appeal process should be available for patients in the admission process, allowing for a decision within 24 hours. (d) Insurers and HMOs should provide clearly written educational materials on "observation care" to subscribers highlighting differences between inpatient and "observation care" benefits and patient appeal procedures. 3. Our AMA will work with all appropriate governmental and non-governmental organizations to assure that both patients and physicians are treated fairly in the process of delineating the hospital admission status of patients, and to ensure that the process is transparent and administratively simple.	
H-160.983	Satellite and Commercial Medical Clinics	The AMA believes that (1) in principle, self-regulatory measures are preferable to mandatory state regulation as a mechanism to ensure quality of care in freestanding emergency and urgent care facilities; and (2) recently initiated self-regulatory programs applicable to freestanding facilities should be given ample opportunity to demonstrate their effectiveness in practice.	Retain.
H-165.829	The Future of Employer-	Our AMA: (1) supports requiring state and federally facilitated Small Business Health Options Program	Retain.

POLICY #	Title	Text	Recommendation
	Sponsored Insurance	(SHOP) exchanges to maximize employee choice of health plan and allow employees to enroll in any plan offered through the SHOP; and (2) encourages the development of state waivers to develop and test different models for transforming employer-provided health insurance coverage, including giving employees a choice between employer-sponsored coverage and individual coverage offered through health insurance exchanges, and allowing employers to purchase or subsidize coverage for their employees on the individual exchanges.	
H-165.865	Principles for Structuring a Health Insurance Tax Credit	(1) AMA support for replacement of the present exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits will be guided by the following principles: (a) Tax credits should be contingent on the purchase of health insurance, so that if insurance is not purchased the credit is not provided. (b) Tax credits should be refundable. (c) The size of tax credits should be inversely related to income. (d) The size of tax credits should be large enough to ensure that health insurance is affordable for most people. (e) The size of tax credits should be capped in any given year. (f) Tax credits should be fixed dollar amounts for a given income and family structure. (g) The size of tax credits should vary with family size to mirror the pricing structure of insurance premiums. (h) Tax credits for families should be contingent on each member of the family having health insurance. (i)Tax credits should be applicable only for the purchase of health insurance, including all components of a qualified Health Savings Account, and not for out-of-pocket health expenditures. (j) Tax credits should be advanceable for low-income persons who could	Retain.

POLICY #	Title	Text	Recommendation
		not afford the monthly out-of-pocket premium costs. (2) It is the policy of our AMA that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the United States Code. (3) Our AMA will support the use of tax credits, vouchers, premium subsidies or direct dollar subsidies, when designed in a manner consistent with AMA principles for structuring tax credits and when designed to enable individuals to purchase individually owned health insurance.	
H-180.951	Tax Treatment of Health Insurance: Comparing Tax Credits and Tax Deductions	Our AMA supports the use of appropriately structured and adequately funded tax credits as the most effective mechanism for enabling uninsured individuals to obtain health insurance coverage.	Retain.
H-180.953	Decreased Insurance Premiums for Nonsmokers	Our AMA: (1) encourages insurance companies to review and make public their current actuarial experience with respect to smokers and nonsmokers and to consider ways of making available to nonsmokers, at reduced rates, policies for accident, auto, life, homeowners, fire, and health insurance; and (2) supports the concept of health insurance contracts with lower premiums for nonsmokers, reflecting their decreased need for medical services and serving as a financial incentive for smokers (tobacco users) to discontinue this destructive habit.	Retain.
H-185.933	Patient Access to Penile Prosthesis as Legitimate Treatment for Erectile Dysfunction	Our AMA will work in concert with national specialty and state medical societies to advocate for patient access to the full continuum of care of evidence-based erectile dysfunction treatment modalities including oral pharmacotherapy, penile vasoactive injection therapy,	Retain.

POLICY #	Title	Text	Recommendation
		vacuum erection device therapy and penile prosthetics.	
H-185.935	Reference Pricing	Our AMA supports the appropriate use of reference pricing as a possible method of providing health insurance coverage of specific procedures, products or services, consistent with the following principles: 1. Practicing physicians must be actively involved in the identification of services that are appropriate for a reference pricing system. 2. Appropriate reference pricing strategies may be considered for elective services or procedures for which there is evidence of a significant variation in cost that does not correspond to a variation in quality of care. Additional considerations include the relative complexity of the service, the potential for variation either across patients or during the course of a treatment, and the sufficient availability of providers in a geographic region. 3. Reference prices should be set at a level that reflects current market conditions and ensures that patients have access to a choice of providers. Prices should be reviewed annually and adjusted as necessary based on changes in market conditions. 4. Hospitals or facilities delivering services subject to reference pricing should avoid cost-shifting from one set of services to another. 5. Information about the services subject to reference pricing and the potential patient cost-sharing obligations must be fully transparent and easily accessible to patients and providers, both prior to and at the point of care. Educational materials should be made available to help patients and physicians understand the incentives and disincentives inherent in the reference pricing arrangement. 6. Insurance companies must notify	Retain.

POLICY #	Title	Text	Recommendation
		patients of all services subject to reference pricing at the time of health plan enrollment. Patients must be indemnified against any additional charges associated with changes to reference pricing policies for the balance of the contract period. 7. Insurers that use reference pricing must develop and maintain systems that allow patients to effectively and appropriately compare prices among providers, including systems that help patients calculate their estimated costs for each provider prior to seeking care. 8. Plan sponsors should continually monitor and evaluate the effect of reference pricing policies on access to high quality patient care and ensure that procedures are in place to make plan modifications as necessary.	
H-185.941	Patient Cost-Sharing Requirements for Hospital Inpatient and Observation Services	Our AMA will advocate that patients be subject to the same cost-sharing requirements whether they are admitted to a hospital as an inpatient, or for observation services.	Retain.
H-185.975	Requiring Third Party Reimbursement Methodology be Published for Physicians	Our AMA: (1) urges all third party payers and self-insured plans to publish their payment policies, rules, and fee schedules; (2) pursues all appropriate means to make publication of payment policies and fee schedules a requirement for third party payers and self-insured plans; (3) will develop model state and federal legislation that would require that all third party payers and self-insured plans publish all payment schedule updates, and changes at least 60 days before such changes in payment schedules are enacted, and that all participating physicians be notified of such changes at least 60 days before changes in payment schedules are enacted. (4) seeks legislation that would mandate that insurers make	Retain.

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		available their complete payment schedules, coding policies and utilization review protocols to physicians prior to signing a contract and at least 60 days prior to any changes being made in these policies; (5) works with the National Association of Insurance Commissioners, develop model state legislation, as well developing national legislation affecting those entities that are subject to ERISA rules; and explore the possibility of adding payer publication of payment policies and fee schedules to the Patient Protection Act; and (6) supports the following requirements: (a) that all payers make available a copy of the executed contract to physicians within three business days of the request; (b) that all health plan EOBs contain documentation regarding the precise contract used for determining the reimbursement rate; (c) that once a year, all contracts must be made available for physician review at no cost; (d) that no contract may be changed without the physician's prior written authorization; and (e) that when a contract is terminated pursuant to the terms of the contract, the contract may not be used by any other payer.	
H-185.997	Insurance Coverage for Complete Maternity Care	Our AMA (1) reaffirms its policy of encouraging health insurance coverage for care of the newborn from the moment of birth; (2) urges the health insurance industry and government to include in their plans, which provide maternity benefits, coverage for normal obstetrical care, and all obstetrical complications including necessary intrauterine evaluation and care of the unborn infant; (3) urges the health insurance industry to offer such plans on the broadest possible basis; (4) urges the health insurance industry to make available, on an optional basis, coverage for	Retain.

POLICY #	Title	Text	Recommendation
		treatment associated with voluntary control of reproduction; (5) will advocate for expanding coverage of maternity care to dependent women under the age of 26 on their parents' large group plans; and (6) will advocate that individual, small and large group health plans provide 60 days of newborn coverage for all newborns born to participants in the plan.	
H-190.965	Claims Denial and Payment Delays	Our AMA policy is that insurers should not deny payment on lost claims discovered beyond the required filing date when the physician has proof that the electronic or paper claim was filed in a timely manner.	Retain.
H-190.970	Status Report on the National Uniform Claim Committee and Electronic Data Interchange	The AMA advocates the following principles to improve the accuracy of claims and encounter-based measurement systems: (1) the development and implementation of uniform core data content standards (e.g., National Uniform Claim Committee (NUCC) data set); (2) the use of standards that are continually modified and uniformly implemented; (3) the development of measures and techniques that are universal and applied to the entire health care system; (4) the use of standardized terminology and code sets (e.g., CPT) for the collection of data for administrative, clinical, and research purposes; and (5) the development and integration of strategies for collecting and blending claims data with other data sources (e.g., measuring the performance of physicians on a variety of parameters in a way that permits comparison with a peer group).	Retain.
H-190.972	Strategy for Eliminating Delayed Payments to Physicians by	It is the policy of our AMA that delayed payments to physicians and hospitals without justification by third party payers should be prohibited by law.	Retain.

POLICY #	Title	Text	Recommendation
	Third Party Payers		
H-190.975	Universality of CMS 1500 Form	The AMA will undertake the task of asking individual carriers and/or their representative organizations to maintain the universal contents and acceptance of specific data in the CMS 1500 Form so that it will remain as a truly universal form for the patient-doctor claim form.	Retain.
H-190.979	Insurance Company Filing Deadlines	Our AMA will work with the insurance industry so that where there is a specified filing deadline for services, this deadline is reset when insurance companies contend that they have either not received a filed claim or require additional supporting documentation.	Retain.
H-190.981	Required Timely Reimbursements by all Health Insurers	Our AMA will prepare and/or seek sponsorship of legislation calling for all health insurance entities and third-party payers--inclusive of not-for-profit organizations and health maintenance organizations--to pay for "clean" claims when filed electronically within 14 days and paper claims within 30 days, with interest accruing thereafter. These time periods should be considered ceilings, not floors or fixed differentials between paper and electronic claims.	Retain.
H-220.939	Activities of The Joint Commission	1. Our AMA supports continued active AMA participation as a corporate member of The Joint Commission. 2. Pursuant to Policy 220.949 (AMA Policy Database), our AMA: (a) Advocates accountability through voluntary, professionally directed quality assurance mechanisms as part of every system of health care delivery; (b) Monitors the effects of The Joint Commission standards, surveys, and other activities on the quality, cost, and outcomes of care; (c) Retains its current role in The Joint Commission and continue to evaluate that role on a regular basis; and (d) Continues to investigate additional methods to facilitate participation in voluntary accreditation mechanisms. 3. Our	Retain.

POLICY #	Title	Text	Recommendation
		AMA establishes the following goals for AMA participation in The Joint Commission: (a) To assist The Joint Commission to define its mission, long-term goals, and role in the accreditation arena; (b) To assure continued physician involvement in medical decision-making by advocating a requirement for integrated medical delivery systems to have organized medical staffs; (c) To advocate the improvement of the quality and consistency of The Joint Commission accreditation process, surveyors, and survey reports; (d) To urge consideration of cost implications when revising The Joint Commission standards, developing and implementing other activities, and increasing the costs of surveys; (e) To work toward minimal revision of The Joint Commission standards, unless there is a clear need to change them to improve patient care or outcome, once the proposed medical staff standards for the 1996 AMH are finalized; (f) To urge The Joint Commission to focus on its accreditation activities and to provide accountability to the public for health services through private sector accreditation activities; and (g) To work toward The Joint Commission recognition as an accreditation body for integrated health care networks.	
H-220.946	Unreasonable Burden of The Joint Commission Standards and Surveys	The AMA requests The Joint Commission to study and consider the ability of small hospitals, particularly in rural areas, to bear the burden of the increasing demands on staff and financial resources in the implementation of the current and proposed standards; and urges The Joint Commission to eliminate standards that increase health care costs without demonstrably improving the quality of care.	Retain.
H-220.959	Compliance with The Joint Commission	The AMA Commissioners to The Joint Commission oppose the accreditation of hospitals that do	Retain.

POLICY #	Title	Text	Recommendation
	Accreditation Standards	not adhere to The Joint Commission standards prohibiting unilateral amendment of medical staff bylaws by either the governing body or the medical staff.	
H-220.983	The Joint Commission Standard IV Should Not Tie Clinical Privilege Termination to Contract	The AMA does not believe The Joint Commission standards should dictate specific provisions of individual contracts between physicians and hospitals that are mutually agreeable to the parties.	Retain.
H-225.989	AMA Opposes Forcing Medical Staffs to Repay Hill-Burton Obligations of Free Medical Care	The AMA (1) opposes attempts to create new and arbitrary requirements for hospital compliance with the Hill-Burton Act by shifting responsibility for these requirements to hospital medical staffs; (2) believes that a hospital's Hill-Burton Act obligations should be satisfied in a manner that does not interfere with the professional rights of its medical staff; and (3) endorses exploration of means to assure equal access to medical care for the people of the U.S.	Retain.
H-225.991	Communication and Cooperation Between Hospital Management and Medical Staff	The AMA encourages hospitals to make known to physicians the diagnostic codes which are recorded by medical records and business departments so the accuracy of these diagnoses can be confirmed.	Retain.
H-230.970	Proper Notification of a Physician Regarding Possible Loss of Medical Staff Membership or Privileges	Except in the instance of summary suspension, hospital notification of possible loss of medical staff membership and/or privileges must be sent by certified mail, return receipt requested, or its equivalent.	Retain.
H-235.971	Amending Medical Staff Bylaws	The AMA provides the assistance of its legal staff to hospital medical staffs and county and state medical associations when a hospital board of directors unilaterally changes, amends, or substitutes medical staff bylaws, or denies seats to duly elected medical staff officers.	Retain.
H-235.976	Medical Staff Bylaws and	Our AMA reaffirms that (1) medical staff bylaws are a contract	Retain.

POLICY #	Title	Text	Recommendation
	Medical Staff Autonomy	between the organized medical staff and the hospital; and (2) application for medical staff appointment and clinical privileges should provide that each member of the medical staff, as well as the hospital, is bound by the terms of the medical staff bylaws, and the terms of the medical staff bylaws should be incorporated by reference into the application.	
H-235.987	Right of Committees of Medical Staffs to Meet in Executive Sessions	The AMA (1) supports the right of any hospital medical staff committee to meet in executive session, with only voting members of the medical staff present, in order to permit open and free discussion of issues such as peer review and to maintain confidentiality; and (2) encourages individual medical staffs to incorporate provisions in their bylaws to affirm this right.	Retain.
H-235.988	Non-Physicians Voting on the Medical Staff	The AMA opposes any regulation that would mandate voting privileges for non-physician members of medical staffs.	Retain.
H-240.961	Definition of a Hospital Day	Our AMA defines a Hospital Day as a 24-hour period that begins at the hour of admission.	Retain.
H-240.998	Preferential Hospital Rates	Our AMA (1) opposes hospital charge/cost arrangements granting unwarranted advantage to any group of patients; and (2) urges all health care payers, government and private, to pay their equitable share of costs incurred by hospitals and other facilities consistent with a reasonable definition of full financial requirements.	Retain.
H-260.980	Clinical Laboratory Improvement Act of 1988	1. It is the policy of the AMA to (a) continue and intensify its efforts to seek appropriate and reasonable modifications in the proposed rules for implementation of the Clinical Laboratory Improvement Amendments (CLIA) 88; (b) communicate to Congress and to the Centers for Medicare & Medicaid Services (CMS) the positive contribution of physician office laboratory testing to high quality, cost effective care so that through administrative revision of	Retain-in-part. Rescind (2); accomplished by October 2015 sign-on letter to Congress.

POLICY #	Title	Text	Recommendation
		the regulations, clarification of Congressional intent and, if necessary, additional legislation, the negative impact of these proposed regulations on patient care and access can be eliminated; (c) continue to work with Congress, CMS, the Commission on Laboratory Assessment, and other medical and laboratory groups for the purposes of making the regulations for physicians' office laboratories reasonable, based on scientific data, and responsive to the goal of improving access to quality services to patients; (d) protest the reported high costs being considered for certification of laboratories and the limited number of laboratory categories proposed; (e) encourage all components of the federation to express to CMS and members of Congress their concerns about the effect of the proposed rules on access and cost of laboratory services; and (f) protest the very limited list of waivered tests. 2. Our AMA will send a letter to CMS stating that CLIA requirements regarding provider-performed microscopy procedures and annual competency assessments are overly burdensome for physicians and their practices.	
H-280.964	Medicare Certified Beds in Nursing Facilities	The AMA will work with CMS to eliminate any unnecessary requirements for designating by location Medicare Certified beds within a nursing facility, thus allowing each facility to flexibly apply the certified status to any appropriate bed within the facility.	Retain.
H-285.917	Stop Trial by Health Insurers	1. Our AMA opposes (a) any health insurer’s efforts to make determinations regarding whether or not a physician has made a medical mistake; and (b) the practice of health plans using adverse event reporting data for purposes other than quality improvement and learning, as it could shift the focus of such reporting from improving patient	Retain.

POLICY #	Title	Text	Recommendation
		safety to fostering a punitive environment. 2. Our AMA will (a) inform all health insurance companies that they are not the appropriate entity for determining medical mistakes; and (b) encourage physicians to be aware of contractual provisions that would allow insurers to deny payment in the event of a medical mistake.	
H-285.918	Mandatory Subspecialty Consultation	Our AMA: (1) opposes the unilateral actions of hospitals and health care organizations to mandate specialty consultation for a patient with a specific disease state, when the mandate specifically denies the physician providing care the ability to determine medical necessity of the consultation and/or the consultation is not requested by the patient, and (2) discourages physicians from requesting hospital medical staff oversight committees, health plans and managed care organizations to mandate specialty consultations when the physician or physician group would gain financially from the mandatory consultation due to increased revenues from consultation billing, unless the consultation is required by law or regulation.	Retain.
H-285.943	Payment for Managed Care Administrative Services	Our AMA: (1) opposes managed care contract provisions that prohibit physician payment for the provision of administrative services; (2) encourages physicians entering into: (a) capitated arrangements with managed care plans to seek the inclusion of a separate capitation rate (per member per month payment) for the provision of administrative services, and (b) fee-for-service arrangements with managed care plans to seek a separate case management fee or higher level of payment to account for the provision of administrative services; and (3) supports the concept of a time-based charge for administrative duties (such as	Retain.

