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REPORT OF THE BOARD OF TRUSTEES

B of T Report 05-I-24

Subject:	Protecting the Health of Incarcerated Patients (Resolution 202-I-23)
Presented by:	Michael Suk, MD, JD, MPH, MBA, Chair
Referred to:	Reference Committee J

INTRODUCTION

At the 2023 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 202-I-23 authored by the Medical Student Section for report at the 2024 Interim Meeting. The resolution asked, "That our American Medical Association advocate against the use of for-profit prisons" and "That our AMA advocate for for-profit prisons, public prisons with privatized medical services, and detention centers to be held to the same standards as prisons with public medical services, especially with respect to oversight, reporting of health-related outcomes, and quality of health care."

This report provides background information on private (also referred to as "for-profit") correctional facilities and private companies providing health care services to public correctional facilities. This report further discusses the role of our AMA in ensuring that appropriate, quality health care is provided to inmates in all facilities, regardless of private or public status. Finally, this report recommends reaffirming existing AMA policy.

BACKGROUND

Private Correctional Facilities

In this report, "correctional facility" includes a jail, prison, or other detention facility used to house people who have been arrested, detained, held, or convicted by a criminal justice agency or a court. "Prisons" are facilities under state or federal control where people who have been convicted (usually of felonies) go to serve their sentences. "Jails" are city- or county-run facilities where a majority of incarcerated people are there awaiting trial (in other words, still legally innocent), many because they cannot afford to post bail. However, some people do serve their sentences in local jails, either because their sentences are short or because the jail is renting space to the state prison system.[1]

The U.S. has the highest rate and number of incarcerated individuals in the world, with 1.9 million people in the carceral system.[2] This includes individuals in 1,566 state prisons, 98 federal prisons, 3,116 local jails, 1,323 juvenile correctional facilities, 142 immigration detention facilities, and 80 Indian country jails, as well as in military prisons, civil commitment centers, state psychiatric hospitals, and prisons in the U.S. territories.[3] To complicate matters further, approximately eight percent of all incarcerated persons are in private prisons.[4] Given that the U.S. does not have one criminal legal system, but rather thousands of federal, state, local, and tribal systems, and the

significant amount of churning in and out of facilities that occurs, it is impossible to generalize about conditions in facilities across the nation.

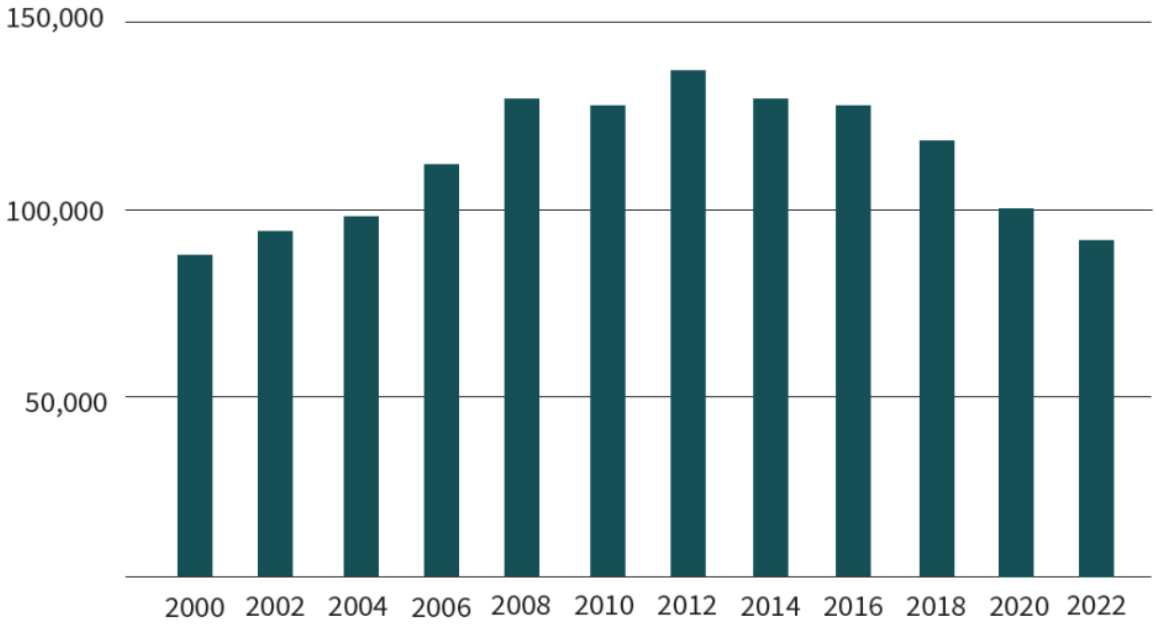
The War on Drugs in the 1970s and harsher sentencing policies, including mandatory minimum sentences, in the 1980s, contributed to a rapid expansion in the nation's incarcerated population. In 1994, former President Bill Clinton signed the Violent Crime Control and Law Enforcement Act into law. The act gave an additional $9.7 billion in funding towards the construction of new prisons. It also created the three-strikes law.[5] The burden on publicly funded prisons led to the rise of for-profit private prisons in many states and at the federal level.[6] Private prisons were seen by many policymakers in state and federal government as an effective solution to the rapid increase of inmates because they arguably could house more of them at a lower cost than state or federal prisons. Congress helped with public funding through the Appropriations Act of 1996, which amended the entire text of Subtitle A of the 1994 Violent Crime Control and Law Enforcement Act and included language specifically authorizing states to use the funding for privatization.[7]

The number of people incarcerated in private prison facilities increased 47 percent while the overall prison population increased only nine percent between 2000 and 2016.[8] At the state level, 27 states used private prison beds, with contracts ranging from 12 in South Carolina to 13,692 in Texas. Six states more than doubled the number of individuals in private prisons between 2000 and 2016, with Arizona having the largest increase, holding 479 percent more people in private facilities during that time period.[9] Privatization in the federal correctional system grew even more than among the states. The number of federal prisoners held in private facilities rose 120 percent from 15,524 in 2000 to 34,159 in 2016, while the number of state prisoners incarcerated privately grew only by 31 percent over the same time period, from 71,845 to 94,164.[10] In 2022, a total of 27 states were utilizing private companies to run some of their correctional facilities.[11]

After a reduction in the overall federal prison population beginning in 2014 and a small decrease in the private prison population, President Obama's Department of Justice (DOJ) decided to phase out federal private for-profit prison contracts.[12] However, the Trump Administration reversed this plan and indicated that the Bureau of Prisons (BOP) would continue to rely on private facilities.[13] This was despite numerous concerns raised by policymakers and advocates about the quality of services and safety in private correctional facilities, which have existed since the growth of the private corrections industry, including a comprehensive report released in August of 2016 by the Office of the Inspector General of the DOJ. This report reviewed the BOP's monitoring of contract prisons and found that contract prisons had more safety and security-related incidents per capita than BOP institutions for most of the indicators that were analyzed, that site visits revealed safety and security concerns and inappropriate housing assignments, and that the BOP's monitoring of contract prisons needed improvement.[14]

Despite the claims of their proponents that private facilities are more cost-efficient at providing services than publicly-run institutions, various studies conducted in the late 1990s and 2000s at both the federal and state levels did not support such assertions.[15] In addition, private prison companies are challenged by reducing costs while at the same time providing adequate services necessary to maintain security and safety, and doing so while also generating a profit for their shareholders.[16] Private prisons have been critiqued by many for prioritizing revenue over rehabilitating incarcerated individuals. Faced with these challenges, the private prison population has been steadily decreasing since 2012, as shown in the chart below.[17]

Number of People in Private Prisons, 2000-2022



In January 2021, as his term began, President Biden signed an executive order which directed the DOJ to phase out the federal criminal system's use of private prisons and eliminate their use. Since this executive order was signed, the BOP has ended its contracts with all for-profit prisons and has transferred the remaining inmates to other Bureau of Prison locations.[18] While this was an important step in limiting the transfer of federal funding to for-profit corporations, it did not cover the federal use of for-profit immigration detention facilities. And, according to an analysis from the American Civil Liberties Union (ACLU) National Prison Project, the U.S. Marshals Service continues to hold nearly a third of its entire detention population in for-profit facilities, totaling 20,000 people. The Marshals Service has obtained waivers from the Biden Administration that allow it to basically ignore the executive order and keep five for-profit facilities open. According to the ACLU, the Marshals Service is also skirting the requirements of the executive order through pass-through agreements, whereby the Service pays a city or county government, which keeps part of the payment and passes along most of the payment to the corporation that runs the facility.[19] An internal government investigation found that these agreements cost the Marshals Service more and provide less control and oversight over operations at its detention facilities.[20]

Privatized Health Care in Correctional Facilities

Privatized health care in federal prisons is a multi-billion-dollar industry led by a handful of companies.[21] Those contracted with these private health care providers pay them a fixed price, regardless of the level of care. Moreover, the company can retain any money that is not spent on health care services. The incentive for these prisons to contract with health care companies is that these privatized health care companies protect prisons from liability through indemnification provisions.[22] These indemnification provisions present themselves as contracts between health care companies and prisons that place the company in a position where they are liable for all liability-related expenses in prison. Critics have stated that this protection enables prisons to prioritize company profits over the wellness of inmates.[23] This includes reports of prison health care services

remaining understaffed or assigning employees to tasks they are not qualified to do to decrease costs intentionally. There are other reports of staff not working enough hours to adequately meet the health care needs of patients.[24] This low standard of care for prisons with health care managed by private companies also has a higher death rate in comparison to prisons that do not utilize privatized health care.[25]

Health of incarcerated populations

It is well documented that justice-involved people have a higher prevalence of acute and chronic health conditions than the general U.S. population.[26] Compared to the general population, individuals with a history of incarceration have worse mental and physical health; they are more likely to have high blood pressure, asthma, cancer, arthritis, and infectious diseases, such as tuberculosis, hepatitis C, and HIV. Several factors contribute to the prevalence of mortality due to illness and disease in this population. The incarcerated population is largely drawn from the most disadvantaged segments of society, with significant health care needs but limited access to regular care. As a result, many incarcerated individuals arrive at correctional facilities in poor health with conditions that were previously undiagnosed.[27] Over half of people in state prisons have a substance use disorder and overdose is a leading cause of death among currently and formerly incarcerated people.[28] [29] Moreover, according to government data last compiled in 2017, close to half of people in jails have a diagnosis of major mental illness.[30] Prisons have been historically ill-equipped to handle the influx of inmates experiencing substance use disorder and mental illness.

Once incarcerated, the conditions of confinement often have a negative impact on health. Stress associated with institutional life, overcrowding, inadequate access to exercise, improper diet, exposure to infectious diseases, and poor sanitation and ventilation can all contribute to mortality. Further, while incarcerated individuals have a constitutional right to health care, the access to and the quality of the care in correctional facilities are variable. As noted above, insufficient resources play a key role, especially limited budgets and regulations that require correctional facilities to prioritize treating certain diseases over others.[31]

National Commission on Correctional Health Care (NCCHC)

Several professional organizations, including the AMA, the American Public Health Association, and later, the National Commission on Correctional Health Care (NCCHC), have established national standards for correctional health care. NCCHC's origins date to the early 1970s, when an AMA study of jails found inadequate, disorganized health services and a lack of national standards. In collaboration with other organizations, the AMA established a program that in 1983 became the NCCHC, an independent, 501(c)(3) nonprofit organization. Forty years later, NCCHC remains the only national organization dedicated solely to improving correctional health care quality. This is done by establishing rigorous standards for health services in correctional facilities, operating a voluntary accreditation program for institutions that meet those standards, offering certification for correctional health professionals, conducting educational conferences and webinars, and producing industry-specific publications and other resources.[32]

EXISTING AMA POLICY AND ADVOCACY

Policy H-430.986, "Health Care While Incarcerated," advocates for adequate payment to health care providers, including primary care and mental health and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process. This policy also advocates for necessary programs and staff training to address the needs of incarcerated individuals. Moreover, this policy

encourages state Medicaid agencies to accept and process Medicaid applications from individuals who are incarcerated, and to work with correctional facilities to assist individuals to apply and receive a Medicaid eligibility determination.

Policy H-430.997, "Standards of Care for Inmates of Correctional Facilities," states that correctional and detention facilities should provide medical, psychiatric, and substance use disorder care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.

Policy D-430.997 "Support for Health Care Services to Incarcerated Persons" supports NCCHC standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities; encourages all correctional systems to support NCCHC accreditation; and encourages the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding. This policy also calls on the AMA to work with an accrediting organization, such as NCCHC, in developing a strategy to accredit all correctional, detention and juvenile facilities and to advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025.

AMA Advocacy

The AMA and Manatt Health released a state toolkit to End the Nation's Drug Overdose Epidemic.[41] The toolkit provides recommendations across several domains, including that "States should provide evidence-based medical care to incarcerated populations, including continuing, initiating, and ensuring access to medications for opioid use disorder (MOUD). States should remove criminal and other penalties for pregnant, postpartum, and parenting women for whom MOUD is part of treatment for an opioid use disorder."

The AMA sent a letter of support for H.R. 955 and S. 285, the "Medicaid Reentry Act," which would provide states with the flexibility to allow Medicaid payment for medical services furnished to an incarcerated individual during the 30-day period preceding the individual's release.

DISCUSSION

The Board believes it is important to ensure that proper health care is administered to those in all correctional facilities, whether public or private, and that the same standards should apply to all health care services delivered in all facilities. As a leading organization committed to improving public health and advancing health equity, the AMA has long advocated for quality health care services, humane treatment, and healthy environments for justice-involved populations. The Board notes that, as discussed, our AMA already has existing policy that supports AMA advocacy for appropriate health care in all forms of correctional facilities, including policy stating that correctional and detention facilities should provide medical, including psychiatric and substance use disorder care, that meets prevailing community standards. Additional policy calls on the AMA to work with an accrediting organization, such as the NCCHC, in developing a strategy to accredit all correctional, detention, and juvenile facilities and to advocate that all such facilities be accredited by the NCCHC no later than 2025. The Board believes that the AMA should remain focused on ensuring that appropriate, quality health care is provided to inmates in all facilities, regardless of private or public status. Accordingly, the Board recommends that existing AMA policy be reaffirmed in lieu of Resolution 202.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 202-I-23, and that the remainder of the report be filed.

> That our American Medical Association reaffirm existing AMA Policies H-430.986, "Health Care While Incarcerated;" H-430.997, "Standards of Care for Inmates of Correctional Facilities;" and D-430.997, "Support for Health Care Services to Incarcerated Persons." (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-I-24

Subject:	AMA/Specialty Society RVS Update Committee (Resolution 821-I-23)
Presented by:	Michael Suk, MD, JD, MPH, MBA, Chair
Referred to:	Reference Committee J

At the 2023 Interim Meeting, the House of Delegates (HOD) referred Resolution 821. Introduced by the American College of Physicians, the American Academy of Family Physicians, and the Florida Medical Association, the resolution calls on the American Medical Association (AMA) to:

> Encourage the AMA/Specialty Society Relative Value Scale (RVS) Update Committee (RUC) to modernize the RUC's processes and implement the following principles:
>
> Data-Driven Decision Making: Enhance the data used in making recommendations by shifting from almost exclusive reliance on surveys of physicians and others who perform services to broader use of evidence-based data and metadata (e.g., procedure time from operating logs, hospital length of stay data, and other extant data sources) that permit assessment of resource use and the relative value of physician and other qualified healthcare professional services comprehensively. This can ensure that data is reliable, verifiable, and can be accurately compared to or integrated with other important databases.
>
> Collaboration and Transparency: Seek collaboration with healthcare data experts, stakeholders, and relevant organizations to maintain transparent data collection and analysis methodologies.
>
> Continuous Review and Adaptation: Expand and enhance its system for continuous review and adaptation of relative value determinations beyond its Relativity Assessment Workgroup (RAW) and other current strategies (e.g., New Technology/New Services list) to stay aligned with evolving healthcare practices and technologies.
>
> Equity and Access: Work with the Current Procedural Terminology (CPT®) Editorial Panel and others, as appropriate, to identify the impact that factors related to healthcare equity and access have on the resources used to provide the services of physicians and other qualified healthcare professionals and how to account for those resources in the description and subsequent valuation of those services.
>
> Broader Engagement: Actively engage with other parties to gather input and ensure that relative value determinations align with the broader healthcare community's goals and values.
>
> Education and Training: Invest in the education and training of its members, AMA and specialty society staff, and other participants (e.g., specialty society RUC advisors) to build expertise in evidence-based data analysis and metadata utilization.

Timely Implementation: Invest the necessary resources and establish a clear timeline for the implementation of these modernization efforts, with regular progress self-assessment.

Testimony ranged from those who perceived that datasets of physician time are readily available and should be used to replace national medical specialty society surveys and clinical input to those who did not support the resolution and explained that specialty society information is currently the most available and reliable data. Many delegates supported referral as the RUC process may not be widely understood and a report would provide a greater understanding of its important work.

This report explains the RUC process, its relationship to the AMA, national medical specialty societies and the Centers for Medicare & Medicaid Services (CMS), and the data and methodology utilized to ensure that the Resource-Based Relative Value Scale (RBRVS) remains accurate.

BACKGROUND

In 1992, Medicare significantly changed the way it pays for physician services, based on statutory requirements from the Omnibus Budget Reconciliation Act of 1989. Instead of basing payments on charges, the federal government established a standardized physician payment schedule based on the RBRVS. In the RBRVS system, payments for services are determined by the resource costs needed to provide them. The cost of providing each service is divided into three components: physician work, practice expense, and professional liability insurance. Payments are calculated by multiplying the combined costs of a service by a conversion factor (a monetary amount that is determined by Congress and CMS). Payments are also adjusted for geographical differences.

The physician work component currently accounts for 50.9 percent of the total relative values units (RVUs) in the RBRVS system. The initial physician work relative values were based on the results of a Harvard School of Public Health study. The factors used to determine physician work, defined by statute and regulation, include the time it takes to perform the service; the technical skill and physical effort; the required mental effort and judgment; and stress due to the potential risk to the patient. The physician work relative values are updated each year to account for changes in medical practice described by new CPT codes. Practice expense accounts for 44.8 percent of the total relative values in the RBRVS system and represents the direct costs (e.g., clinical staff, medical supplies, medical equipment) and indirect costs associated with the individual service. Professional liability insurance accounts for 4.3 percent of the total relative values in the RBRVS system.

THE RUC PROCESS

The RUC has served the physician community for more than 30 years, by most importantly ensuring that all physician specialties have an equal opportunity to represent their members and patients in a consistent, standardized, and fair process. Using its First Amendment right to petition the federal government, the RUC submits recommendations to CMS on resources required to provide a physician service. The RUC's data collection, deliberations, and recommendations must reflect the policy requirements of the RBRVS as determined via statute and regulation.

Data Driven Decision Making

The RUC reviews new services in advance of implementation of new and revised CPT codes. National medical specialty societies and other health care professional organizations use a standardized and rigorous survey process, designed to conform to federal requirements, to collect information from a random sample of physicians and others on the time, intensity, and work to perform the service in relationship to other services commonly performed by their members. The median number of survey responses for individual CPT codes is 70 responses. For services with

higher volume, more than 100 responses are expected. The Evaluation and Management (E/M) office visit survey yielded the highest number of responses in the history of the RUC process, with 1,700 physicians completing the survey. The E/M survey was the concerted effort of 51 specialty societies and other health care professional organizations who represent 95 percent of Medicare claims for office visits. The data collected from these surveys provided the underlying basis for CMS implementing substantial payment increases for E/M office visit services in 2021.

Finally, the RUC also convenes a process to identify potentially misvalued services and then reexamines these services. Since 2006, the RUC has identified, reviewed, and submitted recommendations on nearly 2,800 services, resulting in the deletion of CPT codes or decrease in valuation for 58 percent of these services. As a component of participating in the RUC process and having an opportunity to fairly represent their members, national medical specialty societies conduct surveys to update the data for these identified services. In addition, the RUC provides the opportunity for specialty societies to identify national databases that may be utilized to present extant data. The RUC considers these data sets utilizing an approved list of criteria (e.g., ability to track data over time). To date, the RUC has approved the following databases to be utilized in support of the specialty presentations: Society of Thoracic Surgeons (STS) National Database™; American College of Cardiology (ACC) CathPCI Registry®; ACC LAAO Registry™; ACC EP Device Implant Registry™; STS/ACC TVT Registry™; and American Speech Hearing Language Association National Outcomes Measurement System. All participants are invited to submit extant data sources for consideration.

The RUC utilizes Medicare claims data in its processes to determine the typical patient, site-of-service, specialty, diagnosis, and other information to both determine appropriate relative value recommendations and to determine if a service may be potentially misvalued.

Collaboration and Transparency

The RUC is a transparent process. All RUC meeting minutes, votes, and recommendations are available on the AMA website and in a public database. Anyone may attend a RUC meeting. Hundreds of physicians from national specialty societies and other health care professionals attend as RUC participants. CMS sends representatives to each RUC meeting. Other observers include Medicare carrier medical directors, international delegations, MedPAC staff, Congressional staff, and researchers (e.g., Stanford, RAND). Since its inception in 1991, the RUC has sought the advice of AMA economists and other consultants in reviewing methodological or data methods.

Continuous Review and Adaptation

Federal law requires that all relative values be open for public comment and reviewed at least every five years. After initial implementation of the RBRVS in 1992, these reviews occurred for 1997, 2002, and 2007 implementation. In 2006, the RUC created the Relativity Assessment Workgroup (RAW) to ensure that services are identified and reviewed on an annual basis. In addition, CMS provides an annual opportunity, via federal rulemaking, for any individual or organization to identify services for review. The RUC also identifies new technology and maintains a new technology/new services list, reviewed when sufficient claims data become available.

The RAW, and the RUC, have identified and reviewed 2,800 services since the process inception in 2006. Numerous objective screens (e.g., rapid growth in utilization, site-of-service changes) are utilized to identify potentially misvalued services. To date, the RUC has reviewed services that comprise, in total allowed charges, 95 percent of the Medicare Physician Payment Schedule. More than $5 billion of annual spending has been redistributed, resulting from this process. To ensure a fair and consistent process, all participants in the RUC process may propose objective screens to identify such potential misvaluation. In addition, any member of the public may comment to CMS

on individual services they believe to be misvalued. It should be noted that any increases in valuation must be supported by compelling evidence (e.g., that the service or patient population has substantially changed), a hurdle not only for RUC review, but also CMS consideration.