POLICY #	Title	Text	Recommendation
		phone precertification, utilization review activities, formulary review, etc.), to be assessed to the various insurers.	
H-285.974	Residents Working with Managed Care Programs	The AMA encourages managed care plans to allow residents to care for patients under faculty supervision in the inpatient and outpatient setting.	Retain.
H-285.975	Consensus Opinions	Policy of the AMA is that all managed care programs must provide, or offer reimbursement for acquisition of, sufficient opinions necessary to reach a conclusion regarding the management of a given medical condition.	Rescind. Superseded by Policy H-390.917. **Consultation Follow-Up and Concurrent Care of Referral for Principal Care H-390.917** (1) It is the policy of the AMA that: (a) the completion of a consultation may require multiple encounters after the initial consultative evaluation; and (b) after completion of the consultation, the consultant may be excused from responsibility of the care of the patient or may share with the primary care physician in concurrent care; he/she may also have the patient referred for care and thus become the principal care physician. (2) The AMA communicate the appropriate use of consultation, evaluation and management, and office medical services codes to third party payers and advocate the appropriate reimbursement for these services in order to encourage high quality, comprehensive and appropriate consultations for patients.
H-290.969	Medicaid Waivers and Maintenance of Effort Requirements	Our AMA opposes any efforts to repeal the Medicaid maintenance of effort requirements in the ACA and American Recovery and Reinvestment Act (ARRA), which mandate that states maintain eligibility levels for all existing adult Medicaid beneficiaries until 2014 and for all children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019.	Rescind. No longer relevant.
H-290.984	Mandatory Enrollment of	The AMA, in keeping with its support for free market competition	Retain.

POLICY #	Title	Text	Recommendation
	Medicare-Medicaid Patients in Managed Care Plans	among all modes of health care delivery and financing, strongly opposes mandatory enrollment of Medicare and/or Medicaid patients in managed care plans.	
H-290.987	Medicaid Waivers for Managed Care Demonstration Projects	(1) Our AMA adopts the position that the Secretary of Health and Human Services should determine as a condition for granting waivers for demonstration projects under Section 1115(a) of the Medicaid Act that the proposed project: (i) assist in promoting the Medicaid Act's objective of improving access to quality medical care, (ii) has been preceded by a fair and open process for receiving public comment on the program, (iii) is properly funded, (iv) has sufficient provider reimbursement levels to secure adequate access to providers, (v) does not include provisions designed to coerce physicians and other providers into participation, such as those that link participation in private health plans with participation in Medicaid, and (vi) maintains adequate funding for graduate medical education. (2) Our AMA advocates that CMS establish a procedure which state Medicaid agencies can implement to monitor managed care plans to ensure that (a) they are aware of their responsibilities under EPSDT, (b) they inform patients of entitlement to these services, and (c) they institute internal review mechanisms to ensure that children have access to medically necessary services not specified in the plan's benefit package.	Retain.
H-315.968	Privacy Issues Regarding Insurance Company Explanation of Benefits	1. Our AMA advocates that electronic medical record (EMR) vendors be required to create user-triggered mechanisms that alert health care professionals of confidential medical information that should be safeguarded. 2. Our AMA encourages physicians to clearly identify health care information on both paper and electronic records that the patient has requested to be kept private.	Retain.

POLICY #	Title	Text	Recommendation
		3. Our AMA encourages physicians to develop individualized treatment plans for minors aged 12-17, in collaboration with parents or guardians, that outline expectations for the services provided and transitions toward increased privacy as the minor ages into adulthood. 4. Our AMA encourages physicians to inform their patients that they can request confidential communications from their office and health insurer by alternate means or locations than the policy holder's contact information, and to provide their patients with a Health Insurance Portability and Accountability Act (HIPAA) Privacy Rights Request Form. 5. Our AMA advocates that health insurers be required to develop a method of listing health care services on Explanation of Benefits statements that would preserve confidentiality for all insured individuals. 6. Our AMA advocates that health insurers be required to communicate clear procedures to all insured dependents on how to request confidential communications. 7. Our AMA advocates that health insurers be required to create privacy protections for all insured individuals on information that is contained on their Internet websites.	
H-315.992	Copying Records for Audits	Our AMA supports taking appropriate action to ensure that the financial responsibility for producing or copying patient records at the request of any regulatory agency having the authority to do so shall be borne entirely by the requesting agency and the request for said records shall be made at least 30 days in advance of any deadline.	Retain
H-320.956	Advance Directives and Utilization Review	The policy of the AMA is that: (1) the prior existence of advance directives (expressions of intent to forgo resuscitative, extraordinary,	Retain.

POLICY #	Title	Text	Recommendation
		unwanted or other care highly unlikely to improve or stabilize health status) should not jeopardize the provision of medically appropriate care, if the care is consistent with agreed upon limits; (2) individual physicians should not be reprimanded by reviewing bodies for abiding by the wishes of patients when providing appropriate care to individuals who have exercised advance directives.	
H-320.965	Responsibility for Hospital Admissions	It is the policy of the AMA that the determination of the medical necessity for hospital admission should be made only by a Doctor of Medicine, or a doctor of osteopathy licensed in the same jurisdiction as the treating physician.	Retain.
H-330.944	New Durable Medical Equipment Requirements	The AMA will work with CMS to develop and implement an exemption policy for low-cost DME supplies that are dispensed by physicians through their offices, based on such factors as current Medicare payment amounts, whether the item is usually disposable, linkage to a particular physician treatment, and specialty society recommendations. Claim for such supplies under these circumstances would not be subject to CMS's DME regulatory requirements and would be submitted to the local Medicare carrier.	Retain.
H-335.973	Reimbursement Violations	Our AMA will urge physicians who experience problems with their Medicare carrier's application of Medicare review criteria to report those problems, issues or concerns to their state medical association and state "Medicare Carrier Advisory Committee" for discussion and resolution.	Retain
H-385.927	Additional Prompt Payment Advocacy	Our AMA continues to support state medical association and national medical specialty society efforts and work independently with federal and state legislators and agencies to provide for a percentage of the financial penalty and/or accrued interest to be paid directly to the physician in the	Retain.

POLICY #	Title	Text	Recommendation
		cases where payers do not make payment within the specified time frame.	
H-385.948	Reasonable Charge for Preauthorization	The AMA strongly supports and advocates fair compensation for a physician's administrative costs when providing service to managed care patients.	Retain.
H-385.956	Payment for Ethics Consultations	The policy of the AMA is that physician provision of clinical ethics consultations for the guidance of individual patients or physicians, apart from and beyond their duties as members of hospital ethics committees, is an appropriately compensable medical service. Payment for these services should be made when they are reported with the appropriate existing CPT consultation codes (and prolonged physician service codes, if appropriate). The AMA recognizes that this does not address any aspect of payment for ethics consultations by non-physicians.	Retain.
H-385.959	Primary and Consultative Care	The AMA will promulgate policies to recognize the services of internists, pediatricians, family physicians and obstetrician/gynecologists as capable of providing both primary care and consultative care.	Retain.
H-390.867	Medical Rehabilitation Services	The AMA believes: (1) Rehabilitation criteria for reimbursement should be defined by medical needs of patients for rehabilitative care that includes functional, cognitive, social considerations, and cognitive status, specifically the so called “three-hour rule” is not a valid exclusion criterion for entry into a rehabilitation unit nor can it be the basis for denial of ongoing coverage in such a unit. (2) The severity of medical conditions, regardless of settings, must be accounted for, including a case-mix approach adjusted for regional variances to meet individual patient needs for high quality, cost effective medical, rehabilitation services.	Retain.

POLICY #	Title	Text	Recommendation
H-390.976	Delayed Payment of Medical Insurance Claims	Our AMA (1) expresses its concern and displeasure about CMS's practice of slowing payment of Medicare claims, which places an unwarranted financial burden upon the elderly and the practitioners and facilities which serve senior citizens; (2) supports model state legislation to establish incentives and/or penalties among private and public third party payers to rectify the problem of delayed insurance reimbursements; and (3) believes that reasonable interest should begin on uncontroverted claims not later than 30 days following receipt of a claim by the payer.	Rescind. Superseded by Policies H-190.959 and H-190.981 and AMA Model State Legislation. **Physician Reimbursement by Health Insurance and Managed Care Companies H-190.959** 1. Our AMA shall make it a top priority to seek regulatory and legislative relief to ensure that all health insurance and managed care companies pay for clean claims submitted electronically within fourteen days. 2. When electronic claims are deemed to be lacking information to make the claim complete, the health insurance and managed care companies will be required to notify the health care provider within five business days to allow prompt resubmission of a clean claim. 3. Our AMA shall advocate for heavy penalties to be imposed on health insurance and managed care companies, including their employees, that do not comply with laws and regulations establishing guidelines for claims payment. 4. Our AMA will continue to encourage regulators to enforce existing prompt pay requirements. **Required Timely Reimbursements by all Health Insurers H-190.981** Our AMA will prepare and/or seek sponsorship of legislation calling for all health insurance entities and third-party payers--inclusive of not-for-profit organizations and health maintenance organizations--to pay for "clean" claims when filed electronically within 14 days and paper claims within 30 days, with interest accruing thereafter. These time periods should be considered ceilings,

POLICY #	Title	Text	Recommendation
			not floors or fixed differentials between paper and electronic claims.
H-390.985	CMS Consultation with Physicians	The AMA encourages CMS to consult with clinically experienced practicing physicians on all determinations affecting medical practice and patient care.	Retain.
H-390.987	Medicare Assignments and Laboratory Reimbursements	The AMA supports educational efforts to assist physicians in differentiating between procedural billing and professional billing, particularly as they relate to billing for the drawing of a specimen and billing for interpreting the laboratory test results.	Retain.
H-450.932	Public Reporting of Quality and Outcomes for Physician-Led Team-Based Care	1. Our AMA will advocate that internal reporting of quality and outcomes of team-based care should be done at both the team and individual physician level. 2. Our AMA will advocate that public reporting of quality and outcomes data for team-based care should be done at the group/system/facility level, and not at the level of the individual physician. 3. Our AMA reaffirms the intent of the codified mandate in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA 2008) that public reporting of quality and outcomes data for team-based care should be done at the group/system level, and not at the level of the individual physician. 4. Our AMA will advocate that the current regulatory framework of public reporting for Meaningful Use also provide "group-level reporting" for medical groups/organized systems of care as an option in lieu of requiring MU reporting only on an individual physician basis.	Retain.
H-450.946	Ensuring Quality in Health System Reform	Our AMA: (1) will discuss quality of care in each of its presentations on health system reform; (2) will advocate for effective quality management programs in health system reform that: (a) incorporate substantial input by actively	Rescind. Superseded by Policies H-450.966, H-450.970, H-450.994, and H-450.944.

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		practicing physicians and physician organizations at the national, regional and local levels; (b) recognize and include key quality management initiatives that have been developed in the private sector, especially those established by the medical profession; and (c) are streamlined, less intrusive, and result in real reduced administrative burdens to physicians and patients; and (3) will take a leadership role in coordinating private and public sector efforts to evaluate and enhance quality of care by maintaining a working group of representatives of private and public sector entities that will: (a) provide for an exchange of information among public and private sector quality entities; (b) oversee the establishment of a clearinghouse of performance measurement systems and outcomes studies; (c) develop principles for the development, testing, and use of performance/outcomes measures; and (d) analyze and evaluate performance/outcomes measures for their conformance to agreed upon principles.	**Quality Management, H-450.966** (1) continues to advocate for quality management provisions that are consistent with AMA policy; (2) seeks an active role in any public or private sector efforts to develop national medical quality and performance standards and measures; (3) continues to facilitate meetings of public and private sector organizations as a means of coordinating public and private sector efforts to develop and evaluate quality and performance standards and measures; (4) emphasizes the importance of all organizations developing, or planning to develop, quality and performance standards and measures to include actively practicing physicians and physician organizations in the development, implementation, and evaluation of such efforts; (5) urges national medical specialty societies and state medical associations to participate in relevant public and private sector efforts to develop, implement, and evaluate quality and performance standards and measures; and (6) advocates that the following principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts: (a) Standards and measures shall have demonstrated validity and reliability. (b) Standards and measures shall reflect current professional knowledge and available medical technologies. (c) Standards and measures shall be linked to health outcomes and/or access to care. (d) Standards and measures shall be representative of the range of

POLICY #	Title	Text	Recommendation
			health care services commonly provided by those being measured. (e) Standards and measures shall be representative of episodes of care, as well as team-based care. (f) Standards and measures shall account for the range of settings and practitioners involved in health care delivery. (g) Standards and measures shall recognize the informational needs of patients and physicians. (h) Standards and measures shall recognize variations in the local and regional health care needs of different patient populations. (i) Standards and measures shall recognize the importance and implications of patient choice and preference. (j) Standards and measures shall recognize and adjust for factors that are not within the direct control of those being measured. (k) Data collection needs related to standards and measures shall not result in undue administrative burden for those being measured. (BOT Rep. 35, A-94; Reaffirmed: CMS Rep. 10, I-95; Reaffirmed: CMS Rep. 7, A-05; Modified: CMS Rep. 6, A-13; Reaffirmed in lieu of Res. 714, A-14; Reaffirmed in lieu of Res. 814, I-14; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmed in lieu of Res. 203, I-15; Reaffirmed in lieu of. Res. 216, I-15; Reaffirmed: BOT Rep. 20, A-16; Reaffirmed: CMS Rep. 02, I-17; Reaffirmation: A-22) **Quality Management Principles, H-450.970** Our AMA (1) continues to support the concept that physicians and healthcare organizations should strive

POLICY #	Title	Text	Recommendation
			continuously to improve the quality of health care; (2) encourages the ongoing evaluation of continuous quality improvement models; (3) promotes implementation of effective quality improvement models; and (4) identifies the useful approaches for assisting physicians in implementing quality improvement procedures in their medical practices and office management. (BOT Rep. AA, A-92; Reaffirmed: CMS Rep. 9, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20) **Quality of Care – Essentials and Guidelines for Quality Assessment H-450.995** (1) Including favorable outcome as one characteristic, the AMA believes that medical care of high quality should: (a) produce the optimal possible improvement in the patient's physiologic status, physical function, emotional and intellectual performance and comfort at the earliest time possible consistent with the best interests of the patient; (b) emphasize the promotion of health, the prevention of disease or disability, and the early detection and treatment of such conditions; (c) be provided in a timely manner, without either undue delay in initiation of care, inappropriate curtailment or discontinuity, or unnecessary prolongation of such care; (d) seek to achieve the informed cooperation and participation of the patient in the care process and in decisions concerning that process; (e) be based on accepted principles of medical science and the proficient use of

POLICY #	Title	Text	Recommendation
			appropriate technological and professional resources; (f) be provided with sensitivity to the stress and anxiety that illness can generate, and with concern for the patient's overall welfare; (g) make efficient use of the technology and other health system resources needed to achieve the desired treatment goal; and (h) be sufficiently documented in the patient's medical record to enable continuity of care and peer evaluation. (2) The AMA believes that the following guidelines for quality assessment should be incorporated into any peer review system. (a) The criteria utilized to assess the degree to which medical care exhibits the essential elements of quality should be developed and concurred in by the professionals whose performance will be reviewed. (b) Such criteria can be derived from any one of the three basic variables of care: structure, process, or outcome. However, emphasis in the review process should be on statistically verifying linkages between specific elements of structure and process, and favorable outcomes, rather than on isolated examination of each variable. (c) To better isolate the effects of structure and process on outcome, outcome studies should be conducted on a prospective as well as a retrospective basis to the degree possible. (d) The evaluation of "intermediate" rather than "final" outcomes is an acceptable technique in quality assessment. (e) Blanket review of all medical care provided is neither

POLICY #	Title	Text	Recommendation
			practical nor needed to assure high quality of care. Review can be conducted on a targeted basis, a sampling basis, or a combination of both, depending on the goals of the review process. However, judgment as to performance of specific practitioners should be based on assessment of overall practice patterns, rather than solely on examination of single or isolated cases. By contrast, when general assessment of the quality of care provided by a given health care system or across systems is desired, random sampling of all care episodes may be the more appropriate approach. (f) Both explicit and implicit criteria are useful in assessing the quality of care. (g) Prior consultation as appropriate, concurrent and retrospective peer review are all valid aspects of quality assessment. (h) Any quality assessment program should be linked with a quality assurance system whereby assessment results are used to improve performance. (i) The quality assessment process itself should be subject to continued evaluation and modification as needed. (CMS Rep. A, A-86; Reaffirmed: CMS Rep. E, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: BOT Action in response to referred for decision: Res. 718, A-17) **Quality Assurance in Health Care H-450.994** (1) Accountability through voluntary, professionally directed quality assurance mechanisms should be part of every system of health care delivery. The cost of quality assurance programs and activities should be considered a

POLICY #	Title	Text	Recommendation
			legitimate element in the cost of care. (Reaffirmed: Res. 711, A-94) (2) To fulfill their fundamental responsibility to maximize the quality of services, health care institutions should establish, through their governing bodies, a formal structure and process to evaluate and enhance the quality of their health care services. This should be accomplished by participation of the professional staff, management, patients and the general public. When appropriate, health care institutions should be urged by licensing and accrediting bodies to establish a formal committee to coordinate all quality assurance activities that occur among the various health care professions within the facility. (3) Voluntary accreditation programs with standards that exceed those of state licensure and that focus on quality-of-care issues should be offered to all health care facilities. Various agencies that accredit health care facilities should develop a formal interagency structure to coordinate their activities and to resolve any inter-organizational problems that may arise. (4) Public and private payment programs should limit their coverage for services provided in health care facilities to those that meet professionally acceptable standards of acceptable quality, should structure their reimbursement to support the improvement of quality, and should provide information on quality for the benefit of their subscribers. (5) Educational programs on quality assurance issues for health care professionals should be expanded through the inclusion of such material in health professions education programs, in preceptorships, in

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			clinical graduate training and in continuing education programs. (6) Educational programs should be developed to inform the public about the various aspects of quality assurance. Health care facilities and national and local health care organizations should make information available to the public about the factors that determine the quality of care provided by health care facilities, and about the extent to which individual health care facilities meet professionally acceptable standards of quality. (7) Research should be undertaken to assess the effects of peer review programs and payment mechanisms on the overall quality of health care. (BOT Rep. NN, A-87; Modified: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: BOT Rep. 20, A-16; Reaffirmed: BOT Action in response to referred for decision: Res. 718, A-17)
H-450.965	Medical Staff Leadership in Continuous Quality Improvement	The AMA will work with the AHA to assure that hospitals, in their continuous quality improvement/total quality management (CQI/TQM) programs, include practicing physicians in the development and implementation of such programs, especially the development of criteria sets and clinical indicators; provide feedback on CQI/TQM findings to physicians on a confidential basis; and inform all members of the medical staff on the CQI/TQM programs developed.	Retain.
H-450.997	Quality Assurance and Peer Review for Hospital Sponsored Programs	The AMA urges hospital medical staffs to make certain that all hospital sponsored, initiated, or affiliated medical services have appropriate peer review and quality assurance programs.	Retain.

REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (A-24)
Patient Medical Debt
(Resolution 710-A-23 and Resolution 712-A-23)
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the House of Delegates referred Resolutions 710 and 712. Resolution 710-A-23 asked the American Medical Association (AMA) to work with the appropriate national organizations to address the medical debt crisis by advocating for robust policies at the federal and state levels that prevent medical debt, help consumers avoid court involvement, and ensure that court involved cases do not result in devastating consequences to patient's employment, physical health, mental wellbeing, housing, and economic stability. Resolution 712-A-23 asked the AMA to study the causes of medical bankruptcy in the United States and draft a report for presentation at the 2024 Annual House of Delegates meeting, with such a report to include recommendations to the House of Delegates to severely reduce the problem of medical debt.

An estimated 100 million people in the United States (41 percent of adults) have debt related to unpaid medical bills, totaling between $195-220 billion. A 2021 Census Bureau analysis estimated that 15 percent of households in the United States owed medical debt. Medical debt is the leading cause of bankruptcy in the United States and can take many forms, including past due payments owed directly to a physician or hospital, ongoing payment plans, money owed to a bank or collections that has been assigned or sold the debt, credit card debt, and/or money borrowed from family or friends. Medical debt occurs widely across all demographic groups. Insurance coverage does not protect patients from incurring medical debt and debt is accrued both for patients with chronic medical conditions and as a result of unexpected acute events. Across the United States, approximately 50 million people are on a financing plan to pay off a medical or dental bill and about 25 percent of these individuals are paying interest. A portion of the interest collected may be kept by financing companies who often contract with physicians and hospitals to collect outstanding debt.

Medical financing products, such as medical credit cards and installment plans, can be offered to patients through hospitals or physicians' offices, but they are often serviced through third-party financial services companies. Historically, uninsured and low-income patients have been provided installment plans with zero or low interest rates directly from hospitals or physicians' offices where they received their care. Notably, as more physicians become employed, there is less control and awareness of the debt collection practices of their employers. In recent years, some hospitals and physicians' offices have partnered with financial service or private equity companies to offer more structured loan arrangements, which tend to charge market-level or higher interest rates.

In July 2023, the Biden Administration, the Consumer Financial Protection Bureau, the Department of Health and Human Services, and the Treasury Department issued a Request for Information on medical credit cards and other high-cost specialty financial products to understand their prevalence, patients' experience with them, and incentives driving physicians and other non-physician providers to offer these products.

The Council offers a series of recommendations to reduce patient medical debt.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-A-24

Subject: Patient Medical Debt
(Resolution 710-A-23 and Resolution 712-A-23)

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee G

At the 2023 Annual Meeting, the House of Delegates referred Resolutions 710 and 712. Resolution 710-A-23, introduced by the Michigan delegation, asked the American Medical Association (AMA) to work with the appropriate national organizations to address the medical debt crisis by advocating for robust policies at the federal and state levels that prevent medical debt, help consumers avoid court involvement, and ensure that court involved cases do not result in devastating consequences to patient's employment, physical health, mental wellbeing, housing, and economic stability. Resolution 712-A-23, introduced by the New Jersey delegation, asked the AMA to study the causes of medical bankruptcy in the United States and draft a report for presentation at the 2024 Annual House of Delegates meeting, with such a report to include recommendations to the House of Delegates to severely reduce the problem of medical debt.

BACKGROUND

An estimated 100 million people in the United States (41 percent of adults) have debt related to unpaid medical bills, totaling between $195-220 billion.[1] Of this 100 million, approximately 20 million people owe money directly to their physician, hospital, or other non-physician provider.[2] The remaining 80 million people reflect those that have other debts associated with their health care (i.e., credit card debt, loans from family and friends, etc.) The Consumer Financial Protection Bureau (CFPB) estimates that $88 billion of total medical debt is reflected on Americans' credit reports.[3] A 2021 Census Bureau analysis estimated that 15 percent of households in the United States owed medical debt.[4] Medical debt is the leading cause of bankruptcy in the United States and can take many forms, including past due payments owed directly to a physician or hospital, ongoing payment plans, money owed to a bank or collections that has been assigned or sold the debt, credit card debt, and/or money borrowed from family or friends.[5] Medical debt can often be masked as other forms of debt when someone falls behind on other expenses (i.e., food, housing, household goods) to pay down their medical bills.[6] Those with unaffordable medical bills are more likely to skip or delay needed care, cut back on basic household expenses, take money out of retirement or college savings, or increase credit card debt.[7]

Medical debt occurs across demographic groups, but is more likely if a patient has disabilities, is in worse health, is poor or near poor, is Black, lives in the South, lives in a non-Medicaid expansion state, or is middle aged. Women are more likely to report having medical debt than men (11 percent vs. 8 percent), which is likely due to childbirth-related expenses and lower average incomes.[8]

COVID-19 exacerbated several hardships associated with increased medical debt, including downstream effects of contracting COVID-19, losing employer-sponsored health insurance, or losing income. The Commonwealth Fund completed a study that found that half of all people ages 19-64 affected by

COVID-19 had medical debts or issues tangentially related to medical debt during the study period. COVID-19 hospitalizations and treatment also contributed to individuals' debt.[9]

Besides negative financial impacts, other consequences patients face include being contacted by collectors or negative credit score impacts, which makes it difficult to buy a vehicle, get a job, or buy or rent a home. Additionally, there are consequences associated with care: one in seven adults with health care debt say they have been denied care due to unpaid medical bills.[10]

Causes of Medical Debt in the United States

According to a KFF study, 72 percent of patients with medical debt claim the bills were from an unexpected acute event while 27 percent of those with debt claim that the expenses built up over time from treatments for chronic conditions.[11] Conversely, the Commonwealth Fund reports that the source of debt for many people is chronic conditions and that about half of adults with debt said it was the result from treatment received for ongoing health problems.[12] The discrepancy in these findings indicates that medical debt clearly impacts both patients who experience a one-time acute care event and those with chronic medical conditions.

Approximately 23 million people owe "significant" medical debt, which is considered to be anything $250 or greater, according to both KFF and the Survey of Income and Program Participation.[13] In 2020, the average amount of medical debt was $429.[14] Among single-person, privately insured households in 2019, 32 percent did not have liquid assets over $2,000 and among multi-person households, 20 percent did not have liquid assets over $2,000. Sixteen percent of privately insured adults say they would need to take on credit card debt to meet an unexpected $400 expense, while seven percent would need to borrow money from friends or family.[15]

Adults who are uninsured for six months or more out of the year are more likely to report having significant medical debt. However, medical debt burden does not solely impact those without health insurance. Over 90 percent of Americans have some form of health insurance. Even those with private health insurance may have insufficient liquid assets to meet high deductibles or other cost-sharing expenses.[16] Many working age adults surveyed by the Commonwealth Fund said it was very or somewhat difficult to afford their health care, including 43 percent of those with employer-sponsored coverage, 57 percent with Affordable Care Act (ACA) Marketplace or individual plans, 45 percent with Medicaid, and 51 percent with Medicare.[17]

Insurance coverage does not shield individuals from taking on debt. A substantial portion of people with insurance still have medical debt including 30 percent of people with employer-sponsored coverage, 37 percent enrolled in an ACA Marketplace or individual plan, 21 percent covered by Medicaid, and 33 percent covered by Medicare.[18] Among those in employer plans, those with low incomes especially struggled. Fifty-six percent of those with debt enrolled in employer-sponsored plans had incomes under 200 percent of the federal poverty line (FPL) and reported difficulty in paying for their health care.[19] Additionally, those in employer-sponsored plans with incomes below 400 percent FPL reported much higher rates of delaying or forgoing needed care due to the cost. More than half of these individuals reported that their health problem had gotten worse as a result of skipping care.

One concern with Medicaid specifically is estate recovery for those using Medicaid long-term care. Medicaid beneficiaries over the age of 55 that have used long-term services, such as a nursing home or home care, are subject to estate recovery after their death. State agencies will come after any assets, including the individual's home, in order to recoup the money spent on long-term care for the patient. In 2019, states collected $733 million in estate recovery, which is about 0.5 percent of Medicaid's total long-term care expenditures. Patient's families who do not have the assets to pay the expenses owed back to

Medicaid are often forced to sell the patient's home to cover the costs. These homes are often the last assets a family has and can further exacerbate existing poverty.[20]

Medical debt is a uniquely American problem as nearly half of all working-age Americans struggle with health care costs.[21] The Commonwealth Fund compared the performance of the United States' health system to those of other high-income countries and ranked it last among 11 nations in several categories including access, efficiency, equity, and health outcomes.[22] Health expenditures per person in the United States totaled $12,555 in 2022, which was over $4,000 more than any other high-income nation. The average amount spent on health per person in comparable countries is about half of what the United States spends per person ($6,651).[23] Americans also tend to be unhealthier than those in other countries. However, the comparison is limited due to the variance in health systems in each of the countries that were compared. America's global counterparts either have government health plans (i.e., Britain and Canada) or rely on subsidized private insurers (i.e., Germany and the Netherlands).[24] In addition, it would be unfair to compare the health care costs between America and its global counterparts due to the different tax burdens in each of these countries and how that impacts the total paid for health care. While the discrepancies between how these various systems work and serve patients may be of interest, this report specifically focuses on addressing American medical debt within the current health care system.

Impact on Physicians

An article in the *AMA Journal of Ethics* states that physicians have a responsibility to reduce debt, especially given the impact of patients forgoing care if they are unable to pay. At a minimum, physicians should be aware of their institution's charity care policy or reduced bill payment options.[25] However, physicians cannot continue providing care to patients if they are not paid, especially those working in small private practices. Asking patients to pay outstanding and overdue bills is increasingly difficult if there are reduced financial consequences to patients who fail to pay. According to Medscape's 2022 Physician Compensation Report, physicians react in the following ways when patients do not pay their outstanding bills: 43 percent continue to treat the patients and develop a payment plan; 13 percent send outstanding bills to third-party collection agencies; 12 percent continue to provide care and write off the balance; 25 percent choose other actions; and eight percent drop patients if they continue not to pay.[26]

Physicians are encouraged to have an established payment policy, presented in writing to all patients. These agreements should be clear and easy for all patients to understand. When possible, physicians should try to collect payment at the time of service and provide transparent pricing to patients. This could include explaining that costs for prescribed services (e.g., tests, imaging, medications) are often dictated by the patient's insurance plan and out of the control of the prescribing physician. In the event that unpaid accounts need to be turned over to a third-party collection agency, physicians should be mindful to select agencies that charge reasonable fees, noting that some charge a fee that is 30 to 40 percent of the total amount of debt they collect.

Physician responsibilities regarding patient medical debt and the cost of care are further codified in the following AMA Code of Ethics opinions: 11.1.1, 11.1.4, 11.2.1, 11.2.2, 11.2.4, and 11.3.3.

Patient Financing Programs

Medical financing products, such as medical credit cards and installment plans, can be offered to patients through hospitals or physicians' offices, but they are often serviced through third-party financial services companies. Historically, uninsured and low-income patients have been provided installment plans with zero or low interest rates directly from hospitals or physicians' offices where they received their care. Notably, as more physicians become employed, there is less control and awareness of the debt collection practices of their employers. In recent years, some hospitals and physicians' offices have partnered with

financial service or private equity companies to offer more structured loan arrangements, which tend to charge market-level or higher interest rates. Some even target patients with low credit scores, while others target specific services, such as fertility treatments.

Patient financing is a multi-billion-dollar business that includes private equity and banks buying patient debt from hospitals, physicians, and non-physician providers. Hospitals, physicians, and other non-physician providers, who have traditionally put patients in interest free payment plans, have embraced the patient financing model and have entered into contracts with these lenders. Many of these financing plans offer a promotional period where no interest is charged, but if a patient does not pay off the full amount owed during this time, interest is then charged. These loans can deepen inequities. For example, lower income patients without the means to make large monthly payments can face higher interest rates while wealthier patients who are able to take on larger monthly payments can secure lower interest rates. Additionally, patients with higher incomes can usually pay off the debt during the promotional period and avoid accruing any interest.[27]

Across the United States, approximately 50 million people are on a financing plan to pay off a medical or dental bill and about 25 percent of these individuals are paying interest. A portion of the interest collected may be kept by financing companies who contract with hospitals to collect outstanding debt. Many hospitals are reluctant to share specific details on their agreements with these companies but have cited the need to offset the cost of offering financing options to patients as a reason why they enter into these partnerships.[28]

If patients are unable to keep up with payments to the financing companies, their debt may be sent into collections or returned to the hospital or physician's office where further action may be taken. For example, one of these financing companies, AccessOne, returns patient accounts to the hospital if payments are missed. The hospital can then sue the patient, report them to credit bureaus, or take other collection action. Such actions could also include referring unpaid bills to the state revenue department, which can garnish tax refunds.[29] Medical credit cards may also be offered to patients. These accounts tend to charge patients interest rates higher than regular credit cards if patients are unable to pay their balances during the promotional period. In addition, when a patient uses a medical credit card, a physician's office may charge a fee at the time payment is disbursed. One such company, Alphaeon Credit, markets directly to ophthalmology, plastic surgery, dermatology, and dental practices. As an example, in the fine print of their offer to ophthalmology patients, Alphaeon Credit notes that "minimum payments are not guaranteed to pay the promotional plan balance within the promotional period…you may have to pay more than the minimum payment to avoid accrued interest charges." The annual percentage rate (APR) that a patient is charged if they do not pay off their balance within the promotional period is 31.99 percent, well above the average for a typical credit card.[30]

Hospital Charity Care

Charity care is offered at most hospitals in the United States. Nonprofit hospitals must provide financial aid as a condition of their tax-exempt status, which is something that saves the hospitals billions of dollars each year. However, standards for aid vary widely across hospitals. Aid at some hospitals is limited to patients below the FPL, while at other hospitals, patients with incomes that are five to six times the FPL can receive assistance. Applying for aid can be complicated for patients, requiring lots of personal financial information and documentation. A Kaiser Health News analysis of tax filings found that nearly one half of nonprofit medical systems were billing patients with incomes low enough to qualify for charity care.[31]

Problems associated with charity care are important and closely related to the broader issue of patient medical debt. Notably, the Council will be preparing a report for the 2024 Interim Meeting specifically on charity care and any associated recommendations will be included in the forthcoming report.

Recent Federal and State Efforts

In July 2023, the Biden Administration, CFPB, the Department of Health and Human Services (HHS), and the Treasury Department issued a Request for Information (RFI) on medical credit cards and other high-cost specialty financing products to understand their prevalence, patients' experience with them, and incentives driving physicians and other non-physician providers to offer these products. In the RFI, the agencies cite that hospitals and financial service companies might not be making reasonable efforts to determine when a patient is eligible for financial assistance before offering a medical financing product.[32]

Additionally, the RFI indicates that a typical APR for a medical credit card is 27 percent, while a typical consumer credit card has an average APR of about 16 percent. With medical credit cards, if a patient is unable to pay the balance within the no- or low-interest promotional period, the patient will then owe interest on the entire amount, not just the remaining balance. As a result, patients incurred a total of about $1 billion in deferred interest on health care purchases between 2018-2020.[33]

Although national credit reporting agencies agreed not to report medical debts that are less than a year old or under $500 on Americans' credit reports, using a medical financing product can impact patient credit scores more directly through "hard" credit checks, increased credit line utilization, decreased account age, or eventual account closure.[34] A benefit for hospitals, physicians, and non-physician providers utilizing medical financing products is being paid within days of providing a service and not having to handle disputes, billing, or other administrative work.