The RUC is further supported by an Administrative Subcommittee, Research Subcommittee, Practice Expense Subcommittee, Professional Liability Insurance Workgroup, and ad hoc workgroups to consider and adapt the RUC process and methodology. The CPT Editorial Panel and RUC often form joint workgroups to consider significant issues such as E/M services. The RUC and RUC process continuously evolve. The RUC's Administrative Subcommittee periodically studies the RUC composition. These reviews over the past two decades resulted in additional seats for neurology, geriatrics, physical medicine and rehabilitation, and primary care. The survey methodology is under constant review, including the Research Subcommittee review of customized surveys, such as for E/M office visits, to capture essential information. At each RUC meeting, RUC members, Advisors and other attendees are welcome to introduce new business items which typically relate to process improvements and are studied by these RUC Subcommittees.

Equity and Access

The RUC has actively worked with the CPT Editorial Panel to identify coding and valuation opportunities to address equity issues. For example, the CPT/RUC Workgroup on E/M was successful in changing the medical decision-making component to recognize that when a diagnosis or treatment is significantly limited by social determinants of health, a higher level of medical decision making for E/M coding may be warranted.

The RUC recently asked the American Urological Association and the American College of Obstetricians and Gynecologists to review services, performed by their members, which may be anatomically analogous but described by different CPT codes, such as hysterectomy vs. prostatectomy, to ensure gender equity in valuation. These specialty societies presented to the RUC that there were no overall inequities in the valuation of the services performed by these two specialties.[1] During that discussion, the RUC identified that the cost of providing a pelvic exam should be recognized to ensure equity in visit payments. The RUC referred the issue to CPT. CMS implemented RUC recommended RVUs for a new code on January 1, 2024.

RUC Composition/Broader Engagement

The RUC is comprised of 32 seats, 29 voting. The RUC requires a two-thirds majority approval to submit a recommendation to CMS. The RUC members do not advocate for their specialty and are strictly prohibited to speak to any code that their nominating specialty society members perform. The RUC must have the required clinical expertise to review the full range of physician services described in CPT and Healthcare Common Procedural Coding System codes. Primary care specialties are the top provider of only 184 of 7,392 CPT codes. The RUC does not review "specialties," but rather individual services described by CPT codes. For example, rather than discuss valuation of primary care, the RUC reviews specific CPT codes describing E/M services. Notably, 25 of the 29 voting members on the RUC are from specialties that receive 40 percent or more of their Medicare payment from E/M services. Therefore, nearly every voting member frequently perform and understand the resource costs required to perform E/M services described by individual CPT codes.

The AMA has one vote on the RUC. Every national medical specialty society in the AMA HOD may also appoint an Advisor, Alternate Advisor, and two staff to participate in the RUC process. In addition, the RUC has an active Health Care Professionals Advisory Committee to represent the non-MD/DOs who report their services based on the Medicare Physician Payment Schedule. RUC meetings are open, and observers are welcome to attend and provide feedback to the RUC.

Education and Training of RUC Participants
The RUC has an orientation process for its members, advisors, staff, and other participants. The RUC process is extremely technical, and it does require investment and time to become proficient in the rules and standards of the RBRVS methodology. The orientation includes participation in 12 webinars and annual in-person training sessions. Most RUC members first serve for years as Advisors before being appointed to the RUC to fully be immersed into the RBRVS system.

Timely Improvements and Resources
The RUC has a continuous mechanism to ensure evolution and improvement in its methodology and processes. The RUC's Administrative Subcommittee, Research Subcommittee, and Practice Expense Subcommittee are all actively engaged in this effort. Collectively, the AMA and national medical specialty societies have devoted significant resources to the RUC process since its inception, spending millions of dollars each year for data collection, meetings, and travel. Hundreds of physician volunteers also spend countless hours preparing for and participating in RUC meetings.

AMA POLICY

The AMA has extensive, long-standing policy that supports the RUC process and the ability of physicians to provide clinical input into the refinement and improvement of the RBRVS (Policies D-400.983, D-400.986, D-400.988, D-400.999, H-70.952, H-70.980, H-400-956, H-400.957, H-400.959, H-400.962, H-400.969, H-400.972, H-400.973, H-400.990, H-400.991). Most relevant to the issues discussed in the report are the following AMA policies supporting the RUC and its ability to implement methodological improvements:

Policy D-400.983 states that the AMA, together with state medical associations and national medical specialty societies, will work to ensure that the resource-based relative value system and work values follow the statutory provisions that require the consideration of time and intensity.

Policy H-400.959 supports the RUC's efforts to improve the validity of the RBRVS through development of methodologies for assessing the relative work of new technologies and for assisting CMS in a more comprehensive review and refinement of the work component of the RBRVS.

Policy 400.969 states that the AMA continue to urge CMS to adopt the recommendations of the RUC for work relative values for new and revised CPT codes, and strongly supports the use of the RUC process as the principal method of refining and maintaining the Medicare RBRVS.

DISCUSSION

This report provides the opportunity to summarize the RUC process and the ongoing activities to offer improvements to the RBRVS. The RUC has successfully advocated on behalf of medicine and other health care professionals since 1991, with CMS often accepting more than 90 percent of the RUC's annual recommendations. The RUC also has engaged in the responsible, yet difficult, endeavor to identify potentially misvalued services. The national medical specialty societies are to be applauded for their ongoing effort to survey members and obtain clinical expertise to ensure that services are accurately and fairly evaluated, even when that review may lead to reduction in valuation for their services and a redistribution to other services.

The RUC has a long history of improving payment for primary care services, including increases to RVUs for preventive medicine, immunization administration, care management and E/M services in 1997, 2007 and 2021. Medical home recommendations were submitted to CMS in 2008.

The RUC has developed numerous standards within its review to ensure consistency and relativity using the national specialty society surveys and clinical expertise. Standards are used for physician pre-time evaluation, positioning and scrub, dress and wait times, and for post-time on the date of surgery. Numerous time standards are used for the tasks performed by clinical staff. These standards were developed with significant input by the national medical specialty societies, reviewed by the RUC, and ultimately published for public comment and review via CMS rulemaking. These standards, along with the national medical specialty society data, and the peer review by the RUC, lead to fair and consistent relative value recommendations to CMS.

The AMA supports the RUC's request for additional claims data from CMS, including updated Medicaid data and Medicare Advantage data. The AMA recently commented to CMS on a request for information on Medicare Advantage data and urged CMS to release these claims data in a manner similar to traditional Medicare claims data. The AMA also continues to investigate available claims data from commercial payers.

In addition, AMA staff have engaged in numerous meetings with staff from Epic and Oracle (which acquired Cerner in 2022) regarding the availability of any data within their electronic health systems that may be beneficial in reviewing physician time of individual services. To date, these systems do not collect meaningful physician time data that may be shared or utilized by the RUC. Ongoing discussions with Oracle on potential length of stay data will continue.

As previously noted, several national medical specialty societies have engaged in creating patient registries and some of these registries include time data. Cardiothoracic Surgery and Cardiology have each shared registry information with the RUC and these sources of extant data are approved for use in the valuation process. Other national medical specialties should be encouraged to share relevant extant databases with the RUC. The AMA, as well as the RUC's Research Subcommittee, will continue to investigate additional valid data sources to supplement specialty surveys, registries and claims databases that can enhance the overall RUC process.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 821-I-23, and the remainder of the report be filed.

1. That our American Medical Association (AMA) support the continued efforts of the AMA/Specialty Society RVS Update Committee (RUC) to identify extant data to utilize within the ongoing process to improve the Resource Based Relative Value Scale (RBRVS). (New HOD Policy)

2. That our AMA reaffirm Policy D-400.983, which supports the RUC and its ability to implement methodological improvements. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-400.959, which supports the RUC's efforts to improve the validity of the RBRVS through development of methodologies for assessing the relative work of new technologies. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-400.969, which calls on the Centers for Medicare & Medicaid Services to adopt the recommendations of the RUC for work relative values for new and revised Current Procedural Terminology (CPT®) codes, and strongly supports the use of the RUC process as the principal method of refining and maintaining the Medicare RBRVS. (Reaffirm HOD Policy)

Fiscal Note: $500

REFERENCES

[1]Hathaway, JK, Schuster MS, Richards KA, Turk TMT. Comparison of Work Relative Value Units Assigned to Urological and Gynecological Surgical Procedures. Urology Practice. 2024 July 1: 11 (4):654-60. Available at: https://www.auajournals.org/doi/10.1097/UPJ.0000000000000612

Board of Trustees Report -I-24
AMA/Specialty Society RVS Update Committee
Policy Appendix

Arbitrary Relative Value Decisions by CMS D-400.983
1. Our AMA, together with state medical associations and national medical specialty societies, will work to ensure that the resource-based relative value system and physician work values follow the statutory provisions that require the consideration of time and intensity. 2. Our AMA, working with state medical associations and national medical specialty societies, strongly advocates that the Centers for Medicare and Medicaid Services restore the Refinement Panel to serve as the appeals process that was appropriately in place from 1993-2010. Res. 107, A-16

The RUC: Recent Activities to Improve the Valuation of Primary Care Services D-400.986
Our AMA continues to advocate for the adoption of AMA/Specialty Society RVS Update Committee (RUC) recommendations, and separate payment for physician services that do not necessarily require face-to-face interaction with a patient. BOT Rep. 14, A-08 Reaffirmed: CMS Rep. 01, A-18

PLI-RVU Component of RBRVS Medicare Fee Schedule D-400.988
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. Res. 707, I-03 Reaffirmed: BOT Rep. 18, A-05 Modified: CCB/CLRPD Rep. 2, A-14

Non-Medicare Use of the RBRVS D-400.999
Our AMA will: (1) reaffirm Policy H-400.960 which advocates that annually updated and rigorously validated Resource Based Relative Value Scale (RBRVS) relative values could provide a basis for non-Medicare physician payment schedules, and that the AMA help to ensure that any potential non-Medicare use of an RBRVS reflects the most current and accurate data and implementation methods;.(2) reaffirm Policy H-400.969 which supports the use of the AMA/Specialty Society process as the principal method of refining and maintaining the Medicare relative value scale;(3) continue to identify the extent to which third party payers and other public programs modify, adopt, and implement Medicare RBRVS payment policies;(4) strongly oppose and protests the Centers for Medicare & Medicaid Services Medicare multiple surgery reduction policy which reduces payment for additional surgical procedures after the first procedure by more than 50 percent; and (5) encourage third party payers and other public programs to utilize the most current CPT codes updated by the first quarter of the calendar year, modifiers, and relative values to ensure an accurate implementation of the RBRVS. CMS Rep. 12, A-99 Reaffirmation I-03 Reaffirmation I-07 Modified: BOT Rep. 22, A-17

Medicare Guidelines for Evaluation and Management Codes H-70.952
Our AMA (1) seeks Federal regulatory changes to reduce the burden of documentation for evaluation and management services; (2) will use all available means, including development of new Federal legislation and/or legal measures, if necessary, to ensure appropriate safeguards for physicians, so that insufficient documentation or inadvertent errors in the patient record, that does not meet evaluation and management coding guidelines in and of itself, does not constitute fraud or abuse; (3) urges CMS to adequately fund Medicare Carrier distribution of any documentation

guidelines and provide funding to Carriers to sponsor educational efforts for physicians; (4) will work to ensure that the additional expense and time involved in complying with documentation requirements be appropriately reflected in the Resource Based Relative Value Scale (RBRVS); (5) continues to advise and educate physicians about the guidelines, any revisions, and their implementation by CMS; and (6) AMA policy is that in medical documentation the inclusion of any items unrelated to the care provided (e.g., irrelevant negatives) not be required. Sub. Res. 801, I-97 Reaffirmation I-00 Reaffirmed: CMS Rep. 6, A-10 Modified: CMS Rep. 01, A-20

Bundling CPT Codes H-70.980
1. Our AMA, through its CPT Editorial Panel and Advisory Committee, will continue to work with CMS to provide physician expertise commenting on the medical appropriateness of code bundling initiatives for Medicare payment policies. 2. Our AMA strongly urges the Centers for Medicare & Medicaid Services (CMS) to not treat bundling of existing services into a common code as a new procedure and new code. 3. Our AMA will advocate for a phase-in of new values for codes where the cuts resulting from the identification of misvalued services cause a significant reduction from the value of the existing codes and work with CMS to achieve a smooth transition for such codes. 4. The RUC will take into consideration CMS's willingness or reluctance to transition large payment reductions as it schedules the review of relative values for bundled services or other codes that come before the RUC as a result of the identification of potentially misvalued services. 5. Our AMA strongly supports RUC recommendations and any cuts by CMS beyond the RUC recommendations will be strongly opposed by our AMA. Sub. Res. 801, I-91 Reaffirmed: Res. 814, A-00 Reaffirmed: CMS Rep. 6, A-10 Appended: Res. 118, A-10 Reaffirmation I-13 Reaffirmed: CMS Rep. 01, A-23

RBRVS Development H-400.956
That the AMA strongly advocate CMS adoption and implementation of all the RUC's recommendations for the five-year review; (2) That the AMA closely monitor all phases in the development of resource-based practice expense relative values to ensure that studies are methodologically sound and produce valid data, that practicing physicians and organized medicine have meaningful opportunities to participate, and that any implementation plans are consistent with AMA policies; (3) That the AMA work to ensure that the integrity of the physician work relative values is not compromised by annual budget neutrality or other adjustments that are unrelated to physician work; (4) That the AMA encourage payers using the relative work values of the Medicare RBRVS to also incorporate the key assumptions underlying these values, such as the Medicare global periods; and (5) That the AMA continue to pursue a favorable advisory opinion from the Federal Trade Commission regarding AMA provision of a valid RBRVS as developed by the RUC process to private payers and physicians. BOT Rep. 16, A-95 BOT Rep. 11, A-96 Reaffirmed: CMS Rep. 4, I-02 Reaffirmed: BOT Rep. 14, A-08 Reaffirmed: Sub. Res. 104, A-14 Reaffirmation A-15

Medicare Reimbursement of Office-Based Procedures H-400.957
Our AMA will: (1) encourage CMS to expand the extent and amount of reimbursement for procedures performed in the physician's office, to shift more procedures from the hospital to the office setting, which is more cost effective; (2) seek to have the RBRVS practice expense RVUs reflect the true cost of performing office procedures; and (3) work with CMS to develop consistent regulations to be followed by carriers that include reimbursement for the costs of disposable supplies and surgical tray fees incurred with office-based procedures and surgery. Sub. Res. 103, I-93 Reaffirmed by Rules & Credentials Cmt., A-96 Reaffirmation A-04 Reaffirmation I-04 Reaffirmed: CMS Rep. 1, A-14 Reaffirmed: CMS Rep. 3, A-14 Reaffirmed in lieu of Res. 216,

I-14 Reaffirmed: CMS Rep. 04, I-18 Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19 Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19 Reaffirmation: A-22

Refining and Updating the Physician Work Component of the RBRVS H-400.959
The AMA: (1) supports the efforts of the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee's (RUC's) work with the American Academy of Pediatrics and other specialty societies to develop pediatric-specific CPT codes and physician work relative value units to incorporate children's services into the RBRVS; (2) supports the RUC's efforts to improve the validity of the RBRVS through development of methodologies for assessing the relative work of new technologies and for assisting CMS in a more comprehensive review and refinement of the work component of the RBRVS; and (3) continues to object to use of the relative values as a mechanism to preserve budget neutrality. BOT Rep. I-93-26 Reaffirmed by BOT Rep. 8-I-94 Res. 806, I-94 Reaffirmed: Sub. Res. 816, I-99 Reaffirmed: CMS Rep. 4, I-02 Reaffirmed: BOT Rep. 14, A-08 Reaffirmed: Sub. Res. 104, A-14 Reaffirmation A-15

The AMA/Specialty Society RVS Update Process H-400.962
Our AMA will strengthen its efforts to secure CMS adoption of the AMA/Specialty Society RVS Update Committee's (RUC) recommendations. BOT Rep. N, A-93 Reaffirmed: Sub. Res. 821, I-99 Reaffirmed: BOT Rep. 14, A-08 Reaffirmed: CMS Rep. 01, A-18

RVS Updating Status Report and Future Plans H-400.969
Status Report and Future Plans: The AMA/Specialty Society RVS Update Committee (RUC) represents an important opportunity for the medical profession to maintain professional control of the clinical practice of medicine. The AMA urges each and every organization represented in its House of Delegates to become an advocate for the RUC process in its interactions with the federal government and with its physician members. The AMA (1) will continue to urge CMS to adopt the recommendations of the AMA/Specialty Society RVS Update Committee for physician work relative values for new and revised CPT codes; (2) supports strongly use of this AMA/Specialty Society process as the principal method of refining and maintaining the Medicare RVS; (3) encourages CMS to rely upon this process as it considers new methodologies for addressing the practice expense components of the Medicare RVS and other RBRVS issues; (4) opposes changes in Relative Value Units that are in excess of those recommended by the AMA/Specialty Society Relative Value Scale Update Committee (RUC); and (5) supports the ongoing effort of members of the federation to analyze the valuation of CPT codes describing similar services by gender to ensure equitable valuation. BOT Rep. O, I-92 Reaffirmed by BOT Rep. 8-I-94 Reaffirmed by BOT Rep. 7, A-98 Reaffirmed: CMS Rep.12, A-99 Reaffirmed: CMS Rep. 4, I-02 Reaffirmed: BOT Rep. 14, A-08 Reaffirmation I-10 Appended: Res. 822, I-12 Reaffirmation I-13 Reaffirmed: Sub. Res. 104, A-14 Reaffirmed in lieu of Res. 216, I-14 Reaffirmation A-15 Appended: Res. 105, A-23

Physician Payment Reform H-400.972
It is the policy of the AMA to (1) take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but not limited to, (a) reduction of allowances for new physicians; (b) the non-payment of EKG interpretations; (c) defects in the Geographic Practice Cost Indices and area designations; (d) inappropriate Resource-Based Relative Value Units; (e) the deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system; (f) the need for restoration of the RBRVS conversion factor to levels consistent with the statutory requirement for budget neutrality; (g) the inadequacy of payment for services of assistant surgeons; and (h) the loss of surgical-tray benefit for many outpatient procedures (Reaffirmed by Rules & Credentials Cmt., A-96); (2) seek an evaluation of (a) stress factors (i.e., intensity values) as they affect the calculation of the Medicare Payment

Schedule, seeking appropriate, reasonable, and equitable adjustments; and (b) descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and payment levels and to seek adjustments so that the resulting values and payment levels appropriately pertain to the elderly and often infirm patients; (3) evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment Schedule and to ascertain that the concept for the work component continues to be an appropriate part of a resource-based relative value system; (4) seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors; (5) seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with preoperative office visits, concomitant office procedures, and/or future procedures; (6) seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992; (7) seek the elimination of regulations directing patients to points of service; (8) support further study of refinements in the practice cost component of the RBRVS to ensure better reflection of both absolute and relative costs associated with individual services, physician practices, and medical specialties, considering such issues as data adequacy, equity, and the degree of disruption likely to be associated with any policy change; (9) take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs; (10) support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of 1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare geographic practice costs indices (GPCIs) and work with CMS and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect actual physician costs, including gross receipt taxes; (11) request that CMS refine relative values for particular services on the basis of valid and reliable data and that CMS rely upon the work of the AMA/Specialty Society RVS Updating Committee (RUC) for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations; (12) pursue aggressively recognition and CMS adoption for Medicare payment schedule conversion factor updates of an index providing the best assurance of increases in the monetary conversion factor reflective of changes in physician practice costs, and to this end, to consider seriously the development of a "shadow" Medicare Economic Index; (13) continue to implement and refine the Payment Reform Education Project to provide member physicians with accurate and timely information on developments in Medicare physician payment reform; and (14) take steps to assure all relative value units contained in the Medicare Fee Schedule are adjusted as needed to comply with ever-increasing federal and state regulatory requirements. Sub. Res. 109, A-92 Reaffirmed: I-92 Reaffirmed by CMS Rep. 8, A-95 and Sub. Res. 124, A-95 Reaffirmation A-99 and Reaffirmed: Res. 127, A-99 Reaffirmation A-02 Reaffirmation A-06 Reaffirmation I-07 Reaffirmed: BOT Rep. 14, A-08 Reaffirmation A-09 Reaffirmed: CMS Rep. 01, A-19 Reaffirmed: Res. 212, I-21

Limited Licensed Practitioners and RBRVS H-400.973
It is the policy of the AMA to advocate that Medicare expenditure data clearly differentiate between the services of fully licensed physicians and those of limited licensed practitioners and of other Part B services. Sub. Res. 124, I-91 Reaffirmed: BOT Rep. DD, I-92 Modified: CMS Rep. 10, A-03 Modified: CMS Rep. 4, A-13 Reaffirmed: BOT Rep. 09, A-23

Refinement of Medicare Physician Payment System H-400.990
The AMA: (1) reaffirms its support for development and implementation of a Medicare indemnity payment schedule according to the policies established in Policy 400.991; (2) supports reasonable attempts to remedy geographic Medicare physician payment inequities that do not substantially interfere with the AMA's support for an RBRVS-based indemnity payment system; (3) supports

continued efforts to ensure that implementation of an RBRVS-based Medicare payment schedule occurs upon the expansion, correction, and refinement of the Harvard RBRVS study and data as called for in Board Report AA (I-88), and upon AMA review and approval of the relevant proposed enabling legislation; and (4) continues to oppose any effort to link the acceptance of an RBRVS with any proposal that is counter to AMA policy, such as expenditure targets or mandatory assignment. BOT Rep. BBB, A-89 Reaffirmed: I-92 Reaffirmed and Modified: CMS Rep. 10, A-03 Reaffirmation A-09 Reaffirmed: CMS Rep. 01, A-19 Reaffirmed: Res. 212, I-21

Guidelines for the Resource-Based Relative Value Scale H-400.991
(1) The AMA reaffirms its current policy in support of adoption of a fair and equitable Medicare indemnity payment schedule under which physicians would determine their own fees and Medicare would establish its payments for physician services using: (a) an appropriate RVS based on the resource costs of providing physician services; (b) an appropriate monetary conversion factor; and (c) an appropriate set of conversion factor multipliers. (2) The AMA supports the position that the current Harvard RBRVS study and data, when sufficiently expanded, corrected, and refined, would provide an acceptable basis for a Medicare indemnity payment system. (3) The AMA reaffirms its strong support for physicians' right to decide on a claim-by-claim basis whether or not to accept Medicare assignment and its opposition to elimination of balance billing. (Reaffirmed: Sub. Res. 132, A-94) (4) The AMA reaffirms its opposition to the continuation of the Medicare maximum allowable actual charge (MAAC) limits. (5) The AMA promotes enhanced physician discussion of fees with patients as an explicit objective of a Medicare indemnity payment system. (6) The AMA supports expanding its activities in support of state and county medical society-initiated voluntary assignment programs for low-income Medicare beneficiaries. (7) The AMA reaffirms its current policy that payments under a Medicare indemnity payment system should reflect valid and demonstrable geographic differences in practice costs, including professional liability insurance premiums. In addition, as warranted and feasible, the costs of such premiums should be reflected in the payment system in a manner distinct from the treatment of other practice costs. (8) The AMA believes that payment localities should be determined based on principles of reasonableness, flexibility, and common sense (e.g., localities could consist of a combination of regions, states, and metropolitan and nonmetropolitan areas within states) based on the availability of high-quality data. (9) The AMA believes that, in addition to adjusting indemnity payments based on geographic practice cost differentials, a method of adjusting payments to effectively remedy demonstrable access problems in specific geographic areas should be developed and implemented. (10) Where specialty differentials exist, criteria for specialty designation should avoid sole dependence on rigid criteria, such as board certification or completion of residency training. Instead, a variety of general national criteria should be utilized, with carriers having sufficient flexibility to respond to local conditions. In addition to board certification or completion of a residency, such criteria could include, but not be limited to: (a) partial completion of a residency plus time in practice; (b) local peer recognition; and (c) carrier analysis of practice patterns. A provision should also be implemented to protect the patients of physicians who have practiced as specialists for a number of years. (11) The AMA strongly opposes any attempt to use the initial implementation or subsequent use of any new Medicare payment system to freeze or cut Medicare expenditures for physician services in order to produce federal budget savings. (12) The AMA believes that whatever process is selected to update the RVS and conversion factor, only the AMA has the resources, experience and umbrella structure necessary to represent the collective interests of medicine, and that it seek to do so with appropriate mechanisms for full participation from all of organized medicine, especially taking advantage of the unique contributions of national medical specialty societies. BOT Rep. AA, I-88 Reaffirmed: I-92 Reaffirmed and Modified: CMS Rep. 10, A-03 Reaffirmation A-06 Reaffirmed: CMS Rep. 01, A-16 Reaffirmed: Res 212 I-21

REPORT 15 OF THE BOARD OF TRUSTEES (I-24)
Published Metrics for Hospitals and Hospital Systems
Reference Committee J

EXECUTIVE SUMMARY

At the 2023 Annual Meeting of the House of Delegates (HOD), Resolution 715-A-23, "Published Metrics for Hospitals and Hospital Systems," was referred for report back. The resolution directs our American Medical Association (AMA) to identify transparency metrics, such as physician retention and physician satisfaction, that would apply to hospitals and hospital systems and report back with recommendations for implementing appropriate processes to require the development and public release of such transparency metrics. The following Board of Trustees Report provides this update and will be provided to the HOD for review at the 2024 Interim Meeting.