In addition to the RFI, in September 2023, CFPB released a notice that it is developing a rule to bar credit reporting companies from including medical debt in consumer credit reports. CFPB is seeking to prohibit lenders from using medical collections information when evaluating a borrower's application. The agency plans to issue a Notice of Proposed Rulemaking in 2024,[35] which was not available at the time that this report was written. As of November 2023, CFPB released a notice stating that it is taking steps to ensure medical debt collectors follow the law, including the Fair Debt Collection Practices Act and the Fair Credit Reporting Act. Specifically, these steps include supervision and enforcement efforts, reminding entities about their obligations, support for state-level action, and education and outreach. Although the Fair Debt Collection Practices Act limits how aggressive debt collectors can be by restricting the ways and times they can contact debtors, it does not limit or prohibit the use of legal remedies like wage garnishment or foreclosure. [36] Further, the Fair Debt Collection Practices Act currently only applies to debt collectors and does not include hospitals or other health care entities.

In addition to recent federal efforts, several states have created policies to protect patients from the consequences of having medical debt. A detailed overview, including maps of which states fall into each category can be found here.[37]

A summary of recent state actions include:

- Charging interest on medical debt
    - Eight states have laws prohibiting or limiting interest on all medical debt.
    - Some states have set a ceiling for interest on all medical debt. Others prohibit charging interest to patients who are at or below 250 percent FPL and are ineligible for public insurance programs.

- Regulations on sending medical bills to collections
  - Thirty-seven states do not regulate when a hospital can send a bill to collections. However, unlike hospitals, debt collectors do not have a relationship with patients and can be more aggressive when collecting on the debt.
  - Connecticut prohibits hospitals from sending bills of certain low-income patients to collections and Illinois requires hospitals to offer a reasonable payment plan first.
  - Maryland and Colorado require hospitals to report debt collection actions with demographic data and New Mexico and Colorado extended the requirements that are applicable to nonprofit hospitals to urgent care clinics, freestanding Emergency Departments, and outpatient clinics.[38]
- Sale of medical debt
  - Maryland, New Mexico, and Vermont prohibit the sale of medical debt while California and Colorado regulate debt buyers instead. California prohibits debt buyers from charging interest and Colorado prohibits them from foreclosing on a patient's home.
  - California also recently restricted when hospitals could sell patient debt or report patients to credit bureaus.[39] Debt collection is prohibited for 180 days, regardless of financial status.[40]
- Liens and foreclosures
  - Thirty-three states do not limit hospitals, collection agencies, or debt buyers from placing a lien or foreclosing on a patient's home to recover unpaid medical bills. However, almost all states provide a homestead exemption, which protects some equity in a patient's home from being seized during bankruptcy.
  - Eleven states prohibit or set limits on liens and foreclosures for medical debt.
  - New York and Maryland fully prohibit both liens and foreclosures because of medical debt, while California and New Mexico only prohibit them for certain low-income populations.
- Wage garnishment
  - Under federal law, the amount of wages garnished each week may not exceed the lesser of 25 percent of the employee's disposable earnings or the amount by which an employee's disposable earnings are greater than 30 times the federal minimum wage.
  - Twenty-one states exceed the federal ceiling for wage garnishment.
  - New York fully prohibits wage garnishment to recover medical debt for all patients, yet California only extends protections for certain low-income populations.
  - New Hampshire does not prohibit wage garnishment, but it does require the creditor to keep going back to court every pay period to garnish wages, which significantly limits creditors' ability to garnish wages in practice.

AMA POLICY AND ADVOCACY

AMA policy is limited on the issue of patient medical debt directly. Tangentially related policies address uncompensated care, controlling costs of care, price transparency, patient cost-sharing generally, and expanding coverage and improving affordability of coverage.

Policy D-155.987 states that our AMA: 1) encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status of the patient or other relevant information where possible; 2) advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs; 3) will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for

patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide; 4) will work with states and the federal government to support and strengthen the development of all-payer claims databases; 5) encourages electronic health record vendors to include features that assist in facilitating price transparency for physicians and patients; 6) encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving; and 7) will request that the Centers for Medicare & Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.

Policy H-165.846 states that our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options: a) any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose; b) existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program regulations) should be used as a reference when considering if a given plan would provide meaningful coverage; c) provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations; and d) mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits, and lifetime benefit caps, and excluded services. Policy H-165.846 also advocates that the Early and Periodic Screening, Diagnostic, and Treatment program be used as the model for any essential health benefits package for children and that the AMA: a) opposes the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of- pocket expenses; and b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits.

Policy D-180.979, which comes from CMS Report 9-A-19, states that the AMA will: 1) support the development of sophisticated information technology systems to help enable physicians and patients to better understand financial obligations; 2) encourage states and other stakeholders to monitor the growth of high deductible health plans and other forms for cost-sharing in health plans to assess the impact of such plans on access to care, health outcomes, medical debt, and provider practice sustainability; 3) advocate for the inclusion of health insurance contract provisions that permit network physicians to collect patient cost-sharing financial obligations (e.g., deductibles, co-payments, and co-insurance) at the time of service; and 4) monitor programs wherein health plans and insurers bear the responsibility of collecting patient co-payments and deductibles.

Policy H-373.996 states that our AMA supports the principles contained in the Medical Debt Relief Act as drafted and passed by the US House of Representatives to provide relief to the American consumer from a complicated collections process and supports medical debt resolution being portrayed in a positive and productive manner.

Policy H-160.923 states that our AMA: 1) supports the transitional redistribution of disproportionate share hospital payments for use in subsidizing private health insurance coverage for the uninsured; 2) supports the use of innovative federal- or state-based projects that are not budget neutral for the purpose of supporting physicians that treat large numbers of uninsured patients, as well as the Emergency Medical Treatment and Active Labor Act-directed care; and 2) encourages public and private sector researchers to utilize data collection methodologies that accurately reflect the amount of uncompensated care (including both bad debt and charity care) provided by physicians.

Policy H-165.838 states that the AMA is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components: health insurance coverage for all Americans; insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps; assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials; investments and incentives for quality improvement and prevention and wellness initiatives; repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care; implementation of medical liability reforms to reduce the cost of defensive medicine; and streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens.

DISCUSSION

Medical debt is a huge burden on many Americans across all demographic groups. Patients face negative outcomes associated with debt, including worse health outcomes, stress from being contacted by debt collectors and negative credit score impacts, and the downstream effects of difficulty getting a job or buying or renting a home.

Medical debt is accrued by patients with long-term, chronic conditions, as well as those with acute conditions or those suffering from an accident. Insurance coverage does not automatically protect patients from debt. Even with insurance coverage many patients struggle with high cost-sharing and deductibles offered by their insurance plans. Improved patient education on the cost of care and plan details could help patients better prepare for unexpected medical costs. Both insured and uninsured patients have reported delaying or forgoing needed care due to costs, further exacerbating health concerns.

The growth of high-deductible health insurance plans, which are increasingly offered to patients, have been shown to require deductibles too high for many Americans. In 2021, the average annual deductible for a single worker with employer-based coverage was over $1,400, which is almost four times greater than it was in 2006. Family deductibles can exceed $10,000.[41] Out-of-pocket maximums also prove to be too high for many Americans. For example, although the ACA caps out-of-pocket spending for those on Marketplace plans, in 2024, the out-of-pocket maximum for those on a Marketplace plan is $9,450 for an individual and $18,900 for a family.[42,43]

Many patients are unaware of reduced cost options offered by their hospital or physician's office. These plans should be easy for patients to access and should be discussed with patients at the time of payment. This includes sharing details about interest rates, timelines for payment, and anything else that may impact the patient financially. While physicians should be aware of the charity care policy in their office or institution, it must be understood that physicians cannot continue providing care to patients if they are not paid. This is made more difficult if penalties are reduced for patients who are unable or unwilling to pay their bills. The Council believes that physicians have the opportunity to educate patients on the charity care policy offered by their institution but should be mindful when partnering with third-party collection agencies, especially those who place wage garnishments and property liens on low-wage patients. If possible, physicians should try to handle debts with patients directly, by requiring payment prior to providing services (for non-emergent care), offering flexible payment plans, or forgiveness of debt altogether. Additionally, if a patient's medical bill is part of an ongoing dispute, hospitals and physicians should try to refrain from sending this bill to collections or to a third-party collection agency until the dispute is resolved.

The Council believes that recent efforts by the Biden Administration, CFPB, HHS, and Treasury Department to explore the causes of and solutions to medical debt provide the AMA with an opportunity

to support amendments to laws, such as the Fair Debt Collection Practices Act, to strengthen standards and provide additional clarity to patients about medical billing.

Several states, counties, and cities have taken a creative approach to managing medical debt for their residents. For example, New York City and Cook County (Chicago) in Illinois have recently partnered with RIP Medical Debt, a nonprofit organization that purchases and forgives medical debt from low-wage individuals. At the time that this report was written, Cook County and RIP Medical Debt have used $12 million of federal funds granted by the American Rescue Plan to forgive up to $1 billion in medical debt for residents.[44] New York City is also partnering with RIP Medical Debt and investing $18 million to purchase and forgive $2 billion in medical debt for approximately half a million New York residents.[45] To qualify for relief in both Cook County and New York, a resident must have an annual household income below 400 percent FPL or have medical debt equal to five percent or more of their annual household income. Other states and cities are exploring similar grants and partnerships. The AMA has an opportunity to be further educated on these and other initiatives to reduce medical debt for patients and explore ways to support the missions of these organizations.

Medical debt impacts many patients in the United States, causing negative health outcomes from delayed or denied care to stress from financial pressures from unpaid bills. When possible, the Council believes that physicians should support patient education on the cost of care, including potential downsides for alternative options for paying down debt, such as high interest rates or penalties for missing payments with third-party collection agencies. Understanding both the serious issue of medical debt for patients and that physicians need to be paid to continue providing care, physicians should be thoughtful when navigating this issue by encouraging patients to be informed about their insurance coverage and to take advantage of charity care when they qualify to reduce the burden of the cost of their care.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 710-A-23 and Resolution 712-A-23, and the remainder of the report be filed:

1) That our American Medical Association (AMA) encourage health care organizations to manage medical debt with patients directly, considering several options including but not limited to discounts, payment plans with flexibility and extensions as needed, or forgiveness of debt altogether, before resorting to third-party debt collectors or any punitive actions. (New HOD Policy)

2) That our AMA supports innovative efforts to address medical debt for patients, including public and private efforts to eliminate medical debt. (New HOD Policy)

3) That our AMA support amending the Fair Debt Collection Practices Act to include hospitals and strengthen standards within the Act to provide clarity to patients about whether their insurance has been or will be billed, which would require itemized debt statements to be provided to patients, thereby increasing transparency, and prohibiting misleading representation in connection with debt collection. (New HOD Policy)

4) That our AMA opposes wage garnishments and property liens being placed on low-wage patients due to outstanding medical debt at levels that would preclude payments for essential food and housing. (New HOD Policy)

5) That our AMA support patient education on medical debt that addresses dimensions such as:

a. Patient financing programs that may be offered by hospitals, physicians offices, and other non-physician provider offices;
b. The ramifications of high interest rates associated with financing programs that may be offered by a hospital, physician's office, or other non-physician provider's office;
c. Potential financial aid available from a patient's hospital and/or physician's office; and
d. Methods to reduce high deductibles and cost-sharing. (New HOD Policy)

Fiscal Note: Less than $500.

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Relevant AMA Policy
Patient Medical Debt

Price Transparency, D-155.987
1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.
2. Our AMA advocates that health plans provide enrollees or their designees with complete information regarding plan benefits and real-time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.
3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.
4. Our AMA will work with states and the federal government to support and strengthen the development of all-payer claims databases.
5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.
6. Our AMA encourages efforts to educate patients in health economic literacy, including the development of resources that help patients understand the cost of health care services they receive or anticipate receiving.
7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.
(CMS Rep. 4, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed in lieu of: Res. 213, I-17; Reaffirmed: BOT Rep. 14, A-18; Reaffirmed in lieu of: Res. 112, A-19; Modified: Res. 213, I-19; Reaffirmation: A-23)

Adequacy of Health Insurance Coverage Options, H-165.846
1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options:
a. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose.
b. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage.
c. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations.
d. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services.
2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children.
3. Our AMA: (a) opposes the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and (b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses.
(CMS Rep. 7, A-07; Reaffirmation: I-07; Reaffirmation: A-09; Reaffirmed: Res. 103, A-09; Reaffirmation: I-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: CMS Rep. 2, A-11; Appended: CMS Rep. 2, A-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed in lieu of Res. 812, I-13; Reaffirmed: CMS Rep. 6, I-14; Reaffirmed: CMS Rep. 6, I-15; Appended: CMS Rep. 04, I-17; Reaffirmed in lieu of: Res. 101, A-19)

Health Plan Payment of Patient Cost-Sharing, D-180.979
Our AMA will: (1) support the development of sophisticated technology systems to help enable physicians and patients to better understand financial obligations; (2) encourage states and other stakeholders to monitor the growth of high deductible health plans and other forms of cost-sharing in health plans to assess the impact of such plans on access to care, health outcomes, medical debt, and provider practice sustainability; (3) advocate for the inclusion of health insurance contract provisions that permit network physicians to collect patient cost-sharing financial obligations (e.g., deductibles, co-payments, and co-insurance) at the time of service; and (4) monitor programs wherein health plans and insurers bear the responsibility of collecting patient co-payments and deductibles.
(CMS Rep. 09, A-19)

Exclusion of Medical Debt that Has Been Fully Paid or Settled, H-373.996
Our AMA supports the principles contained in The Medical Debt Relief Act as drafted and passed by the US House of Representatives to provide relief to the American consumer from a complicated collections process and supports medical debt resolution being portrayed in a positive and productive manner.
(Res. 226, I-10; Reaffirmed: BOT Rep. 04, A-20)

Offsetting the Costs of Providing Uncompensated Care, H-160.923
Our AMA: (1) supports the transitional redistribution of disproportionate share hospital (DSH) payments for use in subsidizing private health insurance coverage for the uninsured; (2) supports the use of innovative federal- or state-based projects that are not budget neutral for the purpose of supporting physicians that treat large numbers of uninsured patients, as well as EMTALA-directed care; and (3) encourages public and private sector researchers to utilize data collection methodologies that accurately reflect the amount of uncompensated care (including both bad debt and charity care) provided by physicians.
(CMS Rep. 8, A-05; Reaffirmation: A-07; Modified: CMS Rep. 01, A-17)

Health System Reform Legislation, H-165.838
1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
a. Health insurance coverage for all Americans
b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
d. Investments and incentives for quality improvement and prevention and wellness initiatives
e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
f. Implementation of medical liability reforms to reduce the cost of defensive medicine
g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens
2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.
4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.

5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.
6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.
8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest
9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicates our AMA's position based on AMA policy.
10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.
11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.
12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.
13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.
(Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed in lieu of: Res. 805, I-17; Reaffirmed: CMS Rep. 03, A-18; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 02, I-23)

REPORT 6 OF THE COUNCIL ON MEDICAL SERVICE (A-24)
Economics of Prescription Medication Prior Authorization
(Resolution 725-A-23)
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the House of Delegates referred Resolution 725, which asked that the American Medical Association (AMA) work with the federal government and third-party payers and surrogates to include economic information on medications that are denied prior authorization.

The Council reviewed information regarding factors that contribute to the current state of prior authorization: formularies, rebates, and prescription drug pricing. Each of these factors contain layers of confusion and lack transparency. Not only are these factors opaque and complicated individually, but each interacts with the evolution of prior authorization. To better understand prior authorization denials, the Council examined information on the history of prior authorization and its current state. The Council found that denials are often issued by payers in a manner that is confusing and inconsistent for both physicians and patients. The Council also reviewed potential solutions to the problem, namely the utilization of real-time prescription benefit tools (RTBTs). These tools allow physicians to access patient coverage information at the time of prescribing, presenting an opportunity to improve the care delivery process and workflow. The current prior authorization system relies on communicating decisions after the prescription has been issued, often leading to care delays and adherence issues. Alternatively, RTBTs present coverage information prior to the prescription being written, allowing prescribers to identify care delivery hurdles earlier and avoiding unexpected prior authorization related delays.

Based on its review, the Council recommends the adoption of new AMA policy that outlines the basic requirements for prior authorization denial letters: a detailed explanation of denial reasoning, access to policies/rules cited as part of the denial, approved alternatives, and what is needed to approve the original prescription. Additionally, the Council recommends the amendment of current RTBT policy, to ensure alignment between patient and physician systems, that alternative prescriptions are offered, and that coverage information is honored by payers. Finally, the Council recommends the reaffirmation of a number of current policies to ensure that Pharmacy Benefit Managers (PBMs) are regulated, formulary data is available to physicians in real-time, that PBM actions do not erode the patient-physician relationship, and that prior authorization is not abused.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-A-24

Subject: Economics of Prescription Medication Prior Authorization (Resolution 725-A-23)

Presented by: Sheila Rege, MD Chair

Referred to: Reference Committee G

At the 2023 Annual Meeting, the House of Delegates referred Resolution 725-A-23, The Economics of Prior Authorization, which was sponsored by the Organized Medical Staff Section. This resolution asked;

> That our American Medical Association advocate to the federal government that third party payers and surrogates include economic information on the net costs of medication denied prior authorization and, where applicable, comparative net costs of alternative approved or suggested medications for each rejected prior authorization.

In response to the resolution, this report provides an overview of prior authorization and factors that contribute to prescription medication prior authorization specifically, including formularies, rebates, and drug pricing. The Council also explores that real-time benefit tools (RTBT) have the potential to help solve this issue. The Council presents policy recommendations consistent with the intent of Resolution 725-A-23.