This report provides detailed information about existing publicly available metrics for hospitals and hospital systems and their potential impact on physicians and patients. Additionally, the report outlines AMA efforts to support health systems in regularly measuring important indicators such as physician burnout and turnover including policies, advocacy, partnerships with professional organizations, development and dissemination of tools, educational resources, and hands-on support for health systems.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 15-I-24

Subject:	Published Metrics for Hospitals and Hospital Systems (Res. 715-A-23)
Presented by:	Michael Suk, MD, JD, MPH, MBA Chair
Referred to:	Reference Committee J

INTRODUCTION

At the 2023 Annual Meeting of the House of Delegates (HOD), the American Association of Neurological Surgeons and Congress of Neurological Surgeons introduced Resolution 715-A-23, "Published Metrics for Hospitals and Hospital Systems". The resolution was referred for report back and directs the American Medical Association to identify transparency metrics (e.g., physician retention and physician satisfaction) applicable to hospitals and hospital systems and report back with recommendations for implementing appropriate processes to require the development and public release of such metrics. The following Board of Trustees Report provides this update and will be provided to the HOD for review at the 2024 Interim Meeting.

BACKGROUND

Nearly 63 percent of physicians in the United States experience at least one symptom of burnout, according to recent research. A dramatic increase in burnout and decrease in job satisfaction occurred among U.S. physicians during the first two years of the COVID-19 pandemic, leading many physicians to consider a reduction in work effort or leaving their organization and the profession altogether.[1] Nearly one-quarter of all physicians noted an intent to leave their job, and a recent study also found that the annual rate of physician turnover in the United States increased between 2010 and 2018.[2,3] A Definitive Healthcare report found that an estimated 117,000 physicians left the workforce in 2021.[4] Similarly, a study using AMA-collected data from 2020-2021 found that clinician burnout and intent to leave gradually increased in the early days of the pandemic and rose sharply in late 2021. Work control, teamwork, and feeling valued were both mitigating and aggravating factors for clinician burnout and retention and could provide mechanisms for worker protection.[5]

Overall, these trends are alarming for the U.S. health care system. Nearly one billion dollars in excess patient costs are tied to physician turnover.[6] Physician burnout and turnover may also have a profound impact on patient access, especially for people living in rural areas and health systems caring for underserved communities. Physician burnout and turnover have myriad consequences for physicians, patients, and the overall health care system. While many hospitals and hospital systems have begun to address the underlying system-level issues that cause burnout and turnover, much work remains to be done to address the work environment of physicians to reduce physician burnout and turnover.

Currently, there are reporting mechanisms by which hospitals and hospital systems are held accountable to for the maintenance of quality and safety standards. These existing transparency metrics are largely focused on patient safety and quality of care. These standards have not traditionally focused on the physician experience (e.g., turnover and job satisfaction) but remain largely in place to provide the public (i.e., patients) with transparent information about the performance and safety of the hospital or hospital system. However, over the last ten years, more hospitals and hospitals systems are beginning to measure and track metrics related to the physician experience, including physician burnout and turnover. They have done so as a foundational strategy to address the underlying causes of these outcomes. While collection and reporting of these measures remains voluntary and are not tied to hospital accreditation, these measures can provide insights to help motivated health system leaders develop data-driven approaches to reduce burnout, improve job satisfaction, and increase retention—and thus, provide an enhanced working environment for their physicians, a better care environment for their patients, and improve overall value and costs. Metrics and reporting mechanisms for the physician experience vary widely by hospital systems. Most do not share these measures publicly, although many do share these measures with their physician staff for increased accountability and shared solution-building.

Physician burnout and turnover have myriad causes and addressing these issues to reduce physician burnout (and lessen physician turnover) is a key pillar of the AMA's "You Are Why We Fight" campaign. Central to these efforts are AMA's collaborations over the past five years with more than 300 hospitals or hospital systems in measuring physician burnout and turnover, and incentivizing health systems to improve the physician experience through the AMA's Joy in Medicine Health System Recognition Program.

In addition to further outlining existing transparency metrics for health systems in the United States, this report provides a more in-depth review of existing AMA resources for hospital systems and its leadership for the adoption of metrics to accurately assess the physician experience.

DISCUSSION

Existing public reporting, accreditation, and grading systems include the Leapfrog group, Joint Commission, and National Integrated Accreditation for Healthcare Organizations (NIAHO) accreditation program. The details of each system are discussed below in addition to the opportunities and risks associated with mandatory reporting of transparency metrics.

Leapfrog Hospital Safety Grades

Overview

The Leapfrog group is an independent, national not-for-profit organization focused on measuring and publicly reporting hospital performance. Hospitals voluntarily participate free of charge.[7] Leapfrog Hospital Safety Grade uses up to 30 national performance measures from the Centers for Medicare & Medicaid Services (CMS) and other supplemental data sources. The goal of the Leapfrog Hospital Safety Grade is to publicly report patient safety and quality information for consumers, purchasers, and physicians to guide their decisions regarding where to seek care and direct patients. Leapfrog Hospital safety grades can be searched by anyone in the public via their website. This public reporting is largely focused on supporting patients in selecting a hospital and advocating for better hospital safety.[8] None of the Leapfrog metrics or related reporting focus on physician or clinician experiences, suggesting an opportunity for Leapfrog to enhance their portfolio of measures.

Some research has been done to assess Leapfrog's grading system. A 2017 analysis found that Leapfrog's measure skews toward positive self-report and bears little association with Medicare outcomes and penalties.[9] A 2023 examination of Leapfrog safety measures and Magnet designation found that Magnet-designated hospitals had higher Leapfrog grades for structural safety measures but not better infection rates.[14] There exists a paucity of literature that provides insights into whether Leapfrog transparency metrics result in behavior or choice modification (e.g., choosing a different hospital) by either patients or physicians. Therefore, the total impact of these measures in their transparent reporting is largely unknown or unattributed.

The Joint Commission

Overview

The Joint Commission is an independent, not-for-profit organization in the United States that accredits and certifies health care organizations and programs. It sets standards for health care quality and safety and conducts regular evaluations to ensure compliance. Hospitals, health care systems, nursing homes, clinics, and other health care facilities voluntarily seek Joint Commission accreditation to demonstrate their commitment to meeting high standards of patient care.

The Joint Commission does not have specific accreditation standards solely focused on physician burnout, turnover, or satisfaction. The Joint Commission touts that their accreditation may help attract and retain qualified personnel who prefer to serve in an accredited organization.[12] The Joint Commission includes reference to several physician well-being resources on its website, but workforce well-being is not explicitly a part of its accreditation standards.[13]

While having Joint Commission accreditation may signal to physicians that their institutions are prioritizing patient safety, quality care, and efficient processes, there has been little to no exploration on whether organizations that have Joint Commission accreditation have lower physician burnout or turnover. In fact, a 2023 study found that while half of Joint Commission-accredited hospitals and Federally Qualified Health Centers are taking steps to improve physician well-being, a small minority of them are measuring well-being and very few are taking a comprehensive approach to advancing well-being as an organizational priority.[14]

Existing Literature

There does not currently appear to be literature that provides insights into whether Joint Commission accreditation and their transparency metrics result in behavior or choice modification (e.g., choosing a different hospital) by either patients or physicians. Therefore, the total impact of these measures in their transparent reporting is largely unknown or unattributed.

DNV Healthcare – NIAHO® Hospital Accreditation

Overview

DNV GL Healthcare offers yet another hospital accreditation—the NIAHO accreditation program. Similar to the Joint Commission, this accreditation program also largely focuses on patient safety, quality of care, facility manager, and adherence to regulatory requirements. Further, this accreditation directly addresses CMS requirements, and standards vary by facility type.[15]

NIAHO measures do include evaluation of leadership and management, clinical excellence, and facility and environmental management. Although this may influence physicians' decisions about joining a hospital, measurements of physician turnover, job satisfaction or burnout are not part of the standard measures.[16]

The Pathway to Excellence Program®

The Pathway to Excellence Program is one accreditation program that can be used as a model for health care organizations interested in utilizing metrics to improve physician well-being. The program is the premier designation for health care organizations and long term care organizations that have achieved healthy practice environments for nurses. To qualify for designation, organizations are required to meet the six Pathway Standards that have been identified as essential for a positive practice environment for nurses. These standards are designed to support nurse satisfaction, high-quality nursing practice, and interprofessional collaboration, and impact an array of factors that in turn influence results such as employee turnover, job satisfaction and engagement, errors and safety events, and patient satisfaction.[17]

Public Reporting of Metrics in Health Care: Benefits and Potential Unintended Consequences

Public and transparent reporting of hospital metrics can have a positive impact but there may also be unintended consequences for physicians, patients, hospitals, and hospital systems that must be weighed against those benefits.

Some benefits of public reporting may include transparency and accountability, informed decision-making, quality improvement initiatives, and benchmarking and learning. Publicly reporting hospital metrics, such as quality of care, patient outcomes, infection rates, and readmission rates creates transparency. Hospitals are held accountable for their performance, encouraging them to strive for better outcomes and quality of care. Patients' and families' access to this information can enable them to make more informed decisions about where to seek care. When patients have access to data on hospital performance, they can choose facilities with better outcomes, which incentivizes hospitals to improve their services to attract patients. Additionally, public reporting can drive hospitals to implement quality improvement initiatives. Knowing that their performance is being publicly evaluated can motivate hospitals to identify areas for improvement and implement changes to enhance care quality and outcomes. Further, public reporting can facilitate hospitals' comparisons of their performance against others, allowing them to identify best practices and areas where improvement is needed. This benchmarking helps hospitals learn from each other and adopt successful strategies to improve care.

Also of importance to recognize is that public reporting of transparency metrics influences, at least to some degree, hospital and health system behavior. For instance, in a 2012 survey of hospital leaders from over 600 U.S. hospitals, participants reported that publicly reported measures impacted planning and improvement initiatives within their organization. Over 70 percent of respondents agreed that public reporting stimulated quality improvement activity at their institution; 89.7 percent reported that their organization's reputation was affected by patient experience measures; 87.1 percent indicated that performance on publicly reported measures was incorporated into their hospital's annual goals; and more than 90 percent reported regularly reviewing the results of publicly reported measures with hospital board of trustees members. However, hospital leadership also expressed concern about the clinical meaningfulness, unintended consequences, and current methods of public reporting.[18] Additionally, in a recent Becker's article, physician executives from four health systems shed light upon their views of national rankings and its use for quality improvement strategies. Many leaders saw greater value in national benchmarking data from private third-party organizations as opposed to rankings from platforms such as Leapfrog, CMS' Overall Hospital Star Ratings, and *U.S. News & World Report's* best hospitals since the latter sources are retrospective in nature.[19]

Importantly, public reporting is not a singular solution and there may be unintended consequences from public and transparent reporting that have implications for patients, physicians, hospitals, and hospitals systems. Much of the concern about publicly reporting hospital and hospital system metrics generally question the validity of these metrics and the potential for misuse. For instance, authors from a 2005 *JAMA* article argue that the value of publicly reporting quality information is largely undemonstrated.[20] Additionally, measures that have been validated for one purpose can be inappropriately used for another purpose. For instance, patient safety indicators from administrative data sources are helpful tools for case identification and tracking rates at a single organization but not useful for comparing rates across hospitals. Research has reported that when rates of postoperative infections were derived from administrative data sources, over 50 percent of the variation in risk-adjusted postoperative infection rate observed across hospitals could be attributed to differences in coding practices rather than actual outcomes. [21]

Another major potential unintended consequence of publicly reporting transparency metrics is reduced access to – and even disparities in – care. For instance, hospitals in neighborhoods with greater social risk often care for patient populations with increased medical complexity and fewer resources than hospitals in other neighborhoods. This has been shown to unfairly and negatively impact hospital ratings, as well as reinforce disincentives to care for patient populations living in neighorhoods with greater social complexity. One study that examined the relationship between neighborhood social risk factors and hospital ratings in Medicare's Hospital Compare Program found that lower hospital summary scores were associated with caring for neighborhoods with higher social risk. This included a reduction in hospital score for every ten percent of residents who reported dual-eligibility for Medicare and Medicaid, lacking a high school diploma, unemployment, Black race, and high commute times to work.[22] Another study found that compared to other hospitals, total reimbursements for patient care at hospitals serving the most Black patients were on average 21.6 percent lower. Mean and median profits per patient day at Black-serving hospitals were also eight dollars and 17 dollars, respectively, while these values were $64 and $126 at other hospitals.[23] Taken together, these studies have implications for the public reporting of hospital metrics such as physician burnout, turnover, and job satisfaction rates and their impact on the care of some of America's most marginalized patient populations. For example, publicly reporting such metrics could potentially exacerbate inequities for patients that receive care at majority Black-serving hospitals, physicians that work at these organizations, and quality rankings appointed to these facilities.

Moreover, publicly reporting physician burnout, turnover, and job satisfaction rates could possibly lead to hospitals becoming risk-averse in their hiring practices to keep these metrics low similar to evidence demonstrating hospitals avoiding high-risk patients when subject to public reporting. For example, a study compared the percentages of white, Black, and Hispanic patients that received coronary artery bypass grafting (CABG), percutaneous transluminal coronary angioplasty, and cardiac catheterization prior to and following the availability of the New York State CABG public report. The study found that there was a greater racial disparity in the percentage of patients who received CABG in the periods after public reporting versus before. Additionally, the disparity was found to be greater in New York as opposed to the twelve comparison states assessed in the study that had not released CABG public reports.[24] This begs the question of whether publicly reporting hospital metrics could potentially lead to hospitals and hospital systems avoiding hiring marginalized and minoritized clinical staff with demonstrated disproportionate rates of burnout such as physicians of color, women physicians, and physicians who are caregivers for children, aging parents or other dependents rather than collaborating with physicians to actually and effectively improve burnout, turnover, and job satisfaction.[25,26]

Lastly, making these metrics publicly available bears the risk of patients and payers misinterpreting this information and incorrectly using it to make decisons about where to seek care and direct patients. Too much data, particularly when devoid of context, can overwhelm the public and fuel misinformation. Patients using this data to guide where to receive care is especially risky because poor performance in one area (e.g., physician burnout) does not mean that performance in another area is also poor (e.g., the percentage of patients that are able to receive a certain procedure).[24]

While transparent reporting of metrics, particularly those related to physician turnover, job satisfaction, or burnout, may increase accountability from hospital system leadership, it could also act as a detractor in establishing physician-organization collaboration and may feel more punitive than solution-seeking. Establishing a strong and collaborative relationship between physicians and their organizations is shown to reduce physician burnout and increase physician engagement.[27] Public and transparent reporting of burnout, satisfaction, and turnover metrics could have the unintended consequence of disrupting the establishment of a strong and collaborative relationship between physicians and their leadership, as hospital leadership could become hyper-focused on specific measures that do not completely capture the nuances and intricacies of the physician experience.

AMA POLICY

The AMA has several policies related to increased transparency of hospital and hospital system metrics that reflect the physician experience.

The AMA will study current tools and develop metrics to measure physician professional satisfaction (Policy D-405.985, "Physician Satisfaction").

The AMA will also foster the creation of quality measures and rating systems that incorporates the satisfaction and perspective of the medical staff regarding individual hospitals (Policy D-215.988, "Capturing Physician Sentiments of Hospital Quality").

Further, the AMA promotes physician-developed guidelines for evaluating patient and physician satisfaction with plans, accreditation standards, utilization, quality and cost policies (Policy H-450.962, "National Committee for Quality Assurance").

Moreover, the AMA supports that the "Triple Aim" be expanded to the Quadruple Aim, adding the goal of improving the work-life balance of physicians and other health care providers.
The AMA will also advocate that addressing physician satisfaction count as a Clinical Practice Improvement Activity under the Merit-Based Incentive Payment System (MIPS) (Policy H-405.955, "Support for the Quadruple Aim").

AMA SUPPORT FOR HEALTH SYSTEMS IN IMPROVING THE PHYSICIAN EXPERIENCE

Overview

The AMA has long supported hospitals and hospital system leadership in measuring the physician experience (i.e., burnout, satisfaction, stress, etc.) and in providing evidence-informed tools and resources to support health systems in comprehensively addressing the physician experience, including physician burnout. Addressing this issue is centered in the AMA's "You Are Why We Fight" campaign and there has been broad investment from the AMA in continuing to support health systems' work to improve the physician experience. The AMA has researched and developed metrics for measuring physician workload, burnout, and experience within their

organizations. Notably, the AMA has worked with hundreds of health systems in providing organizational well-being assessments, evidence-informed resources, a comprehensive roadmap for change, and grants for ongoing research. AMA leaders have been publicly vocal in encouraging health systems to invest in their physician workforce, regularly measure physician burnout, and systemically address issues arising from regular measurement. Outlined below are several programs and initiatives that AMA has continued to undertake in support of health systems improving the physician experience.

The AMA Organizational Biopsy®

The Organizational Biopsy® is an assessment tool and a set of services to support organizations in holistically measuring and taking action to improve the health of their organization. The Organizational Biopsy provides a comprehensive assessment for health systems across four domains: organizational culture (leadership, teamwork, trust, etc.), practice efficiency (team structure, team stability, workflows, etc.), self-care (post-traumatic stress, post-traumatic growth, work-life balance, etc.), and retention (work intentions).[28] The survey is distributed to physicians and other clinicians within the organization and the data is collected by the AMA for analysis.

Following an assessment, organizations receive an executive summary of their key findings and access to the Organizational Biopsy data through an online reporting platform. This platform also includes national comparison data. Following the assessment, the AMA can provide ongoing guidance and communication on interventions, research, and convening opportunities in support of their ongoing improvement efforts. The Organizational Biopsy includes the validated Mini-Z burnout assessment.[29] There is also a separate tool that can be used by residency and fellowship programs to measure and address the trainee experience.[30]

Since 2018, the AMA has collaborated with more than 300 health systems in collecting and sharing organizational well-being assessment results and advising on solutions. A yearly national comparison report is also shared with participating health systems to see how they compare against other institutions. The majority of health systems that the AMA collaborates with complete measurement on an annual basis. The AMA encourages organizations to share their survey results internally with their physicians to allow for greater collaboration, strengthen the physician-organization relationship, support collaborative dialogue about the current state of organization well-being, and identify future solutions and realistic accountability for improvement.

The Joy in Medicine™ Health System Recognition Program

Launched in 2019, the Joy in Medicine Health System Recognition Program (otherwise known as the Recognition Program) incentivizes health systems to improve the physician experience by providing public national recognition for organizations that have met a set of evidence-informed criteria centered on addressing the primary system drivers of physician burnout and organizational well-being.[31]

The Recognition Program provides a comprehensive roadmap to guide organizations through the existing research and interventions to improve organizational well-being—and thus, the physician experience. Measurement of various outcomes and processes are foundational to the program, as AMA asserts that these data can and should be used to understand unique organizational drivers of physician burnout within an organization and to help focus system-specific solutions. Measures included in the Recognition Program criteria include: burnout (using a validated tool), intentions to leave or reduce work effort (via survey), teamwork assessments (via surveys), leadership skills assessments and their impact on direct team members (via surveys), and electronic health record

audit log data to help illuminate the day-to-day experience of physicians and identify workload/workflow improvements. The Recognition Program includes required criteria for health systems to share these data internally with their physicians as well as their executive leadership teams for shared decision making and increased accountability.[32]

Organizational recognition is valid for two years. Since 2019, AMA has recognized more than 100 organizations for their efforts and this body of work continues to gain a national spotlight in the efforts to improve physician well-being.[33] Health system leaders have publicly noted the impact the Recognition Program has had on their efforts to improve conditions for their workforce and in providing them with a critical framework for addressing a complex issue.[34–37]

AMA STEPS Forward®

The program provides free access to a variety of resources to support health systems in implementing interventions. The AMA STEPS Forward program offers a collection of engaging and interactive educational toolkits, playbooks, podcast episodes, and success stories that are practical, actionable guides to transform and improve your practice. They address common practice challenges and offer solutions that aim to save two to three hours a day, reduce physician burnout and improve well-being, optimize team-based workflows, and enhance patient experiences.[38]

Each module provides practical steps to implementation, as well as real-world "success stories", downloadable tools and additional resources.[38] Clinicians, care team members, administrators, and organizational leaders can use these modules to help improve practice efficiency and ultimately enhance patient care, physician satisfaction, and practice sustainability.

Other Activities

The AMA also organizes conferences and provides interactive, hands-on learning opportunities for physicians and members of their care teams including boot camps, coaching, and learning collaboratives.

Alongside the Canadian Medical Association and British Medical Association, the AMA co-sponsors the International Conference on Physician Health™ (ICPH). ICPH is a biennial conference that promotes a healthier culture for physicians through evidence-based solutions, practice skills, and other resources. The theme of this year's conference is "improving well-being through the power of connections".[39] The American Conference on Physician Health (ACPH) is co-sponsored by the AMA, Stanford Medicine, and Mayo Clinic, and is held biennially. ACPH is designed to promote scientific research, discourse about health system infrastructure, and actionable steps that organizations can implement to improve physician well-being.[40]

Another of the offerings provided by the AMA are in-person boot camps wherein the AMA STEPS Forward Innovation Academy convenes attendees over the course of multiple days to equip them with tools and strategies to reform their organization and improve professional satisfaction. Topics discussed in past boot camps include EHR inbox optimization, team-based care practice fundamentals, and reducing barriers to taking paid time off.[41] Additionally, AMA physician faculty provide one to one coaching sessions to health system well-being leaders. These coaching sessions include direct feedback related to establishing strategic well-being initiatives and using data to guide a comprehensive approach to address institutional well-being needs.

Further, the AMA has learning collaboratives planned for this fall designed to transform care delivery. These collaboratives will leverage peer-to-peer learning, group discussions, and the

sharing of results, as well as facilitate connections between health system leaders. Collaborative participants will receive support from physician facilitators and evidence-based resources such as content and education, in addition to benefiting from extra assistance and mentorship during "office hours".

STATEMENTS

AMA President, Dr. Jesse Ehrenfeld released a leadership viewpoint to spotlight the AMA's Joy in Medicine Health System Recognition Program and to encourage health systems and health system leadership to thoroughly examine their support for physician well-being and implement improvements that promote wellness across the entire workforce while strengthening the patient-physician relationship.[42]

Dr. Ehrenfeld also provided remarks at the National Press Club about the physician shortage, where he reaffirmed AMA's commitment to addressing physician burnout and turnover through both advocacy efforts—such as combatting prior authorization—and support for health systems directly through the Joy in Medicine Health System Recognition Program.[43]

CONCLUSION

Although several efforts are currently in place that publicly report hospital performance metrics, these metrics generally do not adequately capture the physician experience. Additionally, insufficient research exists to support that such metrics impact physicians' selection of a particular hospital or hospital system for employment or partnership. The AMA has made substantial efforts to address and improve physician burnout, professional satisfaction, and workforce turnover. Such efforts have included the adoption of a variety of policies, advocacy, partnerships with professional organizations, development and dissemination of tools, educational resources, and hands-on support for health systems to regularly assess the state of their physician workforce. The AMA actively champions and provides resources for the collection of measures related to the physician experience (e.g., burnout, retention, and satisfaction) by health systems to support the development of data-driven solutions. In addition, the Joy in Medicine Health System Recognition Program publicly recognizes organizations taking actionable steps along six domains to improve the work environment for their physicians.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 715-A-23 and the remainder of the report be filed.

1. That our AMA research useful metrics that hospitals and hospital systems can use to improve physicians' experience, engagement, and work environment.

Fiscal Note: Minimal

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REPORT 1 OF THE COUNCIL ON MEDICAL SERVICE (I-24)
Nonprofit Hospital Charity Care Policies
(Resolution 802-I-23)
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2023 Interim Meeting, the House of Delegates referred Resolution 802, which asked the American Medical Association to "advocate for legislation and regulation that requires nonprofit hospitals to notify and screen all patients for financial assistance according to their own eligibility criteria prior to billing, support efforts to establish regulatory standards for nonprofit hospital financial assistance eligibility, and encourage the Centers for Medicare & Medicaid Services to publish the charity-care-to-expense ratio and the charity-care-to-benefit ratio for hospitals listed in Medicare Cost Reports to improve transparency and compliance of charitable care and community benefit activities."

Medical debt is the leading cause of bankruptcy in the United States and can result in those with debt being more likely to skip or delay needed medical care or cut back on basic household expenses. Approximately 100 million individuals have debt related to unpaid medical bills in the United States, totaling between $195-220 billion. Nonprofit hospitals account for 58 percent of community hospitals in the United States. Tax-exempt nonprofit hospitals operate as Section 501(c)(3) organizations, which must be organized and operated exclusively for tax-exempt purposes. As a condition of tax-exempt status, hospitals must administer "charity care" according to broad parameters of federal government regulation, which results in differing terms of eligibility, application procedures, and programs or services. While a patient may be eligible for aid at one hospital, they may not at another hospital across town. In addition, gaps in federal regulation and weak oversight may allow hospitals to provide low levels of charity care.

Hospitals have broad flexibility to establish their own eligibility criteria for charity care, and as a result, criteria vary across hospitals. Aid at some hospitals is limited to patients whose income is below the federal poverty level (FPL), while at others, patients with incomes that are five or six times the FPL can receive assistance. In addition, some nonprofit hospitals may be billing patients with incomes low enough to qualify for charity care. There is also an issue related to the lack of a definition for a community benefit standard and the inability of the Internal Revenue Service to enforce guidelines for nonprofit hospitals to retain their 501(c)(3) status as tax exempt. Charity-care-to-expense ratios may belie the community impact of hospitals because not all spending that hospitals claim as community benefits are meaningful for community health. Beyond this, state regulations vary in terms of eligibility, the minimum level of assistance that must be provided, and the level of transparency required.

The Council on Medical Service recommends new policy for the development of publicly accessible minimum standards for nonprofit hospital financial assistance eligibility programs, required screening of patients for charity care eligibility prior to billing, and standardizing the definition of what is considered a "community benefit" when evaluating community health improvement activities. Additionally, the Council recommends new policy for expansion of governmental oversight of nonprofit hospitals and enforcement of federal and/or state guidelines and standards for community benefit requirements including the ability to enact penalties and/or loss of tax-exempt status.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-I-24

Subject: Nonprofit Hospital Charity Care Policies (Resolution 802-I-23)

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee J

At the 2023 Interim Meeting, the House of Delegates referred Resolution 802. Introduced by the Medical Student Section, the resolution asked the American Medical Association (AMA) to "advocate for legislation and regulation that requires nonprofit hospitals to notify and screen all patients for financial assistance according to their own eligibility criteria prior to billing, support efforts to establish regulatory standards for nonprofit hospital financial assistance eligibility, and encourage the Centers for Medicare & Medicaid Services (CMS) to publish the charity-care-to-expense ratio and the charity-care-to-benefit ratio for hospitals listed in Medicare Cost Reports to improve transparency and compliance of charitable care and community benefit activities."

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 hospital, physician, 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). 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 hospital or physician, 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.[3] 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.[4]

Nonprofit hospitals account for 58 percent of community hospitals in the United States.[5] These hospitals can be exempt from federal, state, and local taxes if they qualify as 501(c)(3) organizations as defined by the Internal Revenue Service (IRS). Seven of the ten most profitable hospitals in the United States are classified as nonprofit.[6]

The IRS defines "charity care" or "financial assistance" as "free or discounted health services provided to persons who meet the organization's eligibility criteria for financial assistance and are unable to pay for all or a portion of these services."[7] Nonprofit hospitals must provide charity care as a condition of their tax-exempt status. The estimated value of tax exemption for nonprofit hospitals has increased from $19 billion in 2011 to $28 billion in 2020.[8] A study by Letchuman, Sunjay, et. al. published in *Health Affairs* (2022) estimated that the exemption from federal, state, and local taxes amounts to roughly $25 billion annually for nonprofit hospitals across the country.[9] Similarly, in 2020, KFF found that the total estimated value of tax exemption for nonprofit hospitals was approximately $28 billion, which divided into $14.4

billion from exempted federal taxes and $13.7 billion from exempted state and local taxes. KFF further found that the $28 billion total estimated value of tax exemption exceeded the total estimated charity costs of $16 billion for these nonprofit hospitals. However, charity care is only a portion of the community benefits reported by nonprofit hospitals.[10]

Within the broad parameters set by government regulation, hospitals establish their own charity care policies, which vary in terms of eligibility criteria, application procedures, and the levels of charity care provided.[11] In 2020, charity care represented 1.4 percent or less of operating expenses at half of all hospitals, although the level of charity care varied significantly across different facilities.[12] One study showed that nonprofit hospitals allocated over 80 percent of their community benefit spending on charity care and payment shortfall from Medicaid, compared to just 12 percent on community health.[13] There could be several reasons for this variation. For example, strengthening the health care safety net by providing charity care is an important community need. It is easier for hospitals to continue investing in clinical programs rather than building infrastructure needed to address social determinants of health, or hospital accounting systems are designed to better track clinical spending, making it difficult to measure the impact of community health initiatives.[14]

According to a recent report by the Lown Institute, approximately 80 percent of nonprofit hospitals give back less to their communities than they receive in tax breaks. For some hospitals, this means that the shortfall was hundreds of millions of dollars a year while they made hundreds of millions of dollars in net income. The 10 hospitals with the largest fair share deficits also reported at least 100 million dollars in net income in 2021, according to the report.[15] The American Hospital Association contested these findings, stating that the Lown Institute's accounting was not done fairly and selectively relies on isolated data to paint a negative picture of nonprofit hospitals and the hospital industry more generally. Specifically, the Lown Institute report does not account for Medicaid shortfall or money spent on medical research. The Lown Institute defended its findings by stating that shortfalls in government reimbursement are different from direct community benefits and hospitals typically receive private or public funds for medical research.[16]

INTERNAL REVENUE SERVICE (IRS) REQUIREMENTS FOR NONPROFIT HOSPITAL CHARITY CARE

Tax-exempt nonprofit hospitals operate as Section 501(c)(3) organizations, which by definition must be organized and operated exclusively for specific tax-exempt purposes and must have the following characteristics: 1) no part of their net earnings is allowed to benefit any private shareholder or individual; 2) no substantial part of their activities can consist of carrying on propaganda or otherwise attempting to influence legislation; and 3) the organization should not participate in or intervene in any political campaign on behalf of (or in opposition to) any candidate for public office.[17]

Additional requirements were added following the passage of the Affordable Care Act (ACA) and are codified in Section 501(r) of the Internal Revenue Code. To retain 501(c)(3) tax-exempt status, nonprofit hospitals must:

- Establish a financial assistance policy (FAP) that describes who is eligible for charity care, the level of assistance provided, and how patients can apply. The FAP must be easily accessible to patients and translated into the languages commonly spoken in the community served by the hospital.
- Cap charges to patients eligible for charity care based on fee-for-service Medicare rates, Medicaid rates, and/or commercial plan payment rates.
- Conduct a community health needs assessment every three years and adopt an implementation strategy to address those needs. Community health needs could include lowering financial barriers to health care or improving social determinants of health.

- Make reasonable efforts to determine if a patient is eligible for charity care before engaging in certain debt collection practices, including selling the patient's debt to third parties, reporting the debt to credit agencies, and taking legal action to control a patient's financial assets.

A hospital has made reasonable efforts under the following conditions:

- The hospital facility notifies the individual about the FAP before initiating any extraordinary collection actions (ECA) to obtain payment for the care and refrains from initiating such ECAs for at least 120 days from the date the hospital facility provides the first post-discharge billing statement for the care.
- In the case of an individual who submits an incomplete FAP application during the 240-day application period, the hospital facility notifies the individual about how to complete the FAP application and gives the individual a reasonable opportunity to do so.
- In the case of an individual who submits a complete FAP application during the 240-day application period, the hospital facility determines whether the individual is FAP-eligible for the care.
- Extension of the application period beyond 240 days to account for a 30-day notification window before initiating one or more ECAs to obtain payment for the care.[18]

Furthermore, to qualify as a 501(c)(3) tax-exempt organization, a nonprofit hospital must demonstrate that it provided benefits to a class of persons that is broad enough to benefit the community and operate to serve a public rather than a private interest. A community benefit for a nonprofit hospital is defined by Revenue Ruling 69-545 as follows: 1) operating an emergency room open to all regardless of ability to pay; 2) maintaining a board of directors drawn from the community; 3) maintaining an open medical staff policy; 4) providing hospital care for all patients able to pay, including those who pay their bills through public programs such as Medicaid and Medicare; 5) using surplus funds to improve facilities, equipment, and patient care; and 6) using surplus funds to advance medical training, education, and research.[19]

Circumstances brought forth by gaps in federal regulation and weak oversight and enforcement may allow hospitals to provide low levels of charity care. Federal regulations do not currently define or set minimum standards for hospitals to determine who is eligible for charity care or the level of assistance that must be provided.[20,21] The IRS requires a tax-exempt hospital to file Schedule H with its Form 990 annually to provide the public with information on its policies and activities and the community benefits that its facilities provide. IRS Schedule H categorizes community benefit spending as charity care, unreimbursed costs for providing services to patients insured by government programs (Medicare and Medicaid), subsidized health service, community health improvement services and community-benefit operations, research, health-professions education, and financial and in-kind contributions to community groups.[22]

According to the Government Accountability Office (GAO), the IRS does not have the authority to define specific types of services and activities that a hospital must undertake to qualify for a tax exemption. Instead, the IRS provides guidance on the types of activities that can demonstrate community benefits. The IRS allows hospitals to report spending on several categories under the community benefit umbrella on Form 990 Schedule H. One category is financial assistance that hospitals provide for eligible patients to help them pay for care. Other categories include programs to improve community health like free clinics in underserved neighborhoods, free screenings or health literacy events, donations to local groups, investments in affordable housing, amongst other things. In addition to these community-based activities, nonprofit hospitals can also report hospital-based activities as community benefits, such as the expense to train health professionals and costs for hospital-based medical research. This can lead to crossover in reporting, which could lead to hospitals receiving credit for these activities in multiple ways. For example, teaching hospitals do not subtract the indirect medical education payments they receive from Medicare from community benefit reporting, thus inflating the amount of community benefit reported. In

addition, hospitals can report the cost of federally funded research as a community benefit even if the hospital did not put any of its own money into the work.[23]

Form 990 Schedule H solicits information inconsistently, resulting in a lack of clarity about the community benefits hospitals provide. As defined on Form 990 Schedule H, the term "community health improvement" is an "activity or program, subsidized by the health care organization, conducted, or supported for the express purpose of improving community health. Such services do not generate inpatient or outpatient revenue, although there may be a nominal patient fee or sliding scale fee for these services." Part II of Schedule H permits hospitals to report expenditures for certain "community building" activities, which encompass physical improvements and housing, economic development, community support, environmental improvements, leadership development and training for community members, coalition building, community health improvement advocacy, workforce development, and other activities.

For some factors, the IRS explicitly directs tax-exempt hospitals to report the extent to which they have addressed them. For the other factors, the IRS provides a space for hospitals to qualitatively describe the community benefits they provide. In the GAO's analysis of hospitals' Form 990 Schedule H filings for tax years 2015 through 2018, it found inconsistencies in what hospitals reported in the narrative description. Therefore, reporting results in inconsistent information on many of the community benefit factors. GAO recommended that the IRS update Form 990 to ensure that the information demonstrating the community benefits a hospital is providing is clear and easily understood by Congress and the public. The IRS made minor adjustments to the form, but still allows hospitals to narratively describe the community benefits they provide which continues to lead to inconsistency among different hospitals and lacks clarity.[24,25]

PATIENT ELIGIBILITY FOR CHARITY CARE

Hospitals have broad flexibility to establish their own eligibility criteria for charity care, and as a result, criteria vary across hospitals. Aid at some hospitals is limited to patients below the federal poverty level (FPL), while at other hospitals, patients with incomes that are five to six times the FPL can receive assistance. One analysis of a large sample of nonprofit hospitals that used FPL to determine eligibility for free care in 2018 found that about 32 percent of the hospitals required patients to have incomes at or below 200 percent FPL or they imposed more restrictive eligibility criteria, while the remaining hospitals (68 percent) relied on higher income caps. For discounted care, about 62 percent of nonprofit hospitals in the study limited eligibility to patients with incomes at or below 400 percent FPL or used lower income levels, with the remaining 38 percent of nonprofit hospitals relying on higher income caps. Hospitals may condition free or discounted care on other criteria in addition to or in lieu of income thresholds based on FPL, such as by requiring that patients have limited assets or reside in the hospital service area or by extending eligibility to patients who are unable to afford large medical bills despite exceeding income or asset thresholds under standard eligibility pathways.[26]

A 2019 *Kaiser Health News* analysis of tax filings found that one half of nonprofit medical systems were billing patients with incomes low enough to qualify for charity care. Eligible patients may not receive charity care because they are unaware that charity care is available, do not know they are eligible, have difficulty finding or completing the application, are improperly denied charity care by the hospital, or choose not to apply. Applying for aid can be complicated for patients, requiring considerable personal financial information and documentation. For example, nonprofit hospitals have estimated that, of the unmanageable debt they reported in 2019, about $2.7 billion came from patients who were eligible for charity care but did not receive it.

COMMUNITY BENEFITS AND CHARITY-CARE-TO-EXPENSE RATIOS

The lack of definition for a community benefit standard and the inability of the IRS to enforce guidelines for nonprofit hospitals to remain 501(c)(3) organizations, and keep their tax-exempt status, complicates this issue further. A 2020 GAO report noted that the IRS had not revoked a hospital's nonprofit status based on providing inadequate community benefits over the prior 10 years. A study by Bai, Ge, et al. published in Health Affairs (2021) found that in aggregate, nonprofit hospitals spent $2.30 of every $100 in total expenses on charity care, which was less than government ($4.10) and for-profit ($3.80) hospitals.[27] For-profit hospitals devote a similar or greater share of operating expenses to charity care than nonprofit. For-profit hospitals may have a greater willingness to provide charity care in some scenarios because they can take a tax deduction for these expenses, and it is possible that some nonprofit hospitals may not expect significant oversight of their charity care practices from government regulators.[28] The discrepancy suggests that many nonprofit hospital charity care provisions are not aligned with their favorable tax treatment. Because IRS guidelines established by the ACA require nonprofit hospitals to provide charity care to eligible patients based on their self-determined criteria, there are no standard qualifications utilized to identify patients eligible for charity care. This lack of standardization is confounded by hospitals' differing definitions of charity. For example, one hospital may include Medicaid shortfall and have a much higher ratio spent on charity care than another hospital, which has a lower ratio but spends more directly on charity care. Due to this inconsistency, charity-care-to-expense ratios may not be reliable forms of comparison between hospitals.

Charity-care-to-expense ratios may also belie the community impact of hospitals, as not all spending that hospitals can claim as community benefits are meaningful for community health. The broad definition of what qualifies as a community benefit allows hospitals to include spending on items that do not directly address community health needs. For example, the largest share of community benefit spending by many nonprofit hospitals is for Medicaid shortfall. Medicaid shortfall is the difference between what Medicaid pays for the care hospitals provide and the actual costs the hospital reports.[29] Some hospitals already make up for the shortfall by charging private insurers higher rates or by receiving disproportionate share hospital (DSH) payments, which are given to hospitals that serve a large population of uninsured or Medicaid patients.[30]

STATE REPORTING REQUIREMENTS AND OUTCOMES

State regulations vary in terms of eligibility criteria and the minimum level of assistance that must be available. State policies aimed at increasing hospital charity care provisions have either used a transparency approach or a minimum requirements approach. The transparency approach mandates hospitals' disclosure or reporting of their charity care policies, implementation plans, or expenses. Examples of states using this approach include California and New York. The minimum requirements approach requires hospitals to provide a minimum charity care amount, such as Illinois and Texas, or provide charity care to patients with incomes below a certain designated threshold, such as Washington and Oregon.[31]

Several states have implemented regulations intended to increase the uptake of charity care among eligible patients and to protect potentially eligible patients from certain debt collection practices. Thirteen states require hospitals to screen patients for eligibility, 16 states require hospitals to notify patients they may be eligible for charity care prior to collecting payment or in every notification about collections, and eight states regulate procedures for patients to appeal denials of charity care.[32]

A recent study by Zare, et al. examined the association between state reporting requirements and community benefit spending by nonprofit hospitals. Nonprofit hospitals in states that required reporting spent a higher percentage of total hospital expenditures on community benefits compared to states without

these requirements. A similar association between the percentage of charity care and total hospital expenditures was found.[33]

Studies have shown that some nonprofit hospitals spend only a small portion of their community benefit spending on services that help the community and a much greater percentage on services that benefit the hospital. A study conducted in 2018 by Singh et al. found that when states adopted multiple community benefit and charity care regulations, hospital community benefit spending increased. Other studies have found a positive association between state regulations on free and discounted care, the amount of charity care, and resource allocation decisions.[34]

Twenty-eight states have passed legislation requiring nonprofit hospitals to report data on community benefits and charity care. Nonprofit hospitals in states with reporting requirements spent on average 9.1 percent of total hospital expenditures on 17 distinct types of community benefits, which was an average of $32.9 million. Hospitals in states without reporting requirements spent approximately 7.7 percent of their total hospital expenditures on community benefits, which was an average of $17.8 million. After excluding Medicaid shortfall, hospital spending reduced to 5.5 percent ($20.7 million) in states with reporting requirements and 4.3 percent ($9.7 million) in states without reporting requirements. Charity care provision averaged 2.3 percent of total hospital expense ($6.7 million) in states with requirements and 1.5 percent ($3.6 million) in states without requirements. The top four community benefits reported across all types of states were Medicaid shortfall, charity care, education, and non-means-tested health services such as qualifying inpatient programs (e.g., neonatal intensive care and inpatient psychiatric units) and outpatient programs (home health programs). Nonprofit hospitals in states with reporting requirements spent 36.6 percent on Medicaid shortfall, 20 percent on charity care, 16.8 percent on education, and 8.9 percent on non-means-tested health services. Nonprofit hospitals in states without community benefit requirements spent a higher percentage on Medicaid shortfall (44.8 percent) and charity care (22.8 percent), and a lower percentage on education (11.8 percent), and non-means-tested health services (9.8 percent).[35]

Most recently, CMS approved a North Carolina plan that will award additional Medicaid funds to the state in exchange for forgiving the medical debt of two million people, potentially alleviating four billion dollars in medical debt.[36] It will cover Medicaid recipients and individuals not enrolled in Medicaid with incomes at or below at least 350 percent of the FPL ($109,200 for a family of four), or for whom total debt exceeds five percent of annual income. Hospitals receiving the extra funds will have to agree to discount medical bills on a sliding scale for patients with incomes at or below 300 percent of the FPL, or $93,600, and automatically enroll people into financial assistance (i.e., charity care). Finally, for individuals whose income is at or below 350 percent of the FPL, hospitals must agree to not sell their medical debt to debt collectors.[37]

AMA POLICY

Policy H-155.958 states that the AMA encourages hospitals to adopt, implement, monitor, and publicize policies on patient discounts, charity care, and fair billing and collection practices, and make access to those programs readily available to eligible patients.