BACKGROUND

The Council commends the sponsors of Resolution 725-A-23 for bringing forward this important topic and believes that the spirit of the resolution has the potential to positively impact both physicians and patients. Prior authorization is a complex and often frustrating process that physicians face on a regular basis. While additional information in denial letters is warranted, as suggested in the original resolution, the Council emphasizes that resources like RTBTs have the potential to improve the prior authorization process faced by patients and physicians. These tools allow physicians to access detailed information about the coverage of a prescription medication before the prescription is written, which could reduce the number of denial letters, increase the information accessible to physicians, and allow physicians to focus on patient care instead of appeals. To fully understand prior authorization, its economic impact, and how RTBTs could assist care delivery and workflow, it is necessary to understand some of the factors that contribute to the complexity, such as formularies, rebates, and the lack of prescription drug price transparency.

Formularies, or the list of prescription drugs covered by a payer, are created via consultation with experts, often supported or directed by pharmacy benefit managers (PBMs) and typically based on clinical outcomes and the relative costs.[1,2] Formularies are premised on reducing costs and ensuring the appropriate use of pharmaceuticals.[3] However, they often have negative impacts on patients and physicians. Specifically, research has demonstrated that among studied formularies at least half of all patient health care utilization and economic outcomes were not beneficial to

patients.[3] Drugs on a formulary are typically divided into different tiers based on the drug's price and the formulary designer's preference. A drug's tier position depends on a multitude of factors and can differ significantly between payers; however, one of the primary factors influencing any drug's tier placement is the financial arrangement between the payer and the drug manufacturer for that drug. Unfortunately, a drug's efficacy or its appropriateness for a particular patient, and its cost-effectiveness are often secondary considerations compared to the financial implications of the drug.

Manufacturers offer rebates that are typically negotiated between PBMs and the drug manufacturer and are typically based on the list price of the drug. Along with prior authorization, rebates are generally used to encourage a payer to include favorable placement or inclusion on a formulary.[4] Increased rebates are sometimes used to incentivize placement on a preferred formulary tier.[5] Rebates are relied on heavily by PBMs and other payers to negotiate more lucrative deals, and to protect these financial positions, it is critical to PBMs and payers that the specific details of these arrangements remain confidential. Without access to more detailed information about rebates and other financial incentives, it is impossible for physicians to fully understand how much a drug truly costs.

Payers often use prior authorization as a tool to discourage physicians from prescribing medications that are not on the payer's preferred formulary tier. If a payer prefers that a physician prescribe one drug over another within the same drug class, the payer can simply apply a prior authorization requirement to the non-preferred medication. By placing prior authorization on non-preferred drugs, payers can drive utilization in their desired direction. It is often challenging for physicians to determine whether a prior authorization is required at all, let alone what the specific requirements are. The prior authorization process is often so opaque that physicians may not be notified that a prior authorization is required until they receive a denial letter from the payer, or the patient is turned away at the pharmacy counter, which can lead to delays and significant interruptions in ongoing care as well as disruptions to patient adherence. Although these payer coverage determination delays and/or issues are rarely the physician's fault, patients may blame the physician, undermining the patient's trust in the physician and potentially impacting the patient-physician relationship long-term.

Physicians are often prescribing without access to drug cost and coverage information at the point of prescribing, making it almost impossible to avoid prescribing a drug that may be unaffordable under that specific patient's plan. This can cause the physician to unknowingly prescribe a more expensive medication when a lower-cost and equally beneficial medication is available and can cause significant harm to patient outcomes. Specifically, more expensive medications have been linked to lower treatment adherence, and, in extreme cases, increases in morbidity and/or mortality.[6] While there have been efforts from federal regulators and legislators to mitigate some of the negative impacts from medication prior authorization, the process remains opaque and complicated and, as a result, patients may not be able to readily access lower-cost alternative medications. Additionally, there is very little transparency from PBMs and payers regarding rebates, formulary makeup, and drug costs.[6] Rebate information is considered proprietary data and as such is not accessible for scrutiny, making it incredibly difficult for any regulating body to have accurate data leading to challenges in effective regulation.

PRIOR AUTHORIZATION DENIALS

The roots of prior authorization can be traced back to the original Medicare and Medicaid legislation from the 1960s which introduced utilization review, or the process of verifying the need for treatment, often hospital stays, for a confirmed diagnosis.[7] Over time, this process has expanded

to include the coverage of prescription medications and to what is now recognized as prior authorization.[7] When introduced, prior authorization was touted as a method to restrict significant increases in the cost of prescription drugs, however this process has become one that is burdensome for both patients and physicians.[8] Prior authorization has resulted in several adverse consequences ranging from increased administrative burden to patient inability to access necessary medications.[8] Additionally, the prior authorization process can undermine the patient-physician relationship. Physicians and patients frequently have limited knowledge if prior authorization will be required for a medication, hindering the ability for physicians to ensure affordable, timely access to the medication they deem the most appropriate.[9]

Today, prior authorization has become pervasive throughout the health care system. A recent report found that 99 percent of Medicare Advantage (MA) plans require prior authorization for at least some services; most often for Part B drugs.[10] Additionally, a study investigating MA plans found that prior authorizations are submitted, on average, 1.5 times for each enrollee, adding up to approximately 35 million requests in one year.[11] Of the submitted requests in MA plans this study found that six percent, or approximately 2 million, were denied. However, this denial rate ranged greatly among payers with some denial rates as high as double the average. Importantly, this study found that only 11 percent of denied prior authorizations were appealed by either the patient or provider. The vast majority of appeals were successful with 82 percent resulting in a full or partial overturning of the denial. Similar to rates of denials, some payers saw much higher rates of appeal, some reaching 20 percent of all denials. Further, for some payers, appeals were successful as much as 94 percent of the time.[11] While this study is helpful in beginning to understand the rates of prior authorization denials, the researchers did not have access to disaggregated data showing the service type of prior authorization requests and were unable to access reasoning for each denial or information on the timeliness of requests or appeals. Additionally, these statistics were only based on MA plans; private plans were not included. It is important to note that physicians who are forced to appeal prior authorization denials often face significant administrative costs. Physicians and their offices are often required to hire additional staff and/or spend personal time managing authorizations and appeals.

Legislators and regulators have introduced rules and regulations that are designed to minimize the struggles that plague the prior authorization process. For example, a recent final regulation from the Centers for Medicare & Medicaid Servicecs (CMS) requires that as of January 1, 2027, payers, including MA, Medicaid, Children's Health Insurance Program, and Qualified Health Plans on the Federally Facilitated Exchange are required to maintain a prior authorization application programming interface (API). This API must include information on covered items and services, identification of documents required for prior authorization, be supportive of prior authorization requests and payer responses, and communicate approvals, denials, or requests for additional information.[12] Effective January 1, 2026, payers will be required to report metrics and follow a stricter response timeline.[13] While this rule will improve the regulation of prior authorization, it does not extend to prescription drug prior authorization requests.

One of the biggest issues with prior authorization is the opaque and extensive denial process. Not only is this a frustrating process for the patient looking to access treatment, but it is also exasperating for physicians who are attempting to support their patients. When a denial letter is sent out, it may not include effective information to understand and/or appeal the denial itself. For example, physicians and patients may simply be informed that a medication has not been approved without providing justification as to why the denial took place or an alternative treatment option. Without clear information regarding the clinical rationale for the denial, patients and physicians are often left to the frustrating process of guess work in attempting to find a treatment covered by the patient's plan.

In order to improve the quantity and quality of information provided in denial letters, CMS has implemented basic requirements for all Medicare health plans.[14] These requirements, outlined in CMS-10003-Notice of Denial of Medical Coverage or Payment form are in place for all medical services and prescription drug denials. Specifically, in denial letters, plans must provide the patient/physician with detailed information as to why the request was denied. Plans are required to include a "specific and detailed" explanation for the denial, applicable coverage rules or plan policies cited in the denial, and specific information as to what needs to be done to approve coverage.[14] These requirements ensure that the Medicare beneficiaries and their physicians are able to have an understanding of the full scope of the denial via the notification letter.

REAL-TIME BENEFIT TOOL

To address the underlying concerns of Resolution 725-A-23, the Council worked to better understand available data and what could feasibly be provided to physicians and patients. Not only are there issues related to a lack of transparency due to prior authorization, at present, prior authorization denial systems are not capable of producing specific net cost information on denials. The Council believes that advocacy efforts supporting the betterment of alternative solutions, like RTBTs, instead of the expansion of prior authorization systems better serve physicians and their patients. One potential solution to the challenges faced due to prior authorization are RTBTs, which allow patients and prescribers to access real-time information about coverage, including formularies and benefit information at the point of prescribing.[15] These tools simplify prescribing with real-time information during an appointment. RTBTs allow prescribers to enter prescription details, like type, amount, and intended pharmacy, and be informed, prior to writing the prescription, of the cost and prior authorization requirements. RTBTs also allow physicians and other prescribers to view alternative medications that may be lower cost to the patient and/or not require prior authorization, thus allowing the prescriber to identify and prescribe the most appropriate and accessible medication for a patient.[16]

RTBTs present an opportunity to improve the care delivery process by presenting prescribers with critical prescription coverage and cost information at the point of prescribing. The current prior authorization system relies heavily on relaying information to the patient/prescriber after a prescription has been written and the patient has attempted to get that prescription filled. These "post-prescription written denials," usually delivered to prescribers via letters, often lead to additional work for prescribers and their staff and result in immense administrative practice burdens. In addition to increased work for physicians and their staff, the current prior authorization process also often leads to patient care delays and adherence issues. RTBTs present all of the cost, coverage, and other pertinent benefit information within the prescriber's typical prescribing workflow and allow the prescriber to not only identify prior authorization requirements prior to writing the prescription, but also submit the prior authorization request directly to the payer sooner.

By providing information at the beginning of the prescribing process, RTBTs allow prescribers to identify care delivery impediments earlier so they avoid any unexpected utilization management delays. RTBTs have the potential to mitigate the impact of prior authorization denial letters by informing prescribers of alternative, therapeutically equivalent medications that do not require prior authorization at the point of care. RTBTs allow physicians to see which medications would be covered and thus prior authorizations, and subsequent denial letters, should only be necessary if the prescriber determines that the alternative, covered medication is not clinically appropriate. With fewer denial letters, physicians can spend more time caring for patients and less time on appeals.

Current CMS regulation requires that all Medicare Part D plans provide at least one RTBT. In practice, for physicians and qualified providers to have access to RTBT information for all patients, they may need to support and integrate multiple RTBT and Electronic Health Records (EHR) systems. This is burdensome and complicated for all physicians to implement, and nearly impossible for smaller practices. Managing multiple systems is not only expensive and complex, it also may lead to confusion on RTBTs. In response to the complications that arose with the need to manage and support multiple RTBT and EHR systems, CMS has proposed a rule that would require Part D plans to implement a standardized system.[17] This standard, the National Council for Prescription Drug Programs RTPB Standard Version 13 would allow for standardized formulary and benefit data in a manner that is reliable, detailed, and effectively integrated into systems.[18] The AMA has been vocal in advocating for and supporting this proposed rule.[19] Should the proposed rule be implemented, starting January 2027, this standardized system would allow for increasingly efficient physician access to clear information at the time of prescribing. Of note, this requirement would not extend to private insurers, however the requirement of this standard system by CMS could lead to future implementation in the private sector.

AMA ADVOCACY

The AMA's extensive advocacy efforts work to address each of the systemic factors cited by Resolution 725-A-23, including prior authorization, formularies, rebates, prescription drug pricing transparency, and RTBTs. Regarding prior authorization, the AMA has an ongoing grassroots campaigns "Fix Prior Auth" to address the harm incurred by patients and physicians by prior authorization,[20] and TruthinRx, which aims to educate patients, physicians, providers, and legislators about the issues that arise from the lack of price transparency.[21] TruthinRx advocates for transparency from PBMs, payers, and manufacturers around formularies and rebates. The goals of these campaigns are to spread awareness, create legislative changes, and serve as an extensive resource for patients, physicians, and employers on these high priority issues.

Additionally, the AMA conducts regular surveys to track and report the impact of prior authorization on patients and physicians. The survey includes questions aimed at better understanding the impact of prior authorization for generic medication. In addition to this work, AMA advocacy has commented on prior authorization via letters and testimony to state legislators, Congress, and federal agencies 35 times in 2023 alone and has already been active in advocating for these issues in 2024.

AMA advocacy has commented on relevant transparency issues through 21 letters and testimonies to state legislators, Congress, and federal agencies in 2023. Finally, to support the implementation of RTBTs, AMA advocacy has sent 18 letters and testimonies in 2023 to Congress and federal agencies. Efforts have already been made, and continue to be made, in 2024 to advocate on these issues. Each of these factors contribute to the issues raised in Resolution 725-A-23 and are clearly on the AMA advocacy's ongoing agenda.

AMA POLICY

Underscoring the extensive advocacy work on these issues is a robust body of AMA policy aimed at ensuring that prior authorization is monitored and minimized, PBMs are monitored and regulated, the process is transparent, and to support the implementation of adequate RTBT tools.

Policy H-125.991 outlines the standards that both formulary systems and Pharmacy and Therapeutic Committees should meet. For example, this policy outlines that formulary systems should include oversight from organized medical staff. This policy is reinforced by similar

guidelines in Policy H-285.965, which, among other things, outlines that both physicians and patients should have access to clear information about a payer's formulary and that these formularies should be created and maintained with the input of physicians. In addition to these policies dealing directly with the creation and maintenance of formularies, Policy H-110.981 details advocacy efforts to ensure that PBMs and regulatory bodies make rebate and discount reports available to the public, ideally, assisting in disentangling the influence rebates have on the complex and opaque process that is formulary creation.

AMA policy also deals directly with efforts to ensure that PBMs are monitored and that there is an increase in transparency regarding their operation. Specifically, Policy D-110.987 outlines the advocacy efforts that the AMA continues to implement to ensure that PBMs are required to increase transparency in their operating procedures and that they are adequately regulated on both a state and federal level. Additionally, Policy H-125.986 encourages physician engagement in reporting issues with PBMs and indicates efforts to increase PBM oversight and reduce PBM overreach in medical practice. Policy H-110.963 expands the coverage of regulation and monitoring to third-party PBMs. Each of these policies aim to implement adequate oversight of PBMs. Finally, Policies H-125.986 and D-120.933 outline the AMA's support to ensure that PBMs' actions do not impede or negatively impact the patient-physician relationship.

In addition to AMA policy on contributing factors to prior authorization, the AMA has extensive policy on prior authorization and increasing physician access to real time prescribing information. Policy H-125.979 specifies AMA efforts to work with appropriate parties to ensure that physicians have access to real-time formulary data when prescribing a medication. Additionally, Policy H-120.919 outlines AMA efforts to support the implementation of RTBT tools that are helpful to prescribers and accurate at the time of prescribing. Finally, Policy H-320.945 outlines AMA opposition to prior authorization abuses and outlines the requirement for payers to report accurate statistics on approvals and denials.

DISCUSSION

Prior authorization is a tool that was initially introduced to save money and ensure that care given to patients was medically necessary. However, in the years since its introduction it has been overutilized and is now a burden for physicians as well as a barrier to patients accessing care. The opaqueness of both rebates and formularies contribute greatly to the confusion and subsequent frustration that results from denied prior authorization. The AMA continues to make significant efforts on multiple fronts to address this issue and ensure that prior authorization is fixed for patients and physicians.

Resolution 725-A-23 asked that the AMA work to encourage the inclusion of economic information when prescription drugs are denied prior authorization. The Council believes that this concept would be beneficial to physicians and that alternative solutions, like RTBT tools, should be supported in order to mitigate the need for some prior authorizations. In the spirit of Resolution 725-A-23, and to address the confusion that can arise from prior authorization denial letters, the Council recommends that a new policy be adopted to support working with appropriate parties to ensure that denial letters include information that is helpful to physicians and patients in understanding the full scope of denial. Such a policy will benefit ongoing and future AMA advocacy letters and testimony.

The AMA has worked, and continues to work, extensively on ensuring that the burden of prior authorization is lessened for both physicians and patients. One aspect of this ongoing work has been rooted in policy outlining the AMA's support for RTBT tools. This work advocates for

physicians to be able to access systems that are effective, efficient, and accurate. Accordingly, the Council suggests amending Policy H-120.919 to better align the standards and language with CMS policy, and to ensure that these tools provide a justification for the prior authorization requirement, offer alternative(s), and that coverage determinations from the RTBT are honored.