Policy H-160.923 states that the AMA: (1) supports the transitional redistribution of 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.

DISCUSSION

Nonprofit hospitals make up most hospitals in the United States and are exempt from federal, state, and local taxes as qualified 501(c)(3) organizations. This determination results in billions of dollars of tax savings annually for these hospitals. As a condition of their tax-exempt status, nonprofit hospitals must provide charity care. Nonprofit hospitals establish their own charity care guidelines within broad parameters of government regulation, resulting in many hospitals having different terms of eligibility, application procedures, and programs or services. A patient may qualify for aid at one hospital, but not at a hospital across town. Often, the application process is not clear and requires patients to complete onerous paperwork and submit personal financial records, discouraging patients from completing financial aid applications. In some cases, patients are not screened by their hospital or physician's office prior to being billed for a service. Therefore, patients who may be eligible for financial assistance may end up getting billed for services they are unable to pay. As a result, patients may accrue medical debt that is sent to collections, beginning a waterfall of associated consequences. In addition, if hospitals were more transparent about their charity care policies, patients would be able to make more informed health care decisions based on charity care coverage.

Some hospitals have routinely engaged in suing their patients over unpaid bills. For instance, the University of Virginia Health System sued more than 36,000 patients over medical debt. It halted the practice after exposure by the media caused public outrage and, in 2021, announced it would cancel all ongoing lawsuits against households with incomes below 400 percent of the FPL.[38] Even amidst the public health crisis related to COVID-19, hospitals continued to sue over debt.[39] A Yale study found that nonprofit hospitals were more likely to sue for medical bills than for-profit hospitals, with the top 10 percent of hospitals filing more than 40 percent of all lawsuits from 2014-2018.[40]

The IRS may not have the authority to define specific types of services a hospital must provide to retain their tax-exempt status, but it could increase enforcement on nonprofit hospitals that provide little to no community benefits. According to the GAO, the IRS has not revoked a hospital's tax-exempt status for failing to provide adequate charity care since 2010. Given that there are no federal regulations defining minimum standards for benefits offered, there is considerable leeway available for nonprofit hospitals and the level of charity care they provide to retain their tax-exempt status. Therefore, increased IRS enforcement would more effectively compel hospitals to abide by charity care regulations by applying more force. In addition, a standardized definition of charity care would aid in providing clear guidelines by which nonprofit hospitals must abide by.

While charity-care-to-expense ratios can be reported based on the amount spent on charity care by nonprofit, for-profit, and government hospitals, those comparisons are limited, as there are many factors that go into determining how much each type of hospital spends on charity care and what qualifies as charity care in the area where the hospital is located. For these measurements to be useful, common definitions and federal regulations would need to be established, which seems unlikely, given the lack of oversight and enforcement by the IRS.

Some states require minimum levels of charity care and other states require nonprofit hospitals to report data on the charity care they provide. Studies have shown that when states adopted regulations to track nonprofit charity care, hospital spending on community benefits increased. More than half of states require all, or a subset of all hospitals, to extend eligibility to certain groups of people. Among those states, 11 broadly extend minimum standards to for-profit, nonprofit, and government hospitals.[41] In addition, 19 states and the District of Columbia fill the gaps in federal law by setting standards for the provision of financial assistance. Some states require hospitals to provide an unspecified amount of financial assistance to people with incomes under a specific threshold (e.g., under 100 percent FPL in Florida; under 400 percent FPL in California), while others require hospitals to provide free care for

people with incomes below certain thresholds (e.g., under 150 percent FPL in Maine; under 250 percent FPL in Vermont).[42] In July 2024, CMS approved a North Carolina plan that will give additional Medicaid funds to hospitals in exchange for forgiving the medical debt of two million people. The plan will alleviate almost four billion dollars in existing medical debt dating back to 2014 and will cover Medicaid enrolled recipients and those not enrolled in Medicaid with incomes at or below at least 350 percent of FPL, or for whom total debt exceeds five percent of total income.[43] A sliding scale has also been agreed upon to discount medical bills for patients at or below 300 percent of FPL.[44]

Certain states have passed laws to institute stricter requirements for screening and to remove barriers related to the application process. Maryland, for example, began requiring hospitals to consider patients already enrolled in financial assistance programs as "presumptively eligible," which means automatic eligibility without applying.[45] Illinois, in addition, has had a similar requirement since 2014 and North Carolina, as part of its 2024 plan, automatically enrolls patients in financial assistance.[46] Beyond this, five states require hospitals to use a state-developed uniform application form to make it easier for community-based organizations to assist patients.[47]

There are several shortcomings with enforcement and regulation of nonprofit community hospitals, including lack of patient screening prior to billing and lack of enforcement and regulation by the IRS. The Council recommends that the AMA support efforts to increase patient screening prior to billing and prior to sending past due bills to collections, in addition to supporting expansion and oversight by the IRS. Additionally, the Council recommends reaffirming Policy H-155.958 which states that the AMA will encourage hospitals to adopt, publicize, and implement policies on charity care and other fair billing and collection processes.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 802-I-23, and the remainder of the report be filed:

1) That our American Medical Association (AMA) support that all nonprofit hospitals be required to screen patients for charity care eligibility and other financial assistance program eligibility prior to billing. (New HOD Policy)

2) That our AMA support efforts to encourage debt collectors to ensure a patient has been screened for financial assistance eligibility before pursuing that patient for outstanding debt, provide an appeals process for those patients not screened previously or deemed ineligible, and require the hospital to reassume the debt account if an appeal is successful. (New HOD Policy)

3) That our AMA support development of minimum standards for nonprofit hospital financial assistance eligibility programs which are publicly accessible. (New HOD Policy)

4) That our AMA support a standardized definition of what is considered a "community benefit" when evaluating community health improvement activities. (New HOD Policy)

5) That our AMA support the development of a transparent, publicly available, standardized data set on community benefit including consideration of charity care-to-expense ratios. (New HOD Policy)

6) That our AMA support expansion of governmental oversight of nonprofit hospitals and enforcement of federal and/or state guidelines and standards for community benefit requirements including the ability to enact penalties and/or loss of tax-exempt status. (New HOD Policy)

7) That our AMA reaffirm existing Policy H-155.958, which states that the AMA will encourage hospitals to adopt, implement, monitor, and publicize policies on patient discounts, charity care, and fair billing and collection practices and make access to those programs readily available to eligible patients. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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Council on Medical Service Report 1-I-24
Nonprofit Hospital Charity Care Policies
Policy Appendix

Appropriate Hospital Charges H-155.958
Our AMA encourages hospitals to adopt, implement, monitor and publicize policies on patient discounts, charity care, and fair billing and collection practices, and make access to those programs readily available to eligible patients.
(CMS Rep. 4, A-09; Reaffirmed in lieu of: Res. 213, I-17)

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)

REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (I-24)
Unified Financing Health Care System
(Resolution 818-I-23, Second Resolve)
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2023 Interim Meeting, the House of Delegates referred the second resolve clause of Resolution 818, which asked the American Medical Association (AMA) to support a national unified financing health care system that meets the principles of choice, freedom and sustainability of practice, and universal access to quality care for patients. Because there has been no serious movement toward unified financing at the federal level in the United States (U.S.), this report describes efforts in California to pursue a unified financing system; outlines the model's potential benefits and challenges; summarizes AMA policy on health system reform policy and the AMA's plan to cover the uninsured; and presents policy recommendations. For the purposes of this report, unified financing is defined as a health care delivery system that pools funding sources to pay for universal coverage of a standard benefits package that is made available to everyone, regardless of age, employment status, and income. A potential role for health plans or other intermediaries distinguishes unified financing from single payer systems, which are a type of unified financing.

Discussions of unified financing at the state level are still in the early stages in this country, with California taking the lead and exploring the pursuit of federal waivers that would permit the state to pool and redistribute federal Medicaid, Medicare, and Affordable Care Act (ACA) funds under a unified financing system. Among its benefits, unified financing has the potential to reduce health system fragmentation, improve health equity, and eliminate insurance churn. However, the Council on Medical Service is strongly concerned that, under this model, patients and physicians would have less choice and physician payments would be reduced. The report cautions that payment cuts under unified financing could negatively impact physician supply and patient access to care, especially given ongoing threats to practice sustainability stemming from Medicare and Medicaid payment inadequacies.

Moreover, many uncertainties about the model's design remain, including how such a system would be funded and what new taxes might be needed; the mechanisms through which and the levels at which physicians and hospitals would be paid; and the role (if any) of private health plans. Without such details and lacking sufficient analyses in the literature on the impact of unified financing on physicians and patients in the U.S., the Council believes it would be premature to comment on the model's advisability. Instead, this report recommends that our AMA continue to monitor federal and state health reform proposals, including the development of state plans and/or waiver applications seeking program approval for unified financing.

Additionally, two policies are recommended for reaffirmation: Policy D-165.942, which advocates that state governments be given the freedom to develop and test different models for covering the uninsured, provided certain standards are met; and Policy H-165.838, which upholds the AMA's commitment to achieving health system reforms that include health insurance for all Americans, expand choice of affordable coverage, assure that health care decisions remain in the hands of patients and their physicians, and are consistent with pluralism, freedom of choice, freedom of practice, and universal access.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-I-24

Subject: Unified Financing Health Care System (Resolution 818-I-23, Second Resolve)

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee J

At the 2023 Interim Meeting, the House of Delegates (HOD) referred the second resolve clause of Resolution 818 and asked the American Medical Association (AMA) to "support a national unified financing health care system that meets the principles of choice, freedom and sustainability of practice, and universal access to quality care for patients." The Board of Trustees assigned this item to the Council on Medical Service for a report back to the HOD at the 2024 Interim Meeting. Relatedly, the HOD voted to not adopt the first resolve clause of Resolution 818-I-23, which would have directed our AMA to remove opposition to single payer health care delivery systems from its policy, and instead evaluate all health care system reform proposals based on our stated principles as in AMA policy.

BACKGROUND

Resolution 818-I-23 defines unified financing as "any system of health care financing that provides uniform and universal access to health care coverage that is high quality and affordable, which can include single payer or multi-payer systems based on managed competition between private insurers and does not necessarily mean government run." Supplemental information provided by the sponsors describes unified financing as a system where all health care financing is managed, to varying levels, through a single integrated mechanism with the aim of streamlining health care funding, reducing fragmentation, enhancing efficiency, and improving access to health services. Analyses of health systems specifically labeled as unified financing models are scant in the health care literature aside from a handful of papers on Brazil's health system and a treatise exploring state-level transformational health reform by the Healthy California for All Commission. This Commission was established by a 2019 state law and charged with developing a plan for achieving a unified financing system in California that could include, among other options, a single payer system. The Commission's deliverable, Key Design Considerations for a Unified Health Care Financing System in California, explains unified financing as a "statewide system to arrange, pay for, and assure health care in which all Californians will be entitled to receive a standard package of health care services; entitlement will not vary by age, employment status, disability status, income, immigration status, or other characteristics; and distinctions among Medicare, Medi-Cal, employer-sponsored insurance, and individual market coverage will be eliminated."[1] A *Health Affairs* paper authored by two California Commission members describes unified financing as a type of single payer system "that pools all sources of financing, public and private, into one source to finance a unified benefit package for everyone."[2] For the purposes of this report, the Council defines unified financing as a health care delivery system that pools funding sources to pay for universal coverage of a standard benefits package that is made available to everyone, regardless of age, employment status, and income. A potential role for health plans or other intermediaries

distinguishes unified financing from single payer systems, which are usually government-run; however, single payer is a type of unified financing. Unified financing also includes multi-payer systems in which a single fund coordinates contributions from various sources while maintaining a standardized approach to benefits and coverage. Interestingly, unified financing can co-exist with supplemental insurance markets or private markets that operate independently, just as substitutive or supplemental private health insurance is available in many countries with unified financing—including single payer—systems. In this country, there has been no serious movement toward unified financing at the federal level and consideration of Medicare-for-All-type proposals has largely stalled; accordingly, this report focuses primarily on California's efforts to implement unified financing reforms.

Because the path towards unified financing in California is still in its early stages, uncertainties about its potential design and implementation remain, including the mechanisms through which or the levels at which physicians, hospitals, and other providers would be paid for their services; the sources of funding that will finance the system; the role (if any) of private health plans; and methods for controlling health care spending, which would be integral to the model's sustainability. According to the Commission, "a threshold issue for California involves securing federal permissions to redirect and consolidate existing federal funding for Medicaid, Medicare, and Affordable Care Act (ACA) advance premium tax credits within a state unified financing system."[3] Furthermore, the reform's sustainability would largely depend on the ability of the state to maintain adequate funding levels and could potentially necessitate new or higher taxes.[4] In October 2023, the California state legislature enacted SB 770, which endorsed the Commission's recommendations for a unified financing system and directed the Secretary of the California Health and Human Services agency to "pursue waiver discussions with the federal government with the objective of a unified health care financing system that incorporates specified features and objectives, including, among others, a comprehensive package of medical, behavioral health, pharmaceutical, dental, and vision benefits, and the absence of cost sharing for essential services and treatments."[5] Updates regarding the need for specific waivers or a timeline for formal waiver applications had not been published at the time this report was written.

At the federal level, unified financing could be implemented through a Medicare-for-All approach, in which eligibility for Medicare is extended to all Americans in a single payer system that replaces employer-sponsored insurance, individual market coverage, and most existing public programs, including Medicaid and Children's Health Insurance Program (CHIP). The Medicare-for-All approach was addressed by the Council in Council Report 2-A-19 and in other reports supporting improvements to the ACA and policies targeting the remaining uninsured. Longstanding AMA policy opposing single-payer systems has been periodically considered by the HOD and was kept in place most recently just a year ago. As the Council has consistently noted, focusing AMA efforts on improving the ACA instead of abandoning it helps promote physician practice viability by maintaining a robust payer mix. Additional concerns about a Medicare-for-All approach include the enormous cost related to implementing such a system and how possible pay-fors would impact patients and physicians.

Some proponents of unified financing also maintain that the model could be implemented by merging employer-sponsored and individual insurance markets and harmonizing their subsidy systems. A Council report presented at the 2024 Annual Meeting addressed this issue and recommended incrementally lowering the ACA affordability firewall so that more workers who have access to employer-sponsored insurance would be eligible to purchase subsidized ACA plans. However, the HOD referred this report back to the Council for further study, in part because of concerns about its potential impact on payer mix and physician practice sustainability. An updated report will be presented by the Council at the 2025 Annual Meeting.

International Unified Financing Models

As noted in Key Design Considerations for a Unified Health Care Financing System in California, a range of unified financing approaches—including single payer systems and mixed models—have been used internationally to achieve universal coverage and access to a standardized set of health services. Under Canada's single payer system, there is no national standardized benefits package; instead, Canadian provinces and territories make most public coverage decisions and administer universal health insurance programs within their jurisdictions. As a result, coverage for services that are not federally mandated (e.g., outpatient prescription drugs and mental health, dental, and vision services) may vary across provinces and territories, most of which provide some level of prescription drug coverage for individuals lacking supplemental private coverage.[6] Two-thirds of Canadians have supplemental private insurance—paid for mostly by employers—that covers vision and dental care, outpatient prescription drugs, private hospital rooms, and other services not covered by the publicly-funded plan.[7]

In addition to Australia's public system, which is funded by general taxation and an income-based tax and covers most hospital and physician services at no cost, patients can purchase private health insurance that facilitates access—at a cost—to private hospitals and specialists and other services not covered by the public system.[8]

Brazil's health system, known as SUS (Sistema Único de Saúde), is decentralized such that the administration and delivery of care is managed at the municipal or state level. Under SUS, which is financed by taxes and contributions from federal, state, and municipal governments, all residents and visitors can access primary, specialty, mental health, and hospital services free of charge and without cost-sharing. Almost a quarter of the population also enrolls in private plans, some of which have their own health facilities, to circumvent delays in accessing care under SUS.[9]

The United Kingdom's (UK) health care system is more centralized; the government-administered National Health Service (NHS), which is funded by general taxation, provides mostly free health care to its residents. NHS owns public hospitals in the UK and pays the salaries of most physicians, nurses, and other care providers and, notably, NHS physicians report high levels of stress and burnout due to staffing shortages and dissatisfaction with pay.[10] As in other countries, more than 10 percent of people in the UK also have private health insurance policies that they either purchase or obtain through an employer. This private coverage provides quicker access to care, greater choice of specialists and hospitals, and amenities for elective hospital procedures but does not include general, emergency, maternity, or mental health care services which are provided by the NHS.[11]

Government plays a lesser role in Germany's universal multi-payer health system, where health insurance is mandatory and provided through either statutory health insurance—administered by competing nonprofit plans known as sickness funds—or substitutive private coverage that individuals can opt into if they make more than €69,300 per year. Health care is financed by mandatory contributions (from employers and workers) imposed as a percentage of wages, which are pooled into a central health fund and reallocated to the sickness funds. Individuals purchasing substitutive private coverage pay risk-adjusted premiums that are determined at the time of enrollment. Although government subsidies are not available to purchase substitutive insurance, these private plans remain attractive, especially to young people, because they may include a broader range of services and lower premiums.[12]

In the Netherlands, all residents must purchase statutory insurance from private health insurers and most people (84 percent) also purchase supplementary insurance that covers dental and vision care and other services not covered by the statutory plan. Statutory insurance is financed through a

combination of a nationally defined income tax, government grants for those under 18 years of age, and community-rated premiums set by each insurer. Such contributions are collected centrally and allocated to insurers according to a risk-based capitation formula. Because supplemental private insurance premiums are not regulated, plans can screen for risks. Interestingly, almost all individuals purchase voluntary supplemental coverage from the same insurer that provides their statutory health insurance.[13]

In its 2017 report on health care financing models around the world, the Council identified both advantages and disadvantages of each of the models studied. In that report, the Council found that the diversity of health care financing models represented different country-to-country priorities, societal beliefs, and acceptable trade-offs related to the level of coverage achieved by the financing model; individual tax burdens; and levels of government regulation, including of health care prices. The Council further found that some financing models were tied to increased government regulation of prices and budgets across the health system, which was perceived as undermining the free market principles long supported by the AMA, and that countries with such systems, including single payer models, tend to have higher rates of taxation and social insurance contributions.

The U.S. is unique among high-income countries in that it lacks a publicly financed system of universal health care. Instead, our pluralistic system incorporates multiple financing models that include a mix of public (e.g., Medicare, financed by federal taxes, a mandatory payroll tax, and individual premiums; and Medicaid and CHIP, jointly financed by federal and state tax revenues) and private (e.g. employment-based insurance, paid for by employers and employees; or plans purchased by individuals, often federally subsidized, on an ACA exchange) options. Although patients enrolled in publicly financed health systems like Medicaid may incur fewer cost-sharing expenses, they may also experience access challenges, lengthier wait times, and/or delayed or lack of access to costly innovative services and therapeutics. The private insurance system in this country reflects free market principles and embraces choice but may be more costly for some patients (and employers), thereby raising equity concerns.[14]

As stated in Council Report 2-A-17, approaches to paying physicians and other providers vary by country and are not wholly dependent on a country's health care financing model. Physicians can be salaried or be paid via fee-for-service or capitation, with fee schedules set by national, regional, or local health authorities, negotiated between national medical societies or trade unions and the government, or negotiated/set by sickness funds or health plans. Hospital financing can vary but generally depends on whether hospitals are public, private, nonprofit, or for-profit. Public hospitals may operate under a global budget determined by the responsible health authority, or receive a majority of their funding from national, regional, or local governments.

While the U.S. surpasses other countries when it comes to health spending, it underperforms on some metrics related to health outcomes. Americans tend to be greater consumers of medical technology and pharmaceuticals and often pay more for care in our market-based system. As noted in Council Report 2-A-17, although many governments across the world finance universal health care, there may be lengthy wait times to see physicians in some countries or an inability to access procedures or innovative therapies that can be obtained in the U.S.

Potential Benefits of Unified Financing

The California Commission's report, Key Design Considerations for a Unified Health Care Financing System in California, outlines many potential benefits of unified financing systems. The report notes that the existing fragmented financing system is administratively burdensome; lacks accountability for quality, costs, and equity; and can lead to coverage gaps for people experiencing job or life changes. According to the report, unified financing would allow the state to achieve notable health goals related to:

- Universality, since unified financing creates universal coverage;
- Improved equity, by eliminating differences in coverage between employer-sponsored insurance, Medicare, Medicaid, nongroup marketplace plans, and the uninsured;
- Affordability, since monthly premiums would no longer be paid, and long-term services and supports and dental services would be covered;
- Access, since uninsurance and underinsurance would be eliminated, and
- Quality, due to the new system being more uniform, which would facilitate quality improvements.[15]

Although it is possible to dispute the report's assertions that unified financing will improve health care quality and access (especially if physician and other provider payments are decreased), unified financing could streamline health care funding and lessen the fragmentation of the existing system, thereby potentially giving rise to a range of benefits, including increased equity and transparency as well as decreased administrative burdens related to the standardization of billing, prior authorization, and other insurance-related expenses, which could produce cost savings for physicians. Additional administrative costs, related to brokers, pharmacy benefit managers, and other middlemen, could also be reduced or eliminated under unified financing.[16] Reduced fragmentation should theoretically result in a system that is less administratively complex for patients to navigate, and if all physicians and hospitals are covered under unified financing, provider networks would be eliminated. Importantly, a unified financing health system would also eliminate insurance churn and reduce gaps in coverage that often occur when individuals, for a variety of reasons, switch coverage types (for example between Medicaid and ESI or ESI and ACA marketplace plans). In principle, universal coverage of standardized benefits should increase access to care, especially among people with lower incomes, and improved access may lead to improved health outcomes.[17]

In terms of design options, the Commission's report analyzed the costs of implementing unified financing under different scenarios that, for example, make direct payments to providers or use a health plan to do so; require zero cost-sharing or income-related cost-sharing; or include long term services and supports (LTSS) as it exists today or expanded LTSS services. According to the report, if federal and state funding streams remain consistent with current levels, and a payroll tax (or combination of other progressive taxes) is used to replace employer-sponsored insurance, a unified financing system would lower health care costs in year one and produce savings over time, primarily because the various scenarios assume significant savings will be incurred from decreases in drug prices as well as provider and payer administrative costs. SB 770 asserts that a unified financing system would save California more than $500 billion over 10 years.

Potential Challenges of Unified Financing

Unifying public and private payers into a single pooled fund would be immensely challenging in this country. Key Design Considerations for a Unified Health Care Financing System in California

recognizes that transitioning to a unified financing system would completely upend health care financing and coverage as it exists today. As such, it is important to consider the feasibility of some of the assumptions delineated above, such as the payroll tax, which—the report states—will produce "winners and losers," since some employers will be required to pay more than others. Additionally, the report assumes that the U.S. Department of Health and Human Services (HHS) will agree to consolidate and redirect current levels of federal Medicaid, ACA, and Medicare funds to the state's new health authority that provides all Californians with the same benefits package, regardless of a person's age, income, or disability. For that to happen, all statutory and regulatory requirements stipulating that certain benefits be provided to particular populations would need to be waived and, moreover, some benefits enshrined in statute may need to be reduced or eliminated. The California Commission acknowledges that a waiver of this magnitude would be unprecedented and controversial, and that it is possible that HHS may not be authorized to approve such a model without new federal authorizing legislation.[18]

Both a direct payment approach, in which providers would be paid directly by the state authority, and an approach that uses health plans or other nonprofits as intermediaries, were discussed in the California Commission's report. If health plans or health systems are used as intermediaries, they would be required to offer the same benefits and cost-sharing structure, which could be perceived as antithetical to choice, which is embraced in AMA policy. Although it is not clear how physicians and other health care providers would be paid under a unified financing system, the report cites the Maryland Total Cost of Care Model, which sets global budgets for hospitals, as a potential design feature. For physicians and other outpatient providers, the Commission's report states that the "unified financing authority would either set or negotiate fee-for-service based payment rates," and that "aggregate payments to physicians would be equal to the weighted average of current Medi-Cal, Medicare, and ESI payments, minus estimated reductions in costs due to reduced billing and administrative costs." The report further states:

> *One implication of [unified financing] UF is that physicians whose patients are currently primarily covered by private insurance will receive less revenue under UF than they do under the status quo, while physicians whose patients are primarily insured by Medicare and Medi-Cal will receive an increase in revenue. The analysis assumes that, because the UF system will be the only source of third-party payment, all California physicians and other health care providers will participate in the UF system.*

Notably, the latter assumption may violate AMA policy on physician choice of practice (Policy H-385.926) and physician freedom to participate in a particular insurance plan or method of payment (Policy H-165.985). Language in SB 770 specifies that unified financing waivers should incorporate "a rate-setting process that uses Medicare rates as the starting point for the development of final rates that avoid disruptions in the health care system and expand the availability of high quality vital services by sustaining a stable, experienced, and equitably compensated workforce."[19] Still, any cuts to physician, hospital, and other provider payments under unified financing in California or any other state, or federally, could have widespread ramifications on the delivery system, physician supply, and patient access to care. As noted in the previous section, fewer administrative burdens under unified financing could lead to reductions in prior authorization and billing costs incurred by physicians producing some cost savings. However, potential payment impacts are especially concerning given that annual Medicare payment reductions and the lack of an inflationary update already threaten the viability of physician practices, add to physician's considerable burdens, and stifle innovation. Medicaid physician payment rates also remain inadequate in many states which negatively impacts patient access to certain care. At the same time, as evidenced by a 3.6 percent projected increase to the MEI in 2025,

the inflationary costs associated with running a practice continue to rise while physician payments under Medicare and Medicaid are failing to keep up.

With regard to pluralism, unified financing assumes a centralization of financing while garnering potential efficiencies, which could potentially cause benefits and payment levels to coalesce into a single or tightly limited range. If this were to occur, patients and physicians would have little recourse should decisions be made to underpay for certain types of medical care or to deny or modify coverage for certain services. In turn, this could affect the adoption of newer technologies and treatments, which some insurers may cover sooner than others or with fewer or more restrictions. Under the current decentralized (pluralistic) system of competing health plans, some patients and physicians can choose not to purchase a particular insurance product, or to not be in network with those payers; however, this may not be feasible in a more centralized unified financing system. These concerns would be mitigated, however, if supplemental private plans offering different benefits become available on top of the standardized unified financing plan.

Although analyses of California's unified financing approach project cost-savings over time, it is important to point out that single payer systems have been estimated to increase federal health spending by more than 50 percent, which may not be politically palatable.[20] Depending on health system design specifications, a unified financing model could necessitate increases in taxation. Additionally, as evidenced by experiences around the world, political and economic shifts can pose serious risks to the stability of unified financing systems which, if not adequately funded, experience capacity and physician shortages as well as bottlenecks that can delay medically necessary care when fiscal austerity measures are put in place. Finally, transitioning residents into a transformed health system could lead to administrative challenges, especially in the early years, similar to those experienced when the ACA was first implemented.

A Potential Feature of Unified Financing: Hospital Global Budgeting

Hospital global budgeting, which has been implemented in other countries (e.g., Canada and the Netherlands) and in U.S. jurisdictions participating in the Centers for Medicare & Medicaid's (CMS) "state total cost of care" demonstrations, was cited by the California Commission as a potential design feature under unified financing that could help control health care costs. In this country, hospitals implementing global budgeting are generally exempt from Medicare's inpatient and outpatient prospective payment systems and are instead paid predetermined, fixed annual budget amounts based on previous years' Medicare and Medicaid payment levels, adjusted for inflation and population changes. Hospitals operating under global budgeting thus experience more payment stability and predictability, since they know what they will be paid from year to year, enabling more proactive planning.[21] Hospitals can also retain some revenues by managing costs below established payment levels, which may incentivize them to provide value-based care and reduce preventable hospitalizations.

To advance hospital global budgeting in more states, CMS launched a new voluntary state total cost of care model called States Advancing All-Payer Health Equity Approaches and Development (AHEAD) in 2023. At the time this report was written, four states had signed on—Maryland, Vermont, Connecticut, and Hawaii.[22] According to CMS, the AHEAD model aims to drive multi-payer alignment across more states through hospital global budgeting coupled with a primary care component. To address improvements in health equity, adjustments for social risk will be incorporated into hospital global budget payments.[23]

Global budgets are not new and could potentially be implemented as part of California's unified financing system. Although about half of the states attempted to regulate hospital prices in the

1970s, Maryland is the only state that has continuously embraced an all-payer approach and has been partnering with CMS to implement global hospital budgeting since 2014.[24] Vermont has administered an all-payer model for accountable care organizations (ACOs) since 2017,[25] the same year that Pennsylvania began implementing a rural health model that pays participating hospitals a fixed amount prospectively, regardless of patient volume.[26] These states have been able to implement such changes by participating in CMS waiver demonstrations and their experiences contributed to the design of the new AHEAD model.

Maryland's global budget is limited to hospitals; physician services provided in hospital settings and care provided outside of hospital campuses are generally excluded. Annual budgets are established by the Health Services Cost Review Commission for each hospital (excluding federal and children's hospitals, and some specialty hospitals) in the state using the previous year's budget as the base coupled with annual updates reflecting inflation and population growth. This independent state agency also sets all-payer pricing for hospital care units of service, which are used to determine a hospital's global budget amount.[27] Through its federal waivers, Maryland has committed to producing $2 billion in Medicare savings between 2019 and 2026 while improving quality and population health in the state. An evaluation of the program found that, in 2022, 41 hospitals were able to retain $1.1 billion in revenue by reducing volume while 11 hospitals surpassed the volume included in their global budgets, resulting in negative $79 million in revenue.[28] From 2014 through 2018, Maryland's all-payer model resulted in $975 million in Medicare savings while reducing inpatient admissions and potentially avoidable hospitalizations.[29]

AMA POLICY ON HEALTH SYSTEM REFORM

The AMA continues to advocate for policies that allow physicians and patients to be able to choose from a range of public and private coverage options with the goal of providing coverage to all Americans. To achieve universal coverage, the AMA has long advocated for the promotion of individually selected and owned health insurance; the maintenance of the safety net that Medicaid and CHIP provide; and the preservation of employer-based coverage to the extent that the market demands it. Notably, the AMA's proposal for health system reform—which is grounded in AMA policies supporting pluralism, freedom of choice, freedom of practice, and universal access for patients—has been extensively debated by the HOD for more than 25 years. Based principally on recommendations developed by the Council, beginning in 1998, AMA policy has advocated for the promotion of individually selected and owned health insurance using refundable and advanceable tax credits that are inversely related to income so that patients with the lowest incomes receive the largest credits (Policies H-165.920 and H-165.865). Our policy also underscores that, in the absence of private sector reforms that would enable people with lower incomes to purchase health insurance, the AMA supports eligibility expansions of public sector programs, such as Medicaid and CHIP, with the goal of improving access to health coverage to groups that would be otherwise uninsured (Policy H-290.974).

The principles and guidelines embedded throughout the AMA's large compendium of health reform policy, which has been refined over the years as the coverage environment has evolved, form the basis by which the AMA continues to thoughtfully evaluate and engage in advocacy around a broad array of approaches to achieve universal health coverage. Since the ACA was enacted, the HOD has adopted a multitude of policies addressing how to cover the remaining uninsured and improve health care affordability, thereby ensuring that our proposal for reform continues to evolve. For example, Policy H-165.823 was amended in 2021 to address uninsured individuals who fall into the "coverage gap" as well as those ineligible for coverage due to immigration status. Policy H-290.955 was adopted in 2022 and subsequently amended in 2023 to address the unwinding of Medicaid's continuous enrollment requirement, which was the most

significant nationwide coverage transition since the ACA and led to improper Medicaid disenrollments of eligible individuals in many states.

This year, the AMA's plan to cover the uninsured focuses on expanding health insurance coverage to five main population targets, which make up the nonelderly uninsured population: 1) individuals eligible for ACA premium tax credits (35 percent of the uninsured); 2) individuals eligible for Medicaid or CHIP (25 percent of the uninsured); 3) people who are ineligible for ACA premium tax credits due to an offer of "affordable" employer-provided insurance (20 percent of the uninsured); 4) individuals ineligible for coverage due to immigration status (15 percent of the uninsured); and 5) people ineligible for Medicaid because they fall into the "coverage gap" in states that have not expanded Medicaid (6 percent of the uninsured).[30] To maximize coverage and improve affordability, the following policies form the basis of the AMA proposal for reform:

- Policy H-165.824 supports improving affordability in health insurance exchanges by expanding eligibility of premium tax credits beyond 400 percent of the federal poverty level (FPL); increasing the generosity of premium tax credits; expanding eligibility for cost-sharing reductions; and increasing the size of cost-sharing reductions.
- Policy H-290.955, which was adopted in response to the Medicaid unwinding, encourages states to facilitate coverage transitions, including automatic transitions to alternate forms of coverage, including for people no longer eligible for Medicaid who are eligible for ACA marketplace plans. This policy also encourages state Medicaid agencies to implement strategies to reduce inappropriate terminations from Medicaid/CHIP for procedural reasons and provide continuity of care protections to patients transitioning to a new health plan that does not include their treating physicians. Finally, this policy supports additional strategies that respond to improper Medicaid disenrollments.
- Policy H-165.828, which is intended to help employees having difficulties affording ESI, supports lowering the threshold used to determine ESI affordability to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized ACA coverage.
- Policy D-290.979 advocates that all states expand Medicaid, as authorized by the ACA.
- Policy H-165.823 advocates for a pluralistic health care system—which may include a public option—that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians. This policy establishes standards for supporting a public option and states that it shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid at no or nominal cost. Policy H-165.823 also directs the AMA to advocate that any federal approach to covering uninsured individuals who fall into the "coverage gap" in non-expansion states makes health insurance coverage available at no or nominal cost, with significant cost-sharing protections. Importantly, this policy supports extending eligibility to purchase ACA marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals recipients. Finally, Policy H-165.823 supports states and/or the federal government pursuing auto-enrollment in health insurance coverage provided it meets certain standards.
- Policies H-165.824, H-290.976, H-290.971, H-290.982 and D-290.982 support investments in outreach and enrollment assistance activities to improve coverage rates of individuals eligible for ACA financial assistance or Medicaid/CHIP.
- Policy D-165.942 advocates that state governments be given the freedom to develop and test different models for covering the uninsured, provided that their proposed alternatives a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care, b)

ensure and maximize patient choice of physician and private health plan, and c) include reforms that eliminate denials for pre-existing conditions.

A plethora of health reform principles are also delineated throughout the AMA's health reform policy, including Policies H-165.838, H-165.888, H-165.846, and H-165.985. Policy H-165.838 commits the AMA to achieving health reforms that include the following components:

- Health insurance coverage for all Americans;
- Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions;
- 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.

Policy H-165.888 directs the AMA to continue its efforts to ensure that health system reform proposals adhere to a range of principles regarding choice and include valid estimates of implementation costs and the identification of sources of funding, including specific types of taxation. Policy H-165.846 supports a series of principles to guide in the evaluation of health insurance coverage options, including that 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. Policy H-165.985 reaffirms core AMA health reform principles, including free market competition, freedom of patients to select and change physicians or health plans, freedom of physicians to choose whom they will serve, to establish their fees at a level which they believe fairly reflect the value of their services, and to participate or not participate in a particular plan or method of payment.

The AMA also has policy addressing some of the federal waivers that would be needed for California or another state to move forward with implementing a unified financing model, including:

- Policy H-165.826, which supports the criteria outlined in Section 1332 of the ACA for the approval of State Innovation Waivers, including that the waiver must: a) provide coverage to at least a comparable number of the state's residents as would be provided absent the waiver; b) provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state's residents as would be provided absent the waiver; c) provide coverage that is at least as comprehensive for the state's residents as would be provided absent the waiver; and d) not increase the federal deficit.
- Policy H-290.987, which supports the provision of state Medicaid waivers, provided they promote improving access to quality medical care; are properly funded; have sufficient physician and other provider payment levels to secure adequate access; and do not coerce physicians into participating.
- Policy H-165.829, which 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.

After thoroughly reviewing the compilation of AMA health reform policies, the Council also notes that, depending on specific design features, unified financing proposals may be inconsistent with the following AMA policies:

- Policy H-165.838, under which the AMA supports health system reform alternatives that are consistent with AMA policies on pluralism, freedom of choice, and freedom of practice. This policy also states that the 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.
- Policy H-165.920, which affirms AMA support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services.
- Policy H-165.888, which states that unfair concentration of market power of payers is detrimental to patients and physicians if patient freedom of choice or physician ability to select mode of practice is limited or denied.
- Policy H-165.985, which opposes socialized or nationalized health care and instead supports: 1) free market competition among all modes of health care delivery and financing, with the growth of any one system determined by the number of people who prefer that mode of delivery, 2) freedom of patients to select and change their physician or medical care plan, 3) freedom of physicians to choose whom they will serve, to establish their fees, and to participate in a particular insurance plan or method of payment, and 4) improved methods for financing long-term care through a combination of private and public resources.
- Policy H-165.844, which reaffirms support of pluralism, freedom of enterprise and strong opposition to a single payer system.
- Policy H-285.998, which is one of the AMA's preeminent policies addressing managed care, states that the needs of patients are best served by free market competition and free choice by physicians and patients between alternative delivery and financing systems.

DISCUSSION

Although the Council last presented a comprehensive report on health care financing models in 2017 (Council Report 2-A-17), several reports since then have enhanced AMA policy on health system reform and covering the uninsured, including:

- Council Report 2-A-18, Improving Affordability in the Health Insurance Exchanges;
- Council Report 3-A-18, Ensuring Marketplace Competition and Health Plan Choice;
- Council Report 2-A-19, Covering the Uninsured Under the AMA Proposal for Reform;
- Council Report 1-Nov-20, Options to Maximize Coverage Under the AMA Proposal for Reform;
- Council Report 3-Nov-21, Covering the Remaining Uninsured;
- Council Report 3-A-22, Preventing Coverage Losses After the Public Health Emergency Ends;
- Council Report 6-A-23, Health Care Marketplace Plan Selection; and
- Council Report 5-I-23, Medicaid Unwinding Update.

Together, these reports have established AMA policy that seeks to guarantee affordable health coverage—and timely access to quality care—for every American while embracing the organization's commitment to universal coverage, and to longstanding principles related to pluralism, choice, freedom and sustainability of practice, and universal access to care. The compilation of health reform policy summarized in this report forms the basis by which the AMA

continues to evaluate and engage in advocacy around health system reform proposals and efforts to improve the health care system for all patients and physicians. As AMA policy evolves, so too does the AMA's plan to cover the uninsured, which is updated biennially to incorporate current metrics on the uninsured and operationalize AMA priorities for improving affordability and covering the remaining uninsured.

At the 2023 Interim Meeting, the HOD voted against removing AMA opposition to single payer systems (e.g., Medicare-for-All-type proposals) from its policy while referring the second resolve of Resolution 818-I-23, which led to the Council's unified financing study and the development of this report. The Council's study of unified financing systems was limited in part by the lack of formal analyses on the impact that such models would have on patients, physicians, hospitals, medical practice, and the costs, quality, and timeliness of care in the U.S. consistent with this limitation, the Council found that discussions of this type of reform are still in the preliminary stages in this country, with California taking the lead as it explores pursuing federal waivers that would be required for the state to pool and redistribute Medicaid, Medicare, ACA, and possibly other federal dollars under a unified financing system. Even in California, the Council believes it is unclear how unified financing would work or how physicians and patients would be impacted. As more details regarding the specific features of California's plan are released, the Council will continue to explore the model's pros and cons and consider critical lessons that will be learned from the state's experience. At this time, while the Council generally finds that unified financing has potential to reduce fragmentation in our health care system, improve health equity, and eliminate insurance churn and coverage gaps, we remain strongly concerned that patients and physicians would have less choice under this model, and that physician and hospital payments may be reduced in order to lower health care costs and fund system redesign. As cautioned in this report, the Council believes that any cuts to physician or hospital payments could have widespread ramifications on the delivery system, physician supply, and patient access to care, especially given ongoing threats to practice sustainability due to longstanding inadequacies of Medicare and Medicaid payment rates.

The Council is intrigued by California's embrace of unified financing and pursuit of transformational health reform; however, we also recognize that the state is likely years away from implementing unified financing and that many uncertainties about its model's design and potential implementation remain, including how such a system would be funded, and what new taxes—payroll or otherwise—might be needed; the mechanisms through which and the levels at which physicians and hospitals would be paid; and the role (if any) of private health plans. Since no state had begun pursuing the necessary waiver applications at the time this report was written, the Council also has lingering questions about the feasibility of unified financing in the U.S., especially since federal waivers, even if approved, can be undone when Administrations change. Furthermore, it is unclear if HHS would even have the statutory authority to consolidate and redirect current levels of federal Medicare, Medicaid, and ACA funds without new federal legislation. As previously noted, there is no significant movement towards unified financing at the federal level and consideration of Medicare-for-All-type proposals has largely stalled.

Although the Council's study included international examples of unified financing systems, we emphasize that models implemented in other countries are not generalizable to the U.S. because of the existing complexities inherent to our current system. Until the aforementioned implementation issues are resolved, we believe it would be premature to recommend new AMA policy on unified financing, such as principles or guardrails that unified financing systems should incorporate (similar to the public option standards delineated in Policy H-165.823). Instead, this report summarizes the potential benefits and challenges of a unified financing model without commenting on its advisability. In order to keep abreast of new unified financing developments in California or

elsewhere, the Council recommends that our AMA continue to monitor federal and state health reform proposals, including the development of state plans and/or waiver applications seeking program approval for unified financing. Consistent with California's exploration of a unified financing model and potential action in other states, the Council also recommends reaffirming Policy D-165.942, which advocates that state governments be given the freedom to develop and test different models for covering the uninsured provided that certain standards are met (e.g., patient choice of physician and private health plan must be ensured).