Finally, the Council recommends that Policies H-110.963; Third-Party Pharmacy Benefit Administrators; H-125.979; Private Health Insurance Formulary Transparency; H-320.945; Abuse of Preauthorization Procedures; H-125.986 Pharmaceutical Benefit Management Companies; and D-120.933 Pharmacy Benefit Managers Impact on Patients be reaffirmed. These policies outline the AMA's efforts to ensure that all PBMs are monitored, regulated, and do not harm the physician-patient relationship, that health insurers are required to be transparent about the creation and maintenance of formularies, and that prior authorization is not abused by payers.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 725-A-23, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support working with payers and interested parties to ensure that prior authorization denial letters include at a minimum (1) a detailed explanation of the denial reasoning, (2) a copy of or publicly accessible link to any plan policy or coverage rules cited or used as part of the denial, and (3) what rationale or additional documentation would need to be provided to approve the original prescription and alternative options to the denied medication. (New HOD Policy)

2. That our AMA amend Policy H-120.919 to read as follows:

   That our AMA will: (1) continue to support efforts to ~~publish~~ implement a ~~Real-Time Prescription Benefit (RTPB)~~ Real-Time Benefit Tool (RTBT) standard that meets the needs of all physicians and other prescribers, utilizing any electronic health record (EHR), and prescribing on behalf of any insured patient; (2) support efforts to ensure that provider-facing and patient facing RTBT systems align; and (3) advocate that all payers (i.e., public and private prescription drug plans) be required to implement and keep up to date an ~~RTPB~~ RTBT standard tool that integrates with all EHR vendors, and that any changes that must be made to accomplish ~~RTPB~~ RTBT tool integration be accomplished with minimal disruption to EHR usability and cost to physicians and hospitals; (4) advocate that RTBT systems provide a justification for why prior authorization is required and include approved/covered alternative prescription medications; ~~and~~ (~~3~~5) develop and disseminate educational materials that will empower physicians to be prepared to optimally utilize ~~RTPB tools~~ RTBT and other health information technology tools that can be used to enhance communications between physicians and pharmacists to reduce the incidence of prescription abandonment; (6) advocate that payers honor coverage information that is based on a RTBT at the time of prescription and that prior authorization approvals should be valid for the duration of the prescribed/ordered treatment; and (7) continue to advocate for the accuracy and reliability of data provided by RTBTs and for vendor neutrality to ensure that it is supportive to physician efforts. (Modify Current HOD Policy)

3. That our AMA reaffirm Policy H-110.963, which addresses the regulation and monitoring of third-party Pharmacy Benefit Managers (PBMs) in an effort to control prescription drug pricing. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-125.979, which outlines advocacy efforts to ensure that physicians have access to real-time formulary data when prescribing. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-320.945, which details opposition to the abuse of prior authorization and the requirement for payers to accurately report denials and approvals. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-125.986, which outlines the AMA's position that certain actions from PBMs interfere with physician practice and may impact the patient-physician relationship. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy D-120.933, which encourages the gathering of data to better understand the impact that PBM actions may lead to an erosion of the patient-physician relationship. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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CMS Report Economics of Prior Authorization
Relevant AMA Policy

Drug Formularies and Therapeutic Interchange (H-125.991)
It is the policy of the AMA:
(1) That the following terms be defined as indicated:

a) Formulary: a compilation of drugs or drug products in a drug inventory list; open (unrestricted) formularies place no limits on which drugs are included whereas closed (restrictive) formularies allow only certain drugs on the list;
b) Formulary system: a method whereby the medical staff of an institution, working through the pharmacy and therapeutics committee, evaluates, appraises, and selects from among the numerous available drug entities and drug products those that are considered most useful in patient care;
c) Pharmacy & Therapeutics (P&T) Committee: an advisory committee of the medical staff that represents the official, organizational line of communication and liaison between the medical staff and the pharmacy department; its recommendations are subject to medical staff approval;
d) Therapeutic alternates: drug products with different chemical structures but which are of the same pharmacological and/or therapeutic class, and usually can be expected to have similar therapeutic effects and adverse reaction profiles when administered to patients in therapeutically equivalent doses;
e) Therapeutic interchange: authorized exchange of therapeutic alternates in accordance with previously established and approved written guidelines or protocols within a formulary system; and
f) Therapeutic substitution: the act of dispensing a therapeutic alternate for the drug product prescribed without prior authorization of the prescriber.

(2) That our AMA reaffirms its opposition to therapeutic substitution (dispensing a therapeutic alternate without prior authorization) in any patient care setting.

(3) That drug formulary systems, including the practice of therapeutic interchange, are acceptable in inpatient hospital and other institutional settings that have an organized medical staff and a functioning Pharmacy and Therapeutics (P&T) Committee, provided they satisfy the following standards:

(a) The formulary system must:
(i) have the concurrence of the organized medical staff;
(ii) openly provide detailed methods and criteria for the selection and objective evaluation of all available pharmaceuticals;
(iii) have policies for the development, maintenance, approval, and dissemination of the drug formulary and for continuous and comprehensive review of formulary drugs;
(iv) provide protocols for the procurement, storage, distribution, and safe use of formulary and non-formulary drug products;
(v) provide active surveillance mechanisms to regularly monitor both compliance with these standards and clinical outcomes where substitution has occurred, and to intercede where indicated;
(vi) have enough qualified medical staff, pharmacists, and other professionals to carry out these activities;

(vii) provide a mechanism to inform the prescriber in a timely manner of any substitutions, and that allows the prescriber to override the system when necessary for an individual patient without inappropriate administrative burden;
(viii) provide a mechanism to assure that patients/guardians are informed of any change from an existing outpatient prescription to a formulary substitute while hospitalized, and whether the prior medication or the substitute should be continued upon discharge from the hospital;
(ix) include policies that state that practitioners will not be penalized for prescribing non-formulary drug products that are medically necessary; and
(x) be in compliance with applicable state and federal statutes and/or state medical board requirements.

(b) The P&T Committee must:
(i) objectively evaluate the medical usefulness and cost of all available pharmaceuticals (reliance on practice guidelines developed by physician organizations is encouraged);
(ii) recommend for the formulary those drug products which are the most useful and cost-effective in patient care;
(iii) conduct drug utilization review (DUR) activities;
(iv) provide pharmaceutical information and education to the organization's (e.g., hospital) staff;
(v) analyze adverse results of drug therapy;
(vi) make recommendations to ensure safe drug use and storage; and
(vii) provide protocols for the timely procurement of non-formulary drug products when prescribed by a physician for the individualized care of a specific patient, when that decision is based on sound scientific evidence or expert medical judgment.

(c) The P&T Committee's recommendations must be approved by the medical staff;

(d) Within the drug formulary system, the P & T Committee shall recommend, and the medical staff must approve, all drugs that are subject to therapeutic interchange, as well as all processes or protocols for informing individual prescribing physicians; and

(e) The act of providing a therapeutic alternate that has not been recommended by the P&T Committee and approved by the medical staff is considered unauthorized therapeutic substitution and requires immediate prior consent by the prescriber, (i.e., authorization for a new prescription).

(4) That drug formulary systems in any outpatient setting shall operate under a P&T Committee whose recommendations must have the approval of the medical staff or equivalent body and must meet standards comparable to those listed above. In addition:

(a) That our AMA continues to insist that managed care and other health plans identify participating physicians as their "medical staff" and that they use such staff to oversee and approve plan formularies, as well as to oversee and participate on properly elected P&T Committees that develop and maintain plan formularies;
(b) That our AMA continues to insist that managed care and other health plans have well-defined processes for physicians to prescribe non-formulary drugs when medically indicated, that this process impose minimal administrative burdens, and that it include access to a formal appeals process for physicians and their patients; and

(c) That our AMA strongly recommends that the switching of therapeutic alternates in patients with chronic diseases who are stabilized on a drug therapy regimen be discouraged.

(5) That our AMA encourages mechanisms, such as incentive-based formularies with tiered co-pays, to allow greater choice and economic responsibility in drug selection but urges managed care plans and other third-party payers to not excessively shift costs to patients so they cannot afford necessary drug therapies. (BOT Rep. 45, I-93; Reaffirmed by Sub. Res. 501, A-95; Appended: BOT Rep. 7, I-99; Modified: Sub. Res. 524 and Reaffirmed: Res. 123, A-00; Reaffirmed: Res. 515, I-00; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: Res. 533, A-03; Modified: CMS Rep. 6, A-03; Modified: CSA Rep. 2, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 535, A-05; Reaffirmed: BOT Action in response to referred for decision Res. 503, A-05; Reaffirmed: CMS Rep. 2, I-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, A-10; Reaffirmed: CMS Rep. 01, A-20)

The Impact of Pharmacy Benefit Managers on Patients and Physicians (D-110.987)

1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance.
2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.
3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.
4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.
5. Our AMA supports improved transparency of PBM operations, including disclosing:
    - Utilization information;
    - Rebate and discount information;
    - Financial incentive information;
    - Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization, and step therapy;
    - Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;
    - Methodology and sources utilized to determine drug classification and multiple source generic pricing; and
    - Percentage of sole source contracts awarded annually.
6. Our AMA encourages increased transparency in how DIR fees are determined and calculated. (CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 6, I-20)

Pharmaceutical Benefits Management Companies (H-125.986)

Our AMA:

(1) encourages physicians to report to the Food and Drug Administration's (FDA) MedWatch reporting program any instances of adverse consequences (including therapeutic failures and adverse drug reactions) that have resulted from the switching of therapeutic alternates;

(2) encourages the Federal Trade Commission (FTC) and the FDA to continue monitoring the relationships between pharmaceutical manufacturers and PBMs, especially with regard to

manufacturers' influences on PBM drug formularies and drug product switching programs, and to take enforcement actions as appropriate;
(3) pursues congressional action to end the inappropriate and unethical use of confidential patient information by pharmacy benefits management companies;
(4) states that certain actions/activities by pharmacy benefit managers and others constitute the practice of medicine without a license and interfere with appropriate medical care to our patients;
(5) encourages physicians to routinely review their patient's treatment regimens for appropriateness to ensure that they are based on sound science and represent safe and cost-effective medical care;
(6) supports efforts to ensure that reimbursement policies established by PBMs are based on medical need; these policies include, but are not limited to, prior authorization, formularies, and tiers for compounded medications; and
(7) encourages the FTC and FDA to monitor PBMs' policies for potential conflicts of interests and anti-trust violations, and to take appropriate enforcement actions should those policies advantage pharmacies in which the PBM holds an economic interest. (BOT Rep. 9, I-97; Appended: Res. 224, I-98; Appended: Res. 529, A-02; Reaffirmed: Res. 533A-03; Reaffirmation I-08; Reaffirmation A-10; Reaffirmed: Alt. Res. 806, I-17; Modified: Res. 242, A-18; Reaffirmed: CMS Rep. 08, A-19)

Third-Party Pharmacy Benefit Administrators (H-110.963)
1. Our AMA recommends that third-party pharmacy benefit administrators that contract to manage the specialty pharmacy portion of drug formularies be included in existing pharmacy benefit manager (PBM) regulatory frameworks and statutes, and be subject to the same licensing, registration, and transparency reporting requirements.
2. Our AMA will advocate that third-party pharmacy benefit administrators be included in future PBM oversight efforts at the state and federal levels. (Res. 820, I-22)

Private Health Insurance Formulary Transparency (H-125.979)
1. Our AMA will work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing.
2. Our AMA supports legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, that formulary information be specific as to generic versus trade name and include copay responsibilities, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term.
3. Our AMA will develop model legislation (a) requiring insurance companies to declare which drugs on their formulary will be covered under trade names versus generic, (b) requiring insurance carriers to make this information available to consumers by October 1 of each year and, (c) forbidding insurance carriers from making formulary deletions within the policy term.
4. Our AMA will promote the following insurer-pharmacy benefits manager - pharmacy (IPBMP) to physician procedural policy: In the event that a specific drug is not or is no longer on the formulary when the prescription is presented, the IPBMP shall provide notice of covered formulary alternatives to the prescriber promptly so that appropriate medication can be provided to the patient within 72 hours.
5. Drugs requiring prior authorization, shall be adjudicated by the IPBMP within 72 hours of receipt of the prescription.
6. Our AMA (a) promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers nationwide, and (b) supports state medical societies in advocating for state legislation to ensure online access to up-to-date and accurate prescription drug formularies for all insurance plans.

7. Our AMA will continue its efforts with the National Association of Insurance Commissioners addressing the development and management of pharmacy benefits.
8. Our AMA will develop model state legislation on the development and management of pharmacy benefits. (Sub. Res. 724, A-14; Appended: Res. 701, A-16; Appended: Alt. Res. 806, I-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: BOT Rep. 20, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 2, A-21)

Access to Health Plan Information Regarding Lower-Cost Prescription Options (H-120.919)
Our AMA will: (1) continue to support efforts to publish a Real-Time Prescription Benefit (RTPB) standard that meets the needs of all physicians and other prescribers, utilizing any electronic health record (EHR), and prescribing on behalf of any insured patient; (2) advocate that all payers (i.e., public and private prescription drug plans) be required to implement and keep up to date an RTPB standard tool that integrates with all EHR vendors, and that any changes that must be made to accomplish RTPB tool integration be accomplished with minimal disruption to EHR usability and cost to physicians and hospitals; and (3) develop and disseminate educational materials that will empower physicians to be prepared to optimally utilize RTPB tools and other health information technology tools that can be used to enhance communications between physicians and pharmacists to reduce the incidence of prescription abandonment. (CMS Rep. 2, I-21)

Pharmaceutical Costs (H-110.987)
1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by ten percent or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug

shortage, no available comparable generic drug, or a price increase of 10 percent or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation. (CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21; Reaffirmed in lieu of: Res. 810, I-22

Price of Medicine (H-110.991)
Our AMA: (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications; (2) will pursue legislation requiring pharmacies, pharmacy benefit managers and health plans to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication; (3) opposes provisions in pharmacies' contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient's co-pay is higher than the drug's cash price; (4) will disseminate model state legislation to promote drug price and cost transparency and to prohibit "clawbacks"; (5) supports physician education regarding drug price and cost transparency, manufacturers' pricing practices, and challenges patients may encounter at the pharmacy point-of-sale; and (6) work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare's drug-pricing dashboard. (CMS Rep. 6, A-03; Appended: Res. 107, A-07; Reaffirmed in lieu of: Res. 207, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Reaffirmation: A-19; Appended: Res. 126, A-19)

Prescription Drug Price and Cost Transparency (D-110.988)
1. Our AMA will continue implementation of its TruthinRx grassroots campaign to expand drug pricing transparency among pharmaceutical manufacturers, pharmacy benefit managers and health plans, and to communicate the impact of each of these segments on drug prices and access to affordable treatment.
2. Our AMA will report back to the House of Delegates at the 2018 Interim Meeting on the progress and impact of the TruthinRx grassroots campaign. (Alt. Res. 806, I-17)

Abuse of Preauthorization Procedures (H-320.945)
Our AMA opposes the abuse of preauthorization by advocating the following positions:
(1) Preauthorization should not be required where the medication or procedure prescribed is customary and properly indicated, or is a treatment for the clinical indication, as supported by peer-reviewed medical publications or for a patient currently managed with an established treatment regimen.

(2) Third parties should be required to make preauthorization statistics available, including the percentages of approval or denial. These statistics should be provided by various categories,

e.g., specialty, medication or diagnostic test/procedure, indication offered, and reason for denial. (Sub. Res. 728, A-10; Reaffirmation I-10; Reaffirmation A-11; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 08, A-17; Reaffirmed: Res. 125, A-17; Reaffirmation: A-17 Reaffirmation: I-17; Reaffirmed: CMS Rep. 4, A-21; Reaffirmation: A-22)

Pharmacy Benefit Managers Impact on Patients (D-120.933)
Our AMA will: (1) gather more data on the erosion of physician-led medication therapy management in order to assess the impact pharmacy benefit manager (PBM) tactics may have on patient's timely access to medications, patient outcomes, and the physician-patient relationship; (2) examine issues with PBM-related clawbacks and direct and indirect remuneration (DIR) fees to better inform existing advocacy efforts; and (3) request from PBMs, and compile, data on the top twenty-five medication precertification requests and the percent of such requests approved after physician challenge. (Res. 225, A-18)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 701
(A-24)

Introduced by: Medical Student Section

Subject: Opposition to the Hospital Readmissions Reduction Program

Referred to: Reference Committee G

Whereas, the Hospital Readmissions Reduction Program (HRRP) was introduced in 2012 and created mechanisms for the Centers for Medicare and Medicaid Services to evaluate and penalize hospitals based on their readmission rates within 30 days for certain conditions such as heart failure, heart attack, and pneumonia[1]; and

Whereas, while the goal of HRRP was to save costs due to reduced readmissions and improve the quality of post-acute care and care coordination services, HRRP disproportionately penalizes resource-limited hospitals that primarily care for socioeconomically disadvantaged patients, further diminishing funding for health and social services for these communities[2-4]; and

Whereas, HRRP historically imposed up to a 3% percent reduction in Medicare payments for failure to meet ceiling readmission metrics relative to other hospitals, though hospitals were later sorted into peer groups to adjust for socioeconomic conditions of patient populations[5]; and

Whereas, a 2019 study found that even after peer-group stratification, over 75% of hospitals that predominantly care for socioeconomically disadvantaged patients were still penalized[6]; and

Whereas, multiple studies have found that HRRP was associated with increases in 30-day post-discharge mortality for patients with congestive heart failure, chronic obstructive pulmonary disease, and pneumonia, with thousands of excess deaths estimated[7-9]; and

Whereas, a 2019 retrospective cohort analysis found that post-discharge emergency department revisits and observation stays increased over the 3.5 year study period (+0.016 and +0.022 per 100 patient discharges, respectively), exceeding the decline in readmissions (-0.013 per 100 patient discharges)[10]; and

Whereas, a 2022 retrospective cohort analysis found that HRRP's purported reduction in readmissions was actually almost entirely due to reclassifications of readmissions as observation stays, and a 2019 analysis found that a significant portion of the reductions could be explained by regression to the mean and not due to any success of HRRP[11-12]; and

Whereas, in 2018 and 2019 the AMA expressed concern to CMS about the need to re-evaluate HRRP "due to emerging evidence that the program and the associated measures may be leading to negative unintended patient consequences"[13-14]; therefore be it

RESOLVED, that our American Medical Association oppose the Hospital Readmissions Reduction Program. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 4/5/2024

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RELEVANT AMA POLICY

H-450.944 Protecting Patients Rights

Our AMA opposes Medicare pay-for-performance initiatives (such as value-based purchasing programs) that do not meet our AMA's "Principles and Guidelines for Pay-for-Performance," which include the following five Principles: (1) ensure quality of care; (2) foster the patient/physician relationship; (3) offer voluntary physician participation; (4) use accurate data and fair reporting; and (5) provide fair and equitable program incentives. [Sub. Res. 902, I-05; Reaffirmation A-06; Reaffirmation I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 702
(A-24)