The Council continues to stand behind the substantial health reform policies summarized herein, which reflect the organization's commitment to achieving universal coverage by improving the current system and expanding its reach to Americans who fall within its coverage gaps. Instead of upending and fully redesigning the health system, which may be unrealistic, AMA policy builds on the foundation already in place—a pluralistic system that embraces competition and freedom of choice—to achieve the right mix of public and private coverage and expanded Medicaid options in every state. The Council has heard the argument that our policy opposing single payer systems precludes the AMA from engaging in discussions of federal and state health reform proposals. However, we maintain that the AMA stands ready to evaluate any mature reform proposal that is introduced, no matter its structure and scope. Furthermore, the Council did not identify any gaps in existing AMA policy that need to be addressed for the AMA to continue advancing its health reform vision with Congress, the Administration, and states. Even if a moderately detailed unified financing proposal was introduced tomorrow, its provisions could be thoroughly vetted for consistency with the existing health reform policies cited in this report, such as Policy H-165.838, which upholds the AMA's commitment to achieving enactment of health system reforms that include health insurance coverage for all Americans, expand choice of affordable coverage, ensure that health care decisions remain in the hands of patients and their physicians, and are consistent with pluralism, freedom of choice, freedom of practice, and universal access.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted in lieu of the second resolve clause of Resolution 818-I-23, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) continue monitoring federal and state health reform proposals, including the development of state plans and/or waiver applications seeking program approval for unified financing. (Directive to Take Action)

2. That our AMA reaffirm Policy D-165.942, which advocates that state governments be given the freedom to develop and test different models for covering the uninsured, provided that proposed alternatives a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care, b) ensure and maximize patient choice of physician and private health plan, and c) include reforms that eliminate denials for pre-existing conditions. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-165.838, which upholds the AMA's commitment to achieving enactment of health system reforms that include health insurance for all Americans, expand choice of affordable coverage, assure that health care decisions remain in the hands of patients and their physicians, and are consistent with pluralism, freedom of choice, freedom of practice, and universal access. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-I-24

Subject:	Time-Limited Patient Care (Resolution 705-A-24)
Presented by:	Stephen Epstein, MD, MPP, Chair
Referred to:	Reference Committee J

At the June 2024 Annual Meeting, the House of Delegates adopted Resolution 705 (Policy D-450.951), which asks our AMA to "study the impacts of time-limited physician visits on patient care quality, patient satisfaction, and physician satisfaction." Testimony at the 2024 Annual Meeting regarding the resolution was supportive, highlighting a need to study this issue beyond primary care. The Council wishes to note that the core of physician time pressures is not an issue of coding, but rather one of arbitrary time-limits enacted as a result of insurer, administrative, and/or hospital system policies. Therefore, the following report will not focus on coding, but rather on the root causes and possible solutions for this issue. Additionally, this report covers the history of time-limited care and the impact of time limits on patients and physicians, highlights American Medical Association (AMA) advocacy efforts and essential policy, and presents new policy recommendations.

BACKGROUND

While time-limited physician visits are not a national standard or requirement, it is not an uncommon experience for many physicians and patients. The time limits placed on visits, typically 15-20 minutes, have largely been implemented as a result of the need to foster profitability within payment models, especially in large health care systems. When surveyed, only 14 percent of physicians indicated that they felt the time allotted for patient visits was adequate to provide patient care at the desired quality level.[1] For new patient visits, health systems allowed physicians an average of 35 minutes, yet physicians reported needing nearly 46 minutes. Similarly for established patients, physicians indicated that they were allotted an average of 20 minutes but needed close to 24 minutes to satisfactorily meet the patient's needs.[2] Physicians who work in managed care and/or health maintenance organization settings tend to experience these time pressures at an elevated level compared to physicians practicing in other settings. However, pressure to maintain time-limited visits is pervasive throughout the health care system.[2]

Time pressures are thought to be a reflection of the health care system as a whole working to treat acute conditions rather than working preventively, and research has demonstrated that it may be impacting health care disparities. Specifically, patients who are insured through private payers tend to be allotted more time for visits than beneficiaries of public insurance or the uninsured.[3] It has also been shown that Non-Hispanic Black patients had, on average, shorter visits than Non-Hispanic White patients when under the care of the same physician.[3] Additionally, patients dealing with mental health diagnoses, those with disabilities or chronic conditions, and those with limited English proficiency often need more time with their physician(s).[2,3,4] Patients who have more

complex care needs and/or are at higher risk to experience adverse social determinants of health (SDOH) need more time with physicians, and this research demonstrates that they may actually be getting less.[2,3,4]

PHYSICIAN SATISFACTION

Time-limited visits have increased likely as a result of the pressure from payers, hospital systems, and practice administrators to provide short visits, in order to maximize revenue.[2,6] Physicians who report more time pressures, or the inability to complete necessary work in the allotted time, also report decreases in their overall job satisfaction.[1,9] Additionally, strict time pressures on patient visits have been linked to increases in physician stress, burnout, job dissatisfaction, and intent to leave practice.[1,5,9] Interestingly, when physicians consciously choose to ignore the time pressures, associated job satisfaction increases, despite the potential consequences from employers or management.[9] When supported by management or systems to take the necessary time with patients, physicians report better overall personal outcomes, tend to rate their workplace more positively, and are less likely to indicate they are considering leaving practice.[1,5]

With the increase in managed care arrangements, physician pressure to limit visit length seems to be intensifying.[2,3] On average, physicians report being able to spend about 18-20 minutes per visit but are strongly encouraged by administrators to limit visit time to as short as 10 minutes. These pressures have been shown to be more intense for female physicians as opposed to their male counterparts.[5,6] Importantly, this pressure can also stem from low payment rates from insurers and force many physicians to maintain short visit lengths in order to ensure adequate payment.[3,4] Research justifies physician concerns that imposing time limits has negative impacts on patient care and workforce sustainability.

This issue is particularly well studied among primary care physicians (PCPs), as they often face extreme time pressures to maintain the financial viability of a practice or health system. Estimates indicate that PCPs would need to practice for 26.7 hours per day to meet the needs of an average patient panel and maintain financial viability.[7] While much of the research in this area is focused on primary care, there is some research that reveals that physicians across specialties are being pressured by insurers and/or administrators to limit visit length. For example, physicians in the specialties of cardiology, oncology, and urology reported spending as little as nine minutes with patients. Averages from this study indicate that the majority of subspecialists do not spend more than 24 minutes with patients, echoing the trend seen in primary care.[7,8]

PATIENT SATISFACTION & QUALITY OF CARE

Both patients and physicians are in agreement that inappropriately short visits are not just frustrating but can negatively impact patient care and the patient-physician relationship.[1,2,9] When patients feel they have their physician's attention for an adequate amount of time to address concerns, they are more likely to report satisfaction with the specific visit, as well as the physician, practice, or system.[4] This is particularly important as patient satisfaction has been linked to increases in patient willingness to attend appointments and comply with medical advice.[4] In order for physicians to be able to provide effective care, it is essential that patients are comfortable not only attending visits but following advice from their physician.

For patients without complex care needs and/or who are not impacted by SDOH, shorter visits may be appropriate, without any negative impact on quality of care or patient outcomes.[6] However, other research has shown poorer outcomes for all patients when visit time is restricted.[1,10] For example, among patients with chronic noncancer pain (CNCP), time pressures are linked to less

effective pain management, a particular problem as patients with CNCP may be prescribed opioids in lieu of taking the time to explore other pain management options.[11] Similarly, research demonstrates that shorter visits may be linked to less appropriate antibiotic prescribing practices. Due to the time limits, physicians are unable to fully discuss treatment options with patients and may be forced to rely on the "quick fix" of prescribing antibiotics.[3] As previously mentioned, increased time pressures tend to be linked to poorer quality care. This is particularly important as a lack of comprehensive preventive care may lead to higher levels of avoidable downstream health care utilization that burdens an already overwhelmed system.[6]

MANAGEMENT STRATEGIES & OPPORTUNITIES

While the issue of time pressures and its solutions are wrought with complexity, there are some strategies that physicians may utilize to help physicians cope with this stressor. Importantly, none of these strategies are able to fix the core issue of time pressures but may assist physicians in operating in their current systems or employment settings. One of these opportunities is to utilize established management principles and strategies. Research suggests that, among others, strategies like, prioritization, limiting interruptions, and the delegation of responsibilities can assist physicians and yield higher satisfaction and lower stress.[12] Additionally, physician education around cognitive-based principles like cognitive load theory and time-management inventory allowed for physicians to implement changes in their time-management and utilize time more effectively.[13] Finally, established time-management principles, like the Lean Principles,[14] can be helpful for physicians to utilize to manage time pressures. In conjunction with or addition to time-management strategies, physicians may be able to utilize tools which could include virtual scribes, medical or ambient speech recognition, and/or artificial intelligence-based assistants.[15]

In addition to tools and strategies previously mentioned, physicians may be able to utilize collaborative strategies to manage time-pressures. First, physicians could utilize population health management (PHM), a strategy that focuses on improving population health, improving patient experience, and reducing costs. PHM relies on a collaboration between physicians, or other health care providers, social services, and public health departments.[16] Research has begun to show that the utilization of PHM may not only improve patient satisfaction, but also patient outcomes and physician satisfaction.[17,18] Some research has even suggested that PHM may work to reduce health disparities.[19] A second collaboratively-based opportunity that could be utilized by physicians to manage time pressures is medical-legal partnerships (MLPs). In these partnerships, physicians, or other health care providers, work in collaboration with legal professionals to address the legal and social needs that are harming their patient's health.[19] These partnerships can be especially helpful in dealing with time-pressures as physicians caring for patients facing SDOH often report needing more time to address the litany of complex issues their patient is facing.[6] Research has demonstrated that physicians engaged in MLPs not only have partners to rely on in addressing their patient's needs, but also report higher job satisfaction. Additionally, patients treated by physicians in MLPs have shown more positive health outcomes.[20] Not only could MLPs assist in physician time-management through delegation and collaborative teamwork, but they have also been shown to improve outcomes for both patients and physicians.[20] While none of these opportunities are a guaranteed fix, nor do they address the root cause of time pressures, physicians may wish to utilize them in order to operate within the current health care system.

AMA POLICY & ADVOCACY

AMA policy supports physician autonomy, including determination of visit length. Policy H-285.969 outlines AMA efforts to ensure that physicians are able to maintain autonomy in care arrangements or settings. Policy H-70.976 monitors attempts by the third-party payers to institute

time limits on visits and discourages payers from adopting time limit policies. In addition to the policy outlining support for physician autonomy, AMA policy also highlights the importance of ensuring that physicians have the opportunity to be involved with governance structures. Specifically, Policy D-225.977 details support ensuring that employed physicians not only have autonomy, but that opportunities for them to be involved in leadership, self-governance, and partnerships are promoted.

AMA policy also advocates for reducing physician burnout and increasing physician satisfaction. Policy D-310.968 addresses the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient workflows, and regulatory oversight. Policy H-405.948 outlines the variety of factors that cause many physicians and medical students to experience burnout. Policy H-405.972 supports an accreditation program for hospitals and systems that facilitate physician well-being. Policy H-405.957 supports the implementation of programs that are aimed to identify and manage stress and burnout in physicians and medical students.

The *AMA Joy in Medicine Health System Recognition Program* utilizes tools to enable health care systems to evaluate themselves in six competency areas toward reducing physician burnout and increasing physician well-being: (1) assessment of burnout and well-being, (2) commitment to improving workforce well-being, (3) efficiency of practice environment, (4) teamwork, (5) supportive leadership, and (6) a supportive environment. Additionally, the AMA *Physician Well-Being Program* aims to raise awareness and advance change to reduce physician burnout and increase physician well-being by better understanding system-level factors associated with physician burnout and its consequences. Similar to the *Joy in Medicine Program*, it offers organizations a tool to assess the supportiveness of their environment as well as resources for improving or maintaining these efforts. Finally, the *AMA Steps Forward* program provides physicians with educational resources and solutions to address a number of topics, including burnout. These resources include playbooks, podcasts, webinars, toolkits, and real-world examples.

DISCUSSION

While a small body of research indicates that for some low-risk patients, time-limited visits may not negatively impact patient care, the majority of available research demonstrates that time-limited visits can be linked to a decrease in quality of care. Therefore, the Council recommends the adoption of new policy to support efforts to ensure that physicians are able to determine the length of patient care visits without undue influence from outside entities like payers, administrators, and health systems. Not only is it important that physicians have autonomy in the length of visits, but it is also important that those caring for patients with more complex issues or dealing with SDOH are able to incorporate these complexities into visit length. Therefore, the Council recommends the adoption of new AMA policy that supports efforts to ensure that patient complexities and SDOHs are factored into the calculations of the appropriate visit length.

In addition to the new policy, it is recommended that Policy H-70.976 be reaffirmed, as it monitors and seeks to prevent attempts by third party payers to institute time limits on visits and stresses the importance of ensuring that physicians maintain their autonomy as it pertains to determining the length of visits. Finally, in order for physicians to be able to have the autonomy and voice in visit length desired, it is essential that they are involved in the governance and leadership of their employers. Therefore, the Council recommends reaffirmation of Policy D-225.977, which supports employed physician autonomy in clinical decision-making and self-governance.

It is clear that physicians who are practicing in settings with more intense time pressures are more likely to experience burnout, dissatisfaction, and stress, along with burgeoning desire to leave

practice. While it is important to ensure that physicians are able to practice in a setting that is conducive to their staying in practice, it is particularly important in the face of a physician shortage. Therefore, the Council recommends reaffirmation of Policy H-405.957, which supports the implementation of programs that are aimed to identify and manage stress and burnout in physicians and medical students.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support efforts to ensure that physicians are able to exercise autonomy in the length of patient care visits free from undue influence from outside entities such as, but not limited to, payers, administrators, and health care systems. (New HOD Policy)

2. That our AMA support efforts to incorporate patient complexities and social determinants of health in calculating appropriate amounts of expected patient care time. (New HOD Policy)

3. That our AMA reaffirm Policy H-70.976 which monitors and seeks to prevent attempts by third-party payers to institute policies that impose time and diagnosis limits. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy D-225.977 that details support for employed physician involvement in self-governance and leadership. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-405.957 that describes AMA efforts to study, promote, and educate on physician well-being and to prevent physician burnout. (Reaffirm HOD Policy)

6. Rescind Policy D-450.951, as having been completed with this report. (Rescind HOD Policy)

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

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Council on Medical Service Report 3-I-24
Time-Limited Patient Care
Policy Appendix

Corporate Investors H-160.891

1. Our American Medical Association (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. (CMS Rep. 11, A-19; Appended: CMS Rep. 2, I-22; Reaffirmed: BOT Rep. 14, A-23)

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. (Res. 823, A-92; Reaffirmation I-00; Reaffirmed: CMS Rep. 6, A-1; 0Reaffirmed: CMS Rep. 01, A-20)

Physician Burnout D-405.972

Our AMA will work with: (1) Centers for Medicare and Medicaid Services (CMS), The Joint Commission, and other accrediting bodies and interested stakeholders to add an institutional focus on physician wellbeing as an accreditation standard for hospitals, focusing on system-wide interventions that do not add additional burden to physicians; and (2) hospitals and other stakeholders to determine areas of focus on physician wellbeing, to include the removal of intrusive questions regarding physician physical or mental health or related treatments on initial or renewal hospital credentialing applications. (Res. 723, A-22; Reaffirmation I-22)

Programs on Managing Physician Stress and Burnout H-405.957

1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.
2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students. (Res. 15, A-15; Appended: Res. 608, A-16; Reaffirmed: BOT Rep. 15, A-19)

Physician and Medical Student Burnout D-310.968

1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.

6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to: (a) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (b) develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being. (CME Rep. 8, A-07; Modified: Res. 919, I-11; Modified: BOT Rep. 15, A-19; Reaffirmation: A-22)

Factors Causing Burnout H-405.948
Our American Medical Association recognizes that medical students, resident physicians, and fellows face unique challenges that contribute to burnout during medical school and residency training, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, mistreatment, long work and study hours, among others, and that such factors be included as metrics when measuring physician well-being, particularly for this population of physicians. (Res. 208, I-22)

Physician Independence and Self-Governance D-225.977
Our American Medical Association will continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance.
Our AMA will 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. (Res. 801, I-11; Modified: BOT Rep. 6, I-12; Reaffirmed: CCB/CLRPD Rep. 1, A-22)

Managed Care Education H-285.969
The AMA will continue to emphasize professionalism, patient and physician autonomy, patient and physician rights, and practical assistance to physicians as key principles to guide AMA advocacy efforts related to managed care. (Sub. Res. 707, A-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed: CMS Rep. 1, A-15)

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-I-24

Subject: Biosimilar Coverage Structures
(Resolution 207-A-24, Referred Resolve)

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee J

At the June 2024 Annual Meeting, the House of Delegates (HOD) adopted amended Resolution 207-A-24 which encourages the Federal Trade Commission (FTC) and Department of Justice (DOJ) Antitrust Division to closely scrutinize long-term exclusive contracts signed between biologics originators and pharmacy benefit manages (PBMs) to ensure they do not impede biosimilar development and uptake (Policy H-125.973). The HOD also referred a proposed new resolved clause to Resolution 207-A-24, which was introduced by the Medical Student Section and asked the American Medical Association (AMA) to "support coverage structures that increase use of lower cost biosimilars when clinically appropriate, share savings between patients and payers, and reduce patient costs."

This report provides an overview of biosimilars, the current state of coverage, and related incentives to increase their use. Additionally, this report presents policy recommendations consistent with intent of the referred new resolved clause to Resolution 207-A-24.

BACKGROUND

A biosimilar drug is a type of biologic, or drug that is produced by living organisms, which is very similar in both structure and function to a Food and Drug Administration (FDA) approved branded biologic, or reference medication. Biosimilars may not have the same chemical compound as the reference medication but must have the same efficacy and chemical structure to act on the body (detailed definitions can be found in Appendix A).[1] They are often compared to generic medications; however, they are slightly different. While generic medications are identical to the name brand medication, biosimilars have the same performance as the reference biologic, but there are slight chemical differences in the makeup of the medications.[1] For a more in-depth discussion as to the chemical and molecular makeup of biologic medications, how they differ from the reference medication, and interchangeability please see Council on Science & Public Health Report 5-A-24, *Biosimilar/Interchangeable Terminology*.

While biosimilars have been on the European market since 2006, the first biosimilar was approved by the FDA for use in the United States (U.S.) in 2015.[2] Since then, the U.S. market has seen steady, if rather slow, growth of biosimilars.[3,4,5] Between 2015 and 2020, only nine biosimilar medications entered the U.S. market. However, in recent years there has been significant growth in this market; as of August 2024, there are 59 FDA approved biosimilars in the U.S. market.[6] In 2010, via a portion of the Affordable Care Act (ACA), the Biologics Price Competition and Innovation Act, Congress passed an abbreviated pathway to licensure in order to encourage

increases in biosimilar approval in the U.S..[4,5,7] This abbreviated pathway from the ACA made it possible for biosimilars to be approved in a more efficient manner. Congressional support for biosimilars was primarily based on the potential for financial savings that these medications have for both payers and patients.[3,4,8]

Biosimilars are often thought of as preferable to their equivalent reference medication due to the fact that they are typically less expensive. Cost savings have been seen in both the European Union and the United Kingdom National Health System, which have each saved millions annually by switching to biosimilar medications.[5] Estimates indicate that the use of biosimilar medications could result in a 15-35 percent overall savings in the U.S. market.[5,7,8,9] This is especially important as biologic medications account for just over 40 percent, or about $211 billion, of all annual drug spending in the U.S..[9,10] Some research has indicated that an increase in the use of biosimilars could save the U.S. health care system nearly $54 billion over 10 years.[4,5] While there have been actual savings in the U.S. due to the use of biosimilars, they have only amounted to $12.6 billion, or five percent of a projected $54 billion savings. Additionally, research indicates that savings to patient out-of-pocket cost is, if present at all, only marginal and very dependent on medication type.[7,8]

While it is possible that savings have not been realized due to slow introduction of biosimilars to the U.S. market, it is also possible that payment structures often do not incentivize the switch to biosimilar medications.[7] Recent research finds that there may be several factors affecting the likelihood of biosimilar initiation, including type of insurance coverage and patient age.[11] Medicare Advantage beneficiaries were the most likely to initiate, accounting for 74 percent of all biosimilar initiation. Pediatric patients were the least likely to initiate, likely due to complications of approvals for use in children. Overall, the study found that biosimilar initiation is growing, with 27 percent of patients initiating biosimilars in 2022, up from one percent in 2013.[11]

Despite the initial Congressional support and potential for cost savings, biosimilar use has been limited in the U.S. since their initial approval. A leading factor in the slow uptake of biosimilars is centered around patents. Specifically, manufacturers of the reference medication are able to use strategies, like a minor formula or name change, to ensure that patents last longer in order to delay the entry of biosimilars to the market.[7,8] Additionally, payment structures have historically not incentivized the use of biosimilars over reference medications. A full discussion of the impact of coverage structures can be found in a later section of this report. Furthermore, there has been a significant learning curve for patients and physicians as to the potential advantages of choosing a biosimilar medication over a reference medication.

While federal legislation related to biosimilars has been sluggish,[4] the vast majority of states have laws allowing, or in some cases requiring, the substitution of biosimilars.[12] All but four states, Alabama, Indiana, South Carolina, and Washington, have laws that allow for the automatic substitution of biosimilars for a prescribed reference medication by a pharmacist. In nine states, substitution is only permitted if the cost of the biosimilar is lower than the reference medication. Additionally, nearly all states with these laws require that both the patient and physician be notified regarding this change. Importantly, in every state, physicians and other prescribers are able to prevent automatic substitution by indicating that the prescription be “dispensed as written.”[12] Regardless of law, it is important to note that physicians are generally wary of pharmacist-led drug substitutions, and the AMA has advocated widely on this issue and a discussion of efforts can be found in the policy and advocacy section of this report.