Introduced by: Organized Medical Staff Section

Subject: The Corporate Practice of Medicine, Revisited

Referred to: Reference Committee G

Whereas, primary interests of our American Medical Association include sustaining and improving public health, as well as the sustainability of medical autonomy in practice; and

Whereas, for decades, the AMA has maintained a policy that deems unprofessional any contractual arrangement that interferes with physician practice and by so stating, bars unlicensed lay entities from owning or controlling medical practices; and

Whereas, in the current evolution of the healthcare system, increasingly corporate entities including public companies and private equity firms have entered into the arena of healthcare provision with ownership interests; and

Whereas, those ownership interests have become controlling interests in the vast majority of cases, despite most states maintaining laws against the corporate practice of medicine to one degree or another[1,2]; and

Whereas, there are a number of subterfuges by which lay entities get around restrictions against the corporate practice of medicine, including but not limited to intermediate organizations known as medical service organizations (MSOs) as well as “friendly private corporation (PC) models,” wherein there is dual participation by a licensed physician in both the practice and the medical service organization[1,2]; and

Whereas, medical service organizations and other public entities include those of hospital care based organizations, by virtue of medical management oversight, contracting intermediaries, etc. have undue influence on the provision of healthcare by the physician to the patient, essentially dictating type, amount and directions of care[1,2]; and

Whereas, the justification that consolidation of care and control over clinical operations will improve quality and reduce cost of giving healthcare is not substantiated, even contradicted, by academic research to date[1-3]; and

Whereas, in some notable instances, private equity firms that focus on financial bottom line outcomes increasingly resort to substitutions of physicians with nonphysician practitioners, as well as creating environments where there is greater turnover even of physicians (sometimes due to “moral burnout”), which has been shown to reduce the quality of healthcare[1]; and

Whereas, our AMA Advocacy Resource Center posted an issue brief on the corporate practice of medicine in 2015[4]; and

Whereas, our AMA recently established policy (H-215.981) to “provide guidance, consultation, and model legislation regarding the corporate practice of medicine…[and]…continue to monitor

the evolving corporate practice of medicine" but did not establish a mechanism to gather and disseminate that information; and

Whereas, there is renewed attention paid to the erosion of the firewall represented by the original prohibition of the corporate practice of medicine in several recent studies and articles[1,2]; therefore be it

RESOLVED, that our American Medical Association revisit the concept of restrictions on the corporate practice of medicine, including private equities, hedge funds and similar entities, review existing state laws and study needed revisions and qualifications of such restrictions and/or allowances, in a new report to our House of Delegates by Annual 2025 that will inform advocacy to protect the autonomy of physician-directed care, patient protections, medical staff employment and contract conflicts, and access of the public to quality healthcare, while containing healthcare costs. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 4/17/2024

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RELEVANT AMA POLICY

Corporate Practice of Medicine H-215.981

1. Our AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine.
2. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations.
3. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues.
Citation: Res. 247, A-91; Reaffirmed; Sunset Report, I-09; Reaffirmed: CMS Rep. 7, A-11; Modified: CMS Rep. 6, I-13; Reaffirmed: CMS Rep. 07, A-17; Modified Res. 713, A-18; Reaffirmed: CMS Rep. 11, A-19; Reaffirmed: CME Rep. 01, I-22

Corporate Practice of Medicine H-160.887

Our AMA acknowledges that the corporate practice of medicine: (1) has the potential to erode the patient-physician relationship; and (2) may create a conflict of interest between profit and best practices in residency and fellowship training.
Citation: CMS Rep. 2, I-22

Corporate Investors H-160.891

1.Our AMA encourages physicians who are contemplating corporate investor partnerships to consider the following guidelines:
a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor.
b. Due diligence should be conducted that includes, at minimum, review of the corporate investor's business model, strategic plan, leadership and governance, and culture.
c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions.
d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
e. Physicians should consider whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
f. Physicians should consider the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment.
g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.
h. Physicians should consider corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection.
i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships.
j. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non- physician practitioners.
k. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs.
2. Our AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices.
3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty.
4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine.
Citation: CMS Rep. 11, A-19; Appended: CMS Rep. 2, I-22; Reaffirmed: BOT Rep. 14, A-23

Physician-Owned Hospitals D-215.983

1. Our American Medical Association will advocate for policies that remove restrictions upon physicians from owning, constructing, and/or expanding any hospital facility type.
2. Our AMA will study and research the impact of the repeal of the ban on physician-owned hospitals on the access to, cost, and quality of, patient care, and the impact on competition in highly concentrated hospital markets.
3. Our AMA will collaborate with other stakeholders to develop and promote policies that support physician ownership of hospitals.
Citation: Res. 219, A-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 703
(A-24)

Introduced by: Resident and Fellow Section

Subject: Upholding Physician Autonomy in Evidence-Based Off-Label Prescribing and Condemning Pharmaceutical Price Manipulation

Referred to: Reference Committee G

Whereas, the practice of off-label prescribing, the use of pharmaceutical drugs for an unapproved indication or in an unapproved age group, dosage, or route of administration, is a legal and often necessary aspect of medical practice[1-3]; and

Whereas, off-label prescribing is common, accounting for up to one third of all prescriptions and being more common for certain groups including in the treatment of mental health conditions and treatment of the elderly, children, and pregnant people[4]; and

Whereas, the vast discrepancy in prescription drug pricing places an unreasonable financial burden on underinsured patients, for example, $25 per month co-pay with some insurers compared to approximately $1,200 per month without coverage for some GLP-1 medications[5,6]; and

Whereas, pharmaceutical companies are threatening physicians who prescribe certain medications off-label for medically necessary indications, potentially jeopardizing medical licensure and restricting clinical decision-making[5,7]; and

Whereas, such threats interfere with physicians' ability to make appropriate medical judgments for their patients; and

Whereas, timely action is needed to protect physicians' ability to prescribe off-label based on medical necessity without repercussions, ensuring access for vulnerable patient populations, and protecting these vulnerable patient populations from using potentially hazardous fake compounded versions; and

Whereas, differential pricing and restricted off-label use of medications can exacerbate healthcare disparities by limiting treatment access for underserved populations; therefore be it

RESOLVED, that our American Medical Association advocates for transparency, accountability, and fair pricing practices in pharmaceutical pricing, opposing differential pricing of medications manufactured by the same company with the same active ingredient, without clear clinical necessity (Directive to Take Action); and be it further

RESOLVED, that our AMA condemns interference with a physician’s ability to prescribe one medication over another with the same active ingredient, without risk of harassment, prosecution, or loss of their medical license, and calls on regulatory authorities to investigate and take appropriate action against such practices. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 4/24/2024

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RELEVANT AMA POLICY:

Patient Access to Treatments Prescribed by Their Physicians H-120.988

1. Our AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate 'off-label' uses of drugs on their formulary.
2. Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation.
3. Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be provided in its entirety, not be edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts.
4. Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use).
5. Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated.
6. Our AMA supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act. [Res. 30, A-88; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed and Modified by CSA Rep. 3, A-97; Reaffirmed and Modified by Res. 528, A-99; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: CMS Rep. 6, A-03; Modified: Res. 517, A-04; Reaffirmation I-07; Reaffirmed: Res. 819, I-07; Reaffirmation A-09; Reaffirmation I-10; Modified: BOT Rep. 5, I-14; Reaffirmed: Res. 505, A-15; Reaffirmed: CMS Rep. 6, I-20; Reaffirmed: Res. 509, I-20; Reaffirmation: I-22; Reaffirmed: CSAPH Rep. 01, A-23; Reaffirmed: CSAPH Rep. 02, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 704
(A-24)

Introduced by: American Academy of Pediatrics

Subject: Pediatric Readiness in Emergency Departments

Referred to: Reference Committee G

Whereas, there are over 130 million emergency department (ED) visits in the United States annually with nearly 25% of these visits being for infants, children and adolescents[1]; and

Whereas, over 70% of U.S. emergency departments care for less than 10 children per day with over 80% of these visits occurring in a non-children's hospital setting, highlighting the need for emergency care teams to maintain the knowledge, skills, and appropriate resources for immediate assessment and stabilization of children[1]; and

Whereas, the National Pediatric Readiness Project (NPRP) is a multiphase, multidisciplinary, longitudinal quality initiative to improve readiness of US EDs to care for children and is supported by the Health Resources and Services Administration/ Emergency Medical Services for Children Program and cosponsored by the American Academy of Pediatrics, the American College of Emergency Physicians, and the Emergency Nurses Association, with original Institute of Medicine guidelines initially published in 2006 and twice revised through NPRP joint policy statements in 2009 and 2018; and

Whereas, these joint policy statements, endorsed by our AMA and 22 other national organizations and stakeholders, outline essential policies and procedures, patient safety, staff competencies, quality improvement, medications, equipment, and supplies to safely care for children, with comprehensive open access educational resources, policy templates, tools, and other resources are available as part of the National Pediatric Readiness Project (www.pediatricreadiness.org); and

Whereas, pediatric readiness of an emergency department is associated with a 60% and 76% reduction in mortality risk for injured and critically ill children, respectively, with a three-fold reduction in disparities for mortality[1]; therefore be it

RESOLVED, that our American Medical Association reaffirm H-130.939 acknowledging the importance of pediatric readiness in all emergency departments with awareness of the guidelines for Pediatric Readiness in the Emergency Department and stand ready to care for children of all ages (Reaffirm HOD Policy); and be it further

RESOLVED, that our AMA work with appropriate state and national organizations to advocate for the development and implementation of regional and/or state pediatric-ready facility recognition programs. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 4/23/2024

REFERENCES

1. *Remick et al; National Assessment of Pediatric Readiness of US Emergency Departments During COVID-19 Pandemic; JAMA Open Network, 7/7/2023.*

RELEVANT AMA POLICY

H-130.939 Emergency Department Readiness to Care for Children

Our American Medical Association affirms the importance that all emergency departments stand ready to care for children of all ages, and advocates for hospital administrators, emergency department medical directors and emergency department nurse managers to be aware of the guidelines for Pediatric Readiness in the Emergency Department.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 705
(A-24)

Introduced by: Illinois

Subject: 20 Minute Primary Care Visits

Referred to: Reference Committee G

Whereas, the 20 minute primary care visit has been shown to lead to poor outcomes for patient care and is causing burnout of primary care physicians; therefore be it

RESOLVED, that our American Medical Association ask that the appropriate AMA Council conduct a study of the adverse effects of direct patient care time limitations on the quality of care provided, as well as on patient and physician dissatisfaction, with a report back at the next AMA Annual Meeting. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 4/24/2024

RELEVANT AMA POLICY

Limitation of Use of Time Component of Current Procedural Terminology (CPT-4) Coding H-70.976
Our AMA (1) adopts as policy that the time element in the new Evaluation and Management codes in the CPT-4 manual may be used to assist physicians and their staffs in determining appropriate levels of coding;
(2) opposes the use of the time elements to (a) judge how many of any given type of visit may be performed in any one hour; and (b) deny or downgrade services submitted based on a cumulative time;
(3) adopts as policy that there shall be no list of diagnoses used by third party payers to compare against the Evaluation and Management codes in such a fashion as to deny, downgrade, or in any other way seek to limit the submission of any CPT-4 code visit;
(4) will monitor attempts by the third party payers to institute such time limits and diagnosis limits; and
(5) will work with third party payers to prevent them from attempting to adopt and institute policies that would impose such time and diagnosis criteria.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 706
(A-24)

Introduced by: Association for Clinical Oncology

Subject: Automatic Pharmacy-Generated Prescription Requests

Referred to: Reference Committee G

Whereas, while some studies have found that pharmacy-based automatic refill increases medication adherence without additional waste, these studies examine drugs for chronic diseases, and they do not examine settings where a treatment plan may be continually refined; and

Whereas, individual states have recognized the potential harms of automatic refill programs, including wasted drugs, incorrect dosing, and patient receipt of discontinued prescriptions, among other harms; and

Whereas, 27 state Medicaid programs have policy prohibiting the auto-refill process that occurs at the point of sale (i.e. the program must obtain the beneficiary's consent prior to enrolling in the auto-refill program); and

Whereas, automatic pharmacy-generated refills are not necessarily linked to requests from either the patient or the physician and can lead to confusion for both; therefore be it

RESOLVED, that our American Medical Association advocates that pharmacy-generated requests for changes to a prescription (quantity dispensed, refills, or substitutions) clarify whether these requests are generated by the patient or patient's surrogates, or automatically by the pharmacy. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 4/24/2024

REFERENCES

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RELEVANT AMA POLICY

American Pharmacists Association H-120.987
The AMA advocates (1) continued surveillance of mail-order prescriptions; (2) notification by the American Pharmacists Association (APhA) of its members that prescriptions should be refilled only on the physician's order; and (3) that the APhA advise its members to discontinue the practice of assuming a prescription may be refilled unless a form is returned stating that the prescription may not be refilled.

Streamlining the Process for Prescription Refills D-120.984
Our AMA will work with the American Pharmacists Association, the National Community Pharmacists Association, and the National Association of Chain Drug Stores to streamline the process for prescription refills in order to reduce administrative burdens on physicians and pharmacists and to improve patient safety.

Safe and Efficient E-Prescribing H-120.921
Our AMA encourages health care stakeholders to improve electronic prescribing practices in meaningful ways that will result in increased patient safety, reduced medication error, improved care quality, and reduced administrative burden associated with e-prescribing processes and requirements. Specifically, the AMA encourages:
A. E-prescribing system implementation teams to conduct an annual audit to evaluate the number, frequency and user acknowledgment/dismissal patterns of e-prescribing system alerts and provide an audit report to the software vendors for their consideration in future releases.
B. Health care organizations and implementation teams to improve prescriber end-user training and on-going education.
C. Implementation teams to prioritize the adoption of features like structured and codified Sig formats that can help address quality issues, allowing for free text when necessary.
D. Implementation teams to enable functionality of pharmacy directories and preferred pharmacy options.
E. Organizational leadership to encourage the practice of inputting a patient’s preferred pharmacy at registration, and re-confirming it upon check-in at all subsequent visits.
F. Implementation teams to establish interoperability between the e-prescribing system and the EHR to allow prescribers to easily confirm continued need for e-prescription refills and to allow for ready access to pharmacy choice and selection during the refill process.
G. Implementation teams to enhance EHR and e-prescribing system functions to require residents assign an authorizing attending physician when required by state law.
H. Organizational leadership to implement e-prescribing systems that feature more robust clinical decision support, and ensure prescriber preferences are tested and seriously considered in implementation decisions.
I. Organizational leadership to designate e-prescribing as the default prescription method.
J. The DEA to allow for lower-cost, high-performing biometric devices (e.g., fingerprint readers on laptop computers and mobile phones) to be leveraged in two-factor authentication.
K. States to allow integration of PDMP data into EHR systems.
L. Health insurers, pharmacies and e-prescribing software vendors to enable real-time benefit check applications that enable more up to date prescription coverage information and allow notification when a patient changes health plans or a health insurer has changed a pharmacy’s network status.
M. Functionality supporting the electronic transfer and cancellation of prescriptions.

Patient Privacy and Confidentiality H-315.983
20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 707
(A-24)

Introduced by: Association for Clinical Oncology, American College of Rheumatology

Subject: Alternative Funding Programs

Referred to: Reference Committee G

Whereas, alternative funding programs (AFPs) are run by third-party, for-profit vendors that target self-funded plans; and

Whereas, AFPs claim to help companies reduce their healthcare costs by offloading health plans' responsibility for covering most or all specialty drugs; and

Whereas, AFPs exclude or automatically deny prior authorization for specialty medications and instead promise to help patients or providers access those medications through pharmaceutical manufacturers' patient assistance programs (PAPs) or other charitable programs; and

Whereas, patients are required to work with the AFP vendor or be left paying 100% of the cost of their specialty medication; and

Whereas, a 2022 study found that 10% of employers with at least 5,000 employees were using AFPs and 27% were considering AFPs; and

Whereas, PAPs are safety-net programs designed to provide free drugs to uninsured and underinsured individuals; and

Whereas, AFP vendors require patients to provide proof of income and a limited power of attorney to enable the AFP vendor to act on their behalf and apply for manufacturer PAPs; and

Whereas, a patient's application for a PAP may be denied because of high income; and

Whereas, if a patient's PAP application is denied, the patient's employer could, but is not required to, override the denial as a medical necessity or approve the previously denied prior authorization; and

Whereas, an AFP may attempt to seek financial assistance from a charitable foundation on behalf of the patient as an interim measure while awaiting PAP determination; and

Whereas, if an AFP cannot get a drug covered by a PAP, the patient may end up owing the full amount of the drug cost; and

Whereas, regardless of whether the patient is approved for a PAP, the potentially lengthy application process can delay access to necessary care; and

Whereas, if a patient is approved for a PAP, then PAP funds available for the prescribed medication may provide only cover a partial course of treatment; and

Whereas, AFPs divert funds intended for individuals who are uninsured or underinsured with limited or no access to medications; and

Whereas, an ad hoc patient advocacy coalition has sent a letter to the Department of Labor (DOL) expressing concerns about AFPs; and

Whereas, AFPs steer charitable and other patient-assisting funds away from uninsured and underinsured patients; and

Whereas, AFPs hinder patient access to specialty drugs; therefore be it

RESOLVED, that our American Medical Association will educate employers, benefits administrators, and patients on alternative funding programs (AFPs) and their negative impacts on patient access to treatment and will advocate for legislative and regulatory policies that would address negative impacts of AFPs. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 4/24/2024

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RELEVANT AMA POLICY

Third-Party Pharmacy Benefit Administrators H-110.963
1. Our AMA recommends that third-party pharmacy benefit administrators that contract to manage the specialty pharmacy portion of drug formularies be included in existing pharmacy benefit manager (PBM) regulatory frameworks and statutes, and be subject to the same licensing, registration, and transparency reporting requirements.
2. Our AMA will advocate that third-party pharmacy benefit administrators be included in future PBM oversight efforts at the state and federal levels.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 708
(A-24)

Introduced by: National Association of Medical Examiners, American Society for Clinical Pathology, American Society of Cytopathology, College of American Pathologists

Subject: Medicolegal Death Investigations

Referred to: Reference Committee G

Whereas, forensic pathology is the practice of medicine; and

Whereas, the practice of forensic pathology in medicolegal death investigations is critical for many aspects of public health, practice, and research, including death certification, surveillance, epidemiology, and injury prevention in areas such as unexpected child deaths, suicide, violence, and substance use; and

Whereas, the findings noted at a forensic autopsy, as well as the results of ancillary studies, must be interpreted in the context of the medicolegal death investigation to correctly determine the cause and manner of death; and

Whereas, protecting physicians practicing forensic pathology from undue influence is necessary to ensure the independence of medicolegal death investigations, safeguard medical integrity, preserve public trust and confidence; and

Whereas, state and local governments must ensure strong institutional and workplace protections to bolster the independence of physicians practicing forensic pathology in the course of medicolegal death investigations; and

Whereas, state laws and regulations on causes and manner of deaths should not deny or limit physician authority to exercise necessary and appropriate medical judgment in the performance of the forensic autopsy; therefore be it

RESOLVED, that our American Medical Association supports the independent authority of physicians practicing forensic pathology to provide accurate and transparent postmortem assessments and death investigation reporting in a manner free from undue influence (New HOD Policy); and be it further

RESOLVED, that our AMA advocate with state and federal governments to ensure laws and regulations do not compromise a physician’s ability to use their medical judgement in the reporting of postmortem assessments and medicolegal death investigations. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 4/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 709
(A-24)

Introduced by: American College of Emergency Physicians

Subject: Improvements to Patient Flow in the U.S. Healthcare System

Referred to: Reference Committee G

Whereas, delays in patient care result in increased morbidity and mortality[1] [2] [3]; and

Whereas, misaligned healthcare economics pressure hospitals to maintain high inpatient census levels, often preferencing high-margin patients, leading to delays that compromise emergency department, operative, and inpatient surge capacity[4]; and

Whereas, lack of surge capacity may compromise our nation's emergency preparedness[5]; and

Whereas, delayed patient flow through multiple care environments affects many portions of the U.S. healthcare system, including access to post-acute care, emergency department care, hospital-based care, surgical care, and primary care; therefore be it

RESOLVED, that our American Medical Association work with relevant stakeholders and propose recommendations to appropriate entities to improve patient flow and access to care throughout multiple environments in the U.S. healthcare system. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 4/24/2024

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 710
(A-24)

Introduced by: American College of Emergency Physicians

Subject: The Regulation of Private Equity in the Healthcare Sector

Referred to: Reference Committee G

Whereas, healthcare systems controlled by private equity interest failed, putting access to care for patients at risk; and

Whereas, these failures also put the livelihoods of healthcare workers, including physicians, at risk; and

Whereas, in these cases, private equity has frequently saddled healthcare systems with significant debts that cannot be easily repaid; and

Whereas, these healthcare systems have attempted to cut costs by laying off personnel and not purchasing equipment necessary for patient care[1]; and

Whereas, the lack of appropriate resources to care for patients puts significant stress on healthcare workers and can lead to moral injury as well; and

Whereas, these practices have now caught the attention of the United States Congress, and several investigations have been opened; and

Whereas, the FTC has indicated that corporate consolidation of healthcare entities frequently results in increased costs of healthcare without commensurate increases in quality; therefore be it

RESOLVED, that our American Medical Association propose appropriate guidelines for the use of private equity in healthcare, ensuring that physician autonomy in clinical care is preserved and protected (Directive to Take Action); and be it further

RESOLVED, that our AMA modify policy H-215.981, Corporate Practice of Medicine, by addition:
4. Our AMA will work with the federal government and other interested parties to develop and advocate for regulations pertaining to the use of private equity in the healthcare sector such that physician autonomy in clinical care is preserved and protected. (Modify Current HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 4/24/2024

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RELEVANT AMA POLICY

Medical Decision-Making Autonomy of the Attending Physician D-373.994
Our AMA will continue to strongly oppose any encroachment of administrators upon the medical decision making of attending physicians that is not in the best interest of patients. (I-23)

Physician Employment Trends and Principles H-225.947
1. Our AMA encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with the following principles: A. Physician clinical autonomy is preserved. B. Physicians are included and actively involved in integrated leadership opportunities. C. Physicians are encouraged and guaranteed the ability to organize under a formal self-governance and management structure. D. Physicians are encouraged and expected to work with others to deliver effective, efficient and appropriate care. E. A mechanism is provided for the open and transparent sharing of clinical and business information by all parties to improve care. F A clinical information system infrastructure exists that allows capture and reporting of key clinical quality and efficiency performance data for all participants and accountability across the system to those measures.
2. Our AMA encourages continued research on the effects of integrated health care delivery models (that employ physicians) on patients and the medical profession. (I-15, last reaff A-19)

Physician Independence and Self-Governance D-225.977
Our AMA will: (1) continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance; and (2) promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures, including but not limited to hospitals, health care systems, medical groups, insurance company networks and accountable care organizations, in order to assure and be accountable for the delivery of quality health care. (last reaff A-22)

Corporate Investors H-160.891
1.Our AMA encourages physicians who are contemplating corporate investor partnerships to consider the following guidelines:
a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor.
b. Due diligence should be conducted that includes, at minimum, review of the corporate investor's business model, strategic plan, leadership and governance, and culture.
c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions.
d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
e. Physicians should consider whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
f. Physicians should consider the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment.
g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.
h. Physicians should consider corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection.
i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships.
j. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non-physician practitioners.
k. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs.

2. Our AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices.
3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty.
4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine.

Corporate Practice of Medicine H-215.981
1. Our AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine.
2. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations.
3. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 711
(A-24)

Introduced by: Ohio

Subject: Insurer Accountability When Prior Authorization Harms Patients

Referred to: Reference Committee G

Whereas, prior authorization (PA) is an advanced approval process that insurers and other payers use as a healthcare utilization management tool to deny payment for covered benefits when the payer deems the benefit clinically unnecessary[1]; and

Whereas, prior authorization requirements are rapidly increasing each year, which leads to not only increased administrative duties for physicians and their practice staff but also delayed care for patients[2]; and

Whereas, a 2022 study by our AMA on PA demonstrated that 88% of physicians experience high or extremely high administrative burdens due to prior authorization requirements and that 94% of physicians believe prior authorizations delay patient access to necessary care[3]; and

Whereas, the process of PA reviews, which health plans are frequently known to delegate to third-party contractors, causes significant delays in appropriate patient care that can lead to prolonged suffering and unnecessary deaths[4]; and

Whereas, the 2022 physician survey by our AMA found that 89% of physicians believe PA requirements have a negative impact on clinical outcomes for patients, with 33% of physicians reporting that PAs have led to their patients experiencing serious adverse health outcomes, including hospitalization, life-threatening events, or disability[3]; and

Whereas, other surveys by the American Society of Clinical Oncologists (ASCO), the American Cancer Society Cancer Action Network (ACS CAN), and the American Society for Radiation Oncology (ASRO) have reported similar findings, with nearly all oncologists in the 2023 ASCO reporting a patient experienced harms due to PA, including 35% who specifically attributed a patient's loss of life to prior authorization requirements[5-8]; and

Whereas, the data strongly suggests that insurers are denying justified healthcare, with the 2022 AMA physician survey reporting that only 1% of physicians believe that PA criteria are always based on evidence-based medicine or specialty society guidelines[3]; and

Whereas, capitated payment models like Medicaid Managed Care and Medicare Advantage Organizations (MAOs), in which private companies are paid fixed amounts per enrollee based on expected costs regardless of whether the actual cost was higher or lower, create an incentive to minimize enrollee services and maximize PA denials[9]; and

Whereas, reporting by the Office of Inspector General (OIG) for the United States Department of Health and Human Services has frequently shown that many denials were inappropriate, with a 2022 report finding that 13% of PA denials met Medicare coverage requirements and 18% of payment denials met Medicare coverage rules and internal reimbursement guidelines[9]; and

Whereas, a 2023 Kaiser Family Foundation (KFF) study as well as two separate OIG reports found that, although just 11% of PA denials by MAOs are appealed, the vast majority of appeals were either completely or partially overturned[10-12]; and

Whereas, the KFF study and OIG reports noted that their findings were particularly concerning because the appeals process was largely underutilized by beneficiaries and providers with only 1% to 27% of initial denials ever being appealed, meaning insurers are incentivized to deny coverage knowing only a small portion of PA decisions will be formally appealed[10-12]; and

Whereas, despite increasing evidence of inappropriate PA denials by insurers, there currently is no consensus on how to hold insurers liable for denials that result in preventable injury to patients, with largely unsuccessful litigation strategies ranging from bad faith breach of contract to negligent breach of duty, and at least one effort in Texas preempted by the Employment Income & Retirement Act of 1974 (ERISA)[4,13-14]; and

Whereas, even when state statute or case law permits a bad faith claim against an insurance company for a wrongful coverage denial and the claim is not preempted by ERISA, it's often impossible to recover punitive damages, which may require proving that the insurance company acted with a higher degree of intent than that required for compensatory damages[15]; and

Whereas, in a recent New York case in which a delayed PA approval resulted in the preventable, rapid progression of a woman's cancer, the U.S. District Court for the Southern District of New York ruled against the woman when it held that existing New York law does not impose a duty of reasonable care on insurance companies that engage in PA review, highlighting the need for aggressive state legislative reform to increase liability for state-regulated insurers[16]; and

Whereas, efforts to hold insurers liable for PA denials that result in preventable injury have been slowed by the increasing use of mandatory arbitration clauses in beneficiary contracts, which require beneficiaries to settle disputes out of court by an impartial third party rather than before a jury or judge and often include waivers that prevent beneficiaries from bringing class action suits[17-18]; and

Whereas, a 2019 review of arbitration clauses used by Fortune 100 companies found that many of the nation's largest health insurance companies, including UnitedHealth Group, Anthem, Aetna, and Cigna, impose mandatory arbitration clauses with class waivers on consumers[18]; and

Whereas, mandatory arbitration clauses are particularly insidious in health insurance contracts given the wide gap in bargaining power between the insurance company and beneficiary and limited selection of alternate insurers as a result of increasing consolidation in insurance markets[19-20]; and

Whereas, while arbitration may be preferred by some individuals, data suggests it is generally bad for consumers, as the median award for medical malpractice claims in Kaiser Permanente's arbitration program is nearly $400,000 less than median awards for medical malpractice jury trials in California[21]; and

Whereas, in addition to the federal Improving Seniors' Timely Access to Care Act (H.R.3173), nearly 90 prior authorization reform bills have been proposed in current state legislatures, many of which draw on our AMA's model legislation, but none of these proposed bills that have

received AMA support address insurers' legal liability when patients are harmed by prior authorizations[22-26]; therefore be it

RESOLVED, that our American Medical Association advocate for increased legal accountability of insurers and other payers when delay or denial of prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration and limitation on class action clauses in beneficiary contracts. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 4/26/2024

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RELEVANT AMA POLICY

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.
4. Our AMA will advocate 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. [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; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21; Reaffirmation: A-22]

D-320.978 Fair Reimbursement for Administrative Burdens
Our AMA will: (1) continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices; (2) continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes; (3) oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services; and (4) advocate for fair reimbursement of established and future CPT codes for administrative burdens related to (a) the prior authorization process or (b) appeals or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials. [Res. 701, A-22]

D-285.960 Promoting Accountability in Prior Authorization
Our AMA will: (1) advocate that peer-to-peer (P2P) prior authorization (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; (2) 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; (3) advocate that P2P PA reviewers follow evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable; (4) 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; (5) advocate that health plans must undertake every effort to accommodate the physician's schedule when requiring peer-to-peer prior authorization conversations; and (6) 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. [CMS Rep. 4, A-21]

D-320.979 Processing Prior Authorization Decisions
Our AMA will advocate that all insurance companies and benefit managers that require prior authorization have staff available to process approvals 24 hours a day, every day of the year, including holidays and weekends. [Res. 712, I-20; Reaffirmation: A-22]

H-185.936 Lung Cancer Screening to be Considered Standard Care
Our AMA: (1) recommends that coverage of screening low-dose CT (LDCT) scans for patients at high risk for lung cancer by Medicare, Medicaid, and private insurance be a required covered benefit; (2) will empower the American public with knowledge through an education campaign to raise awareness of lung cancer screening with low-dose CT scans in high-risk patients to improve screening rates and decrease the leading cause of cancer death in the United States; and (3) will work with interested national medical specialty societies and state medical associations to urge the Centers for Medicare & Medicaid Services and state Medicaid programs to increase access to low-dose CT screening for Medicaid patients at high risk for lung cancer by including it as a covered benefit, without cost-sharing or prior authorization requirements, and increasing funding for research and education to improve awareness and utilization of the screening among eligible enrollees. [Sub. Res. 114, A-14; Appended: Res. 418, A-22; Appended: Res. 112, A-23]

American Medical Association House of Delegate

Resolution:712
(A-24)

Introduced by: New York

Subject: Full Transparency - Explanation of Benefits

Referred to: Reference Committee G

Whereas, HIPAA Administrative Simplification Requirements mandate a national standard for the X12 835 electronic remittance advice (ERA), paper explanations of benefits (EOB) suffer from vague, incomplete, and often misleading information; and

Whereas, EOBs often show vague descriptions of services, which precludes transparency and makes it difficult for the patient to determine if the charges are legitimate; therefore be it

RESOLVED, that our American Medical Association will advocate legislation and regulations that mandate that explanation of benefits, whether sent to the patient or the physician practice, including the actual CPT codes billed, DRG-codes, CPT descriptions, and optional consumer-friendly descriptions; and EOB must list the actual allowed amount, patient responsibilities (copay, deductible, coinsurance), non-covered and denied amounts with specific X12 reason codes in consumer-friendly explanations, what criteria is used for coverage and non-coverage, and includes detailed explanation on how to appeal, including contact information for plan administrator, applicable laws governing the plan benefits, and contact information to submit external complaints. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 5/8/2024

RELEVANT AMA POLICY

Requiring Third Party Reimbursement Methodology be Published for Physicians H-185.975
Our AMA:
(1) urges all third party payers and self-insured plans to publish their payment policies, rules, and fee schedules;
(2) pursues all appropriate means to make publication of payment policies and fee schedules a requirement for third party payers and self-insured plans;
(3) will develop model state and federal legislation that would require that all third party payers and self-insured plans publish all payment schedule updates, and changes at least 60 days before such changes in payment schedules are enacted, and that all participating physicians be notified of such changes at least 60 days before changes in payment schedules are enacted.
(4) seeks legislation that would mandate that insurers make available their complete payment schedules, coding policies and utilization review protocols to physicians prior to signing a contract and at least 60 days prior to any changes being made in these policies;
(5) works with the National Association of Insurance Commissioners, develop model state legislation, as well developing national legislation affecting those entities that are subject to ERISA rules; and explore the possibility of adding payer publication of payment policies and fee schedules to the Patient Protection Act; and

(6) supports the following requirements: (a) that all payers make available a copy of the executed contract to physicians within three business days of the request; (b) that all health plan EOBs contain documentation regarding the precise contract used for determining the reimbursement rate; (c) that once a year, all contracts must be made available for physician review at no cost; (d) that no contract may be changed without the physician's prior written authorization; and (e) that when a contract is terminated pursuant to the terms of the contract, the contract may not be used by any other payer.
Sub. Res. 805, I-95 Appended: Res. 117, A-98 Reaffirmation A-99 Appended: Res. 219, and Reaffirmed: CMS Rep. 6, A-00 Reaffirmation I-01 Reaffirmed and Appended: Res. 704, A-03 Reaffirmation I-04 Reaffirmation A-08 Reaffirmation I-08 Reaffirmed: CMS Rep. 3, I-09 Reaffirmation A-14

American Medical Association House of Delegates

Resolution: 713
(A-24)

Introduced by: New York

Subject: Transparency – Non-Payment for Services to patients with ACA Exchange Plans with Unpaid Premiums

Referred to: Reference Committee G

Whereas, patients can sign up for health insurance without paying for up to 2 months, during which eligibility verification shows active coverage. Yet, health plans have a right to deny payment to physicians if a patient fails to pay premiums, which leaves physicians with uncollectible debt for physician professional services as well as expensive physician-administered and prior-authorized medications that cost thousands of dollars; and

Whereas, X12 is designated by CMS as a national standards organization that sets national standards for electronic eligibility transaction X12 270/271; therefore be it

RESOLVED, that our American Medical Association will advocate for legislation to require that health plans inform healthcare providers whether the plan premium has been paid and whether the account is late on payment as part of benefit verification, whether by phone, fax, or electronic transaction, including but not limited to X12 270/271 (Directive to Take Action); and be it further

RESOLVED, that our AMA will advocate for legislation or regulation to require that health plans inform healthcare providers whether the plan premium has been paid and whether the account is late on payment as part of benefit verification, whether by phone, fax, electronic transaction including but not limited to X12 270/271 (Directive to Take Action); and be it further

RESOLVED, that our AMA will advocate that X12 includes plan premium payment status as part of X12 270/271 standard transaction code updates (Directive to Take Action); and be it further

RESOLVED, that our AMA will report on the status of this resolution at the 2025 Annual Meeting. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 5/8/2024