BIOSIMILAR COVERAGE

Historically, public and private payers in the U.S. have not incentivized the use of biosimilar medications and, in some cases, actually incentivized the use of reference biologic medications.[4,7,8,9,13] While rebate information is not publicly disclosed, experts hypothesize that due to the higher list price of biologic reference medications, payers are able to negotiate greater rebates, making the reference medication more financially lucrative for the payer. As a result, payers may not include biosimilar medications on preferred formulary tiers or may deny coverage altogether.[12] Research has indicated that among 17 major private insurance plans, less than half had at least one biosimilar placed on a "preferred" formulary tier and only two plans placed at least half of biosimilar medications on the "preferred" tier.[7] Additionally, research indicates that private payers are either excluding or imposing serious restrictions on biosimilar medication coverage nearly 20 percent of the time. Coverage is most likely to be given in cases of cancer treatment and least likely in pediatric patients.[10] Recently, a few major plans have started to shift to cover biosimilars instead of the reference biologic. Interestingly, plans managed by the three largest PBMs were less likely to impose coverage restrictions on biosimilar medications. It is thought that this is a result of these PBMs leveraging their significant market power to negotiate for more advantageous rebates on biosimilars.[10,14]

In addition to the recent shift towards private payers covering biosimilars, federal legislation has encouraged the usage of biosimilars. The Bipartisan Budget Act of 2018 implemented Medicare formulary changes that provided discounts for biosimilars and led to 23 percent higher coverage of these medications.[5,9] The Inflation Reduction Act of 2022 (IRA) is likely to begin incentivizing biosimilar use in the Medicare program starting in 2025. The IRA has, among other things, a focus on lowering the cost of prescription medication for Medicare beneficiaries and to reduce the federal government's drug spending.[15,16] Historically, Medicare Part D, the portion of Medicare that covers prescription medications, has favored reference biologics over biosimilars. Biosimilars are covered at 80 percent, but only when the patient reaches the "catastrophic coverage" phase, meaning that the patient's out-pf-pocket spending has exceeded $8,000. Prior to patients reaching this phase, plans are formulated in a manner where the reference medication is covered more advantageously.[15]

The IRA has two portions that are expected to significantly alter this and lead to greater coverage of biosimilars before patients reach the "catastrophic coverage" phase. First, the IRA implements federally-mandated discounts for certain branded drugs. This is likely to lessen the power of high list prices yielding more lucrative rebates for payers, thereby removing a major incentive to choose reference biologics over biosimilars. Second, the IRA altered Medicare's catastrophic coverage by eliminating the beneficiary coinsurance requirement. Specifically, the IRA capped out-of-pocket costs at $3,250 and added a hard cap on out-of-pocket spending of $2,000. This is indexed in future years to the rate of increase in per capita Part D costs. It is anticipated that this removal of the catastrophic coverage gap will motivate coverage decisions to favor biosimilars over the reference biologic.[15,16] Additionally, the IRA implemented guidelines to ensure that physicians are not incentivized to prescribe higher cost medications due to greater reimbursement based on the higher sticker price. Specifically, starting in October 2022 the IRA implemented an add-on payment rate for biosimilars if the average sale price of that medication is lower than the reference biologic. This is intended to not only incentivize the use of lower-cost biosimilars but also mitigate issues around physician incentivization based in greater reimbursement for higher-cost biologics.[15]

BIOSIMILAR INCENTIVES

Trends in both public and private payers indicate that biosimilars will not only be covered at a greater rate, but plans may actually be transitioning to incentivizing their use.[14,17] Additionally, across all payer types, biosimilar medications are moving towards self-administration, eliminating the need for a medical professional to administer the medication. This is significant as the administration change may lead to more biologic, both reference and biosimilar, medications to be covered under plans' pharmacy benefits. Coverage under the pharmacy benefit could in turn allow for more efficient switches to biosimilar medications.[14]

In addition to medication administration changes, other incentives are being implemented to ensure greater use of biosimilar medications when clinically appropriate, such as the movement of financial incentives to biosimilars in lieu of reference biologics. Historically, the rebates tied to reference biologics have made them the more financially lucrative choice for payers. However, due in part to a 2022 Executive Order from the Biden Administration to the FDA, the FTC, and the Centers for Medicare & Medicaid Services, financial incentives for payers have started to shift towards biosimilar medications.[10] In turn, some plans are utilizing financial incentives for patients to encourage switching to biosimilars. Plans have provided patients with a monetary reward for switching from a reference biologic to a biosimilar.[14] Additionally, initial research indicates that payers are placing biosimilars on formularies or on more advantageous formulary tiers at a greater rate in recent years.[14]

It remains to be seen if payers' biosimilar financial savings will be passed on to patients in the long-term. However, it does seem that the financial incentives are initially leading to greater coverage of biosimilar medications. If the switch to biosimilar medications is to be successful, it is vital that physicians and patients are adequately educated and in control of the switch. With time, physicians have become increasingly well-educated on biosimilars and their potential advantages, allowing some to become more comfortable; however, others continue to express concern.[18,19] It is important to note that there are still significant legitimate concerns from physicians related to switching to biosimilars. For example, studies have found that as many as 65 percent of physicians indicated concerns with switching a patient from a reference biologic to a biosimilar medication. Physicians listed a wide range of reasons for concern related to the safety, efficacy, and immunogenicity of the biosimilar.[14]

It is also important that patients are adequately educated and supported in the use of biosimilars. Research has demonstrated that patients, like physicians, have a diverse set of opinions on the use of biosimilars.[19] While financial incentives or savings can be a powerful tool to increase interest in a biosimilar medication, some patients cite other advantages of a reference biologic, driving resistance to switching to a biosimilar. Specifically, services from reference biologic medication manufacturers like copay support, on-call support/transport services, and educational or administration materials/devices are often powerful in maintaining patient preference for the reference biologic over the biosimilar.[4,14] Additionally, patients often echo physician concerns related to the safety, efficacy, and immunogenicity of biosimilar medications.[18,19] While some of these concerns can be mitigated by physician/patient education as to the benefits of biosimilars, it is important to ensure that any switch to a biosimilar medication is done in agreement from both the physician and patient.

Finally, two strategies seem to be particularly salient to incentivize the use of biosimilars. First, ensuring that patient cost-sharing or out-of-pocket costs are reduced. In many European countries, patient cost-sharing strategies have been utilized to incentivize the use of biosimilars. Specifically, countries have adopted policies that dictate more expensive medications have a higher co-pay and

cheaper medications have a lower co-pay. In some cases, such as in Germany, the lower cost biosimilar has a copay as low as zero dollars, resulting in significant patient incentive to use that medication. Initial implementation of these plans seems to be resulting in higher uptake of the biosimilars with higher patient cost-sharing.[20] Second, allowing for cost-sharing to be shared between the physician and the patient. Shared savings-type programs have been successfully implemented in international settings and, more recently, in the Medicare program.[20,21] In France and Germany, shared savings programs have been implemented with the intent of increasing biosimilar use. These programs are based on agreements between payers and hospitals/physicians regarding the cost savings of specific biosimilars. Initial research has shown that these programs have been successful in increasing the rate of biosimilar uptake in both countries.[19]

AMA POLICY & ADVOCACY

The AMA has a strong body of policy meant to ensure that prescription medications are affordable and that physicians are educated about and able to prescribe biosimilars. Policy H-110.997 supports physician involvement in prescription medication pricing and ensuring that physicians are able to prescribe the medication that is best for the patient. Policy H-110.987 supports advocacy with federal legislators and regulators to reduce anticompetitive behaviors, like patent manipulation, in drug manufacturing and outlines the importance of physician support in lowering pharmaceutical costs. Policy H-110.990 outlines efforts to ensure that cost-sharing and out-of-pocket costs for prescription drugs are fair and patient-friendly.

In addition to policy designed to ensure that prescription drugs are affordable and accessible to patients and that physicians can prescribe what is most clinically appropriate, the AMA has policy supporting the use of biosimilar medications. Policy D-125.989 supports physician autonomy in determining if a biosimilar or biologic product is dispensed to a patient and ensuring that switches from biologics to biosimilars are not done without notification and authorization of the prescribing physician. Policy H-125.972 outlines AMA efforts to support physician education on biosimilars, their FDA approval process, and surveillance requirements. Policy H-125.973 encourages the FTC and DOJ Antitrust Division to closely scrutinize long-term exclusive contracts signed between biologic originators and PBMs to ensure they do not impede biosimilar development and update.

In addition, the AMA has engaged in extensive state level advocacy regarding substitution of interchangeable biosimilar biologic products since 2012. The AMA has worked with dozens of medical societies to support state amendments to pharmacy practice acts to align with new federal definitions. For example, AMA advocated in support of new laws in Indiana, Washington and Mississippi. Based on the concern many physicians express related to pharmacist-led substitution, these laws support the authority of physicians to limit substitution of biologic products. The AMA has rather extensive policy that both works to maintain the proper scope of pharmacist practice and allow physicians to limit or prevent substitution. Specifically, Policies H-125.995 and D-35.987 outline AMA opposition to pharmacist-led substitution without express permission from the physician. Additionally, Policies H-125.991, H-120.918, and D-120.922 all detail efforts to ensure that physicians have the ability to dictate that a prescription should be dispensed as written.

DISCUSSION

Since their approval in the U.S., the initial uptake of biosimilar medications has been slow, but recent years have demonstrated a quicker uptick in their market availability. Public and private payers are continuing to make changes that will likely incentivize and, in turn, increase the prevalence and use of biosimilar medications in the U.S. IRA-derived revisions to the Medicare Part D benefit will be implemented in 2025, and it is likely that these changes will further

encourage the coverage of biosimilars, initially by public payers and, with time, by private payers as well. Additionally, recent changes by large insurers and PBMs have signaled that these players are moving towards not only covering biosimilars at a greater rate but incentivizing their use via financial rewards. In order to ensure that these financial rewards are passed on to patients so that biosimilar medications are affordable and accessible, the Council recommends the reaffirmation of Policies H-110.987 and H-110.997, which both outline advocacy efforts to ensure that prescription medications are affordable and accessible to patients.

If biosimilars are to be successfully incentivized, it is important that it be done holistically and inclusively for all parties involved, and not just centered around financial incentives to payers, and that no physician is forced to prescribe a biosimilar. In some cases, patients and/or physicians may not be comfortable with prescribing a biosimilar over the reference medication. This could be for a number of reasons, including concerns about the safety, efficacy, and/or immunogenicity of the biosimilar. Therefore, the Council recommends the reaffirmation of Policy H-125.989 which ensures that physicians are able to switch patients to biosimilars if they wish, but no substitutions can be made without the notification and approval of the prescribing physician. To ensure that physicians are comfortable and confident in prescribing and discussing biosimilars, the Council recommends the reaffirmation of Policy H-125.972 which outlines support for physician education on the topic of biosimilars.

Finally, in order to further encourage the use of biosimilars, the Council recommends the adoption of two new policies. First, to lower patient out-of-pocket costs, when deemed appropriate by the physician and amenable to the patient, the Council recommends the adoption of new policy to support the development and implementation of incentivization strategies to increase the use of biosimilar medications, when agreed upon by the patient and physician. Second, to ensure that patients are knowledgeable and comfortable with switching from a reference medication to a biosimilar medication, the Council recommends the adoption of new policy to support patient education on the topic of biosimilars by appropriate organizations.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) support the development and implementation of strategies to incentivize the use of lower cost biosimilars when safe, fiscally prudent for the patient, clinically appropriate, and agreed upon as the best course of treatment by the patient and physician. (New HOD Policy)

2. That our AMA support patient education regarding biosimilars and their safety. (New HOD Policy)

3. That our AMA reaffirm Policy H-110.987, which works to ensure that prescription medications are affordable and accessible to patients. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-110.997 which supports the freedom of physicians in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy D-125.989, which outlines efforts to ensure that physicians are able to transition patient to biosimilar medications with coverage from payers. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-125.972 which details efforts to encourage physician education related biosimilars. (Reaffirm HOD Policy)

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

APPENDIX A
Definitions of key terms

Biologic drug (or large molecule drugs): a classification of drugs which are produced by living organisms (such as human or animal cells, yeast, or bacteria), rather than by chemical synthesis. As such, this class of drug tends to replicate or mimic common biologic entities. For example, antibody- or protein-based drugs are common examples of biologic drugs.

Small molecule drug: A classification of drugs based on the number of atoms (typically <100) in their structure. Small molecule drugs are generally prepared using chemical synthesis techniques. Small molecule drugs are estimated to represent over 90 percent of all pharmaceuticals used in the clinic today. Typically, small molecule drugs function by binding to a biological entity (protein, receptor, etc.) and altering its function.

Generic drug: A drug produced by a second manufacturer after the patent or other market protections have expired, allowing for manufacturers to be able to produce their own products with the same chemical substance as a branded drug. The term generic drug only applies to small molecule drugs, with few exceptions.

Biosimilar: A biologic drug that has a very similar structure and function to a branded biologic drug after its patent or market protections have expired. Unlike generic drugs, biosimilars are not required to be the same chemical compound, but they are required to have the same chemical structure to act on the body and efficacy.

Interchangeable: An additional designation provided for biosimilar drugs by the FDA. This designation is not required for market approval and indicates that a biosimilar has successfully demonstrated no changes in efficacy or immunogenicity when the biosimilar is substituted for the reference product after a patient has already initiated treatment with the reference product. This designation has implications for reimbursement, and state regulations around pharmacist practice.

Note: these definitions were originally outlined in the Council on Science & Public Health Report 5-A-24, Biosimilar/Interchangeable Terminology. A more in-depth discussion as to the scientific details of these definitions, and biosimilars in general, can be found in the aforementioned CSAPH report.

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Council on Medical Service Report 4-I-24
Biosimilar Coverage Structures
Policy Appendix

Cost of Prescription Drugs H-110.997
Our American Medical Association (AMA):
(1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs;
(2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices;
(3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;
(4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;
(5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies;
(6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and
(7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients. (BOT Rep. O, A-90; Sub. Res. 126 and Sub. Res. 503, A-95; Reaffirmed: Res. 502, A-98; Reaffirmed: Res. 520, A-99; Reaffirmed: CMS Rep. 9, I-99; Reaffirmed: CMS Rep.3, I-00; Reaffirmed: Res. 707, I-02; Reaffirmation A-04; Reaffirmed: CMS Rep. 3, I-04; Reaffirmation A-06; Reaffirmed in lieu of Res. 814, I-09; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18)

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 drugv 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 10 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; Reaffirmed: Res. 801, I-23; Reaffirmed: Res. 801, I-23)

Cost Sharing Arrangements for Prescription Drugs H-110.990
Our AMA:

1. believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients;
2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes;

3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and patient-specific out-of-pocket costs of individual prescription drugs, taking into account insurance status or payer type, prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition;
4. supports public and private prescription drug plans in offering patient-friendly tools and technology that allow patients to directly and securely access their individualized prescription benefit and prescription drug cost information; and
5. believes payers should not establish a higher cost-sharing requirement exclusively for prescription drugs approved for coverage under a medical exceptions process. (CMS Rep. 1, I-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed in lieu of Res. 105, A-13; Reaffirmed in lieu of: Res. 205, A-17; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: CMS Rep. 07, A-18; Appended: CMS Rep. 2, I-21; Reaffirmed: Res. 113, A-23Appended: CMS Rep. 01, A-23)

Substitution of Biosimilar Medicines and Related Medical Products D-125.989
Our AMA urges that State Pharmacy Practice Acts and substitution practices for biosimilars in the outpatient arena: (1) preserve physician autonomy to designate which biologic or biosimilar product is dispensed to their patients; (2) allow substitution when physicians expressly authorize substitution of a product; (3) in the absence of express physician authorization to the contrary, allow substitution of the biologic or biosimilar product when (a) the biologic product is highly similar to the reference product, notwithstanding minor differences in clinically inactive components; and (b) there are no data indicating clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product; and (c) the prescribing physician has been adequately notified by the pharmacist. (Res. 918, I-08; Modified: CSAPH Rep. 1, I-11; Modified: CSAPH Rep. 4, A-14; Modified; CSAPH Rep. 5, A-24)

Biosimilar/Interchangeable Terminology H-125.972
1. Our AMA encourages the FDA to continually collect data and critically evaluate biosimilar utilization including the appropriateness of the term "interchangeable" in regulatory activities.
2. Our AMA supports evidence-based physician education on the clinical equivalence of biosimilars, the FDA approval process, and post-market surveillance requirements. (CSAPH Rep. 5, A-24)

Therapeutic and Pharmaceutical Alternatives by Pharmacists H-125.995
The AMA opposes legislative attempts at any level of government that would permit pharmacists, when presented with a prescription for a drug product, to: (1) dispense instead a drug product that is administered by the same route and which contains the same pharmaceutical moiety and strength, but which differs in the salt or dosage form (pharmaceutical alternatives); and (2) dispense a drug product containing a different pharmaceutical moiety but which is of the same therapeutic and/or pharmacological class (therapeutic substitution). Our AMA will work with state medical associations to ensure that state pharmacy laws and medical practice acts are properly enforced so that treating physician's directions cannot be overruled or substituted without prior physician approval. (Res. 89, I-85; Reaffirmed by Sub. Res. 501, A-95; Reaffirmed by CLRPD Rep. 2, I-95; Appended by Res. 501, A-98; Reaffirmed: CSAPH Rep. 2, A-08; Modified: CSAPH Rep. 01, A-18)

Evaluation of the Expanding Scope of Pharmacists' Practice, D-35.987

1. Our AMA will re-evaluate the expanding scope of practice of pharmacists in America and develop additional policy to address the proposed new services provided by pharmacists that may constitute the practice of Medicine.
2. Our AMA will continue to collect and disseminate state specific information in collaboration with state medical societies regarding the current scope of practice for pharmacists in each state; studying if and how each state is addressing these expansions of practice.
3. Our AMA will develop model state legislation to address the expansion of pharmacist scope of practice that is found to be inappropriate or constitutes the practice of medicine, including but not limited to the issue of interpretations or usage of independent practice arrangements without appropriate physician supervision and work with interested states and specialties to advance such legislation.
4. Our AMA opposes federal and state legislation allowing pharmacists to independently prescribe or dispense prescription medication without a valid order by, or under the supervision of, a licensed doctor of medicine, osteopathy, dentistry or podiatry.
5. Our AMA opposes federal and state legislation allowing pharmacists to dispense medication beyond the expiration of the original prescription.
6. Our AMA opposes the inclusion of Doctors of Pharmacy (PharmD) among those health professionals designated as a "Physician" by the Centers for Medicare & Medicaid Services. (Res. 219, A-11; Appended: Res. 218, A-12; Reaffirmed: BOT Rep. 9, A-22)

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)

Prescription Drug Dispensing Policies H-120.918

1. Our American Medical Association supports the development and implementation of clear guidelines and mechanisms to indicate that the quantity of a prescription should be dispensed only as written using such language as “dispense quantity as written” or “no change in quantity.”
2. Our AMA supports the development, implementation and/or use of electronic or other means of communication to provide cost and coverage information of various prescribing quantities at the point of care allowing physicians to make the best decisions with their patients regarding prescribed medication quantities. (CMS Rep. 05, A-23)

Transparency at the Pharmacy Counter D-120.922

Our American Medical Association advocates for legislation or regulation that mandates that pharmacies, whether physical or mail-order, must inform patients about their prescriptions, to include at a minimum:

1. The dosage and schedule of treatments as written by the prescriber.
2. Any restriction or alteration of the prescriber’s intent due to third party or pharmacy intervention, with the stated justification.
3. Details of other avenues to obtain the original prescription, including out of pocket options, with comparative costs. (Res. 718, A-24)

Biosimilar Use Rates and Prevention of Pharmacy Benefit Manager Abuse, H-125.973

Our American Medical Association will encourage the Federal Trade Commission (FTC) and Department of Justice (DOJ) Antitrust Division to closely scrutinize long-term exclusive contracts signed between biologics originators and PBMs to ensure they do not impede biosimilar development and uptake. (Res. 207, A-24)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 801
(I-24)

Introduced by: Tennessee

Subject: Reimbursement for Managing Portal Messages

Referred to: Reference Committee J

Whereas, CMS has encouraged physicians to be more readily available to their patients through portal access; and

Whereas, answering portal messages can take a significant amount of time for either the physician or the physician's staff; and

Whereas, ever increasing demands on a physician's time are causing significant burnout and moral injury; therefore be it

RESOLVED, that our American Medical Association immediately collaborate with payers to seek adequate reimbursement for professional time spent answering questions on the patient portal not related to a recent visit (Directive to Take Action); and be it further

RESOLVED, that our AMA continue to advocate for physicians to receive adequate compensation or seek relief from overreaching administrative tasks that take physicians' time away from direct patient care during our present climate of ever-increasing unpaid and unfunded mandates on their time. (Directive to Take Action)

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

Received: 9/3/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 802
(I-24)

Introduced by: Texas

Subject: Address Physician Burnout with Inbox Management Resources and Increased Payment

Referred to: Reference Committee J

Whereas, with advances in medicine, the practice of clinical medicine has become more complex, and patients are more engaged in their health care; and

Whereas, this is laudable, yet it fails to consider the extraordinary demands on physician time; and

Whereas, physician payment in the Medicare Physician Fee Schedule is based on relative value units (RVUs) and some institutions apply RVUs in physician performance/productivity determinations, while other create internal metrics for this purpose; and

Whereas, Electronic Health Records (EHRs) have portals giving 24/7 access to patients, while key performance indicator metrics pressure physicians to address them within 24 hours; and

Whereas, physicians do not get credit in institutional metrics or compensation for addressing in-basket messages; and

Whereas, physicians are burning out trying to keep up with this workload; therefore be it

RESOLVED, that our American Medical Association develop additional inbox management resources (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for increasing the relative value unit for inbox management recognizing that it is asynchronous care that provides value and reduces overall health care costs (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for electronic health record tools that calculate physician time spent in the inbox. (Directive to Take Action)

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

Received: 9/11/2024

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RELEVANT AMA POLICY

Physician Burnout D-405.972

1. Our American Medical Association will work with Centers for Medicare and Medicaid Services (CMS), The Joint Commission, and other accrediting bodies and interested stakeholders to add an institutional focus on physician wellbeing as an accreditation standard for hospitals, focusing on system-wide interventions that do not add additional burden to physicians.
2. Our AMA will work with hospitals and other stakeholders to determine areas of focus on physician wellbeing, to include the removal of intrusive questions regarding physician physical or mental health or related treatments on initial or renewal hospital credentialing applications.

Physician and Medical Student Burnout D-310.968

1. Our American Medical Association recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to:
    a) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight.
    b) develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.

Fair Reimbursement for Administrative Burdens D-320.978

1. Our American Medical Association will 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. Our AMA will 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. Our AMA will oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services.

4. Our AMA will advocate for fair reimbursement of established and future CPT codes for administrative burdens related to:
    a. the prior authorization process.
    b. appeals or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials.

Administrative Simplification in the Physician Practice D-190.974

1. Our American Medical Association strongly encourages vendors to increase the functionality of their practice management systems to allow physicians to send and receive electronic standard transactions directly to payers and completely automate their claims management revenue cycle and will continue to strongly encourage payers and their vendors to work with the AMA and the Federation to streamline the prior authorization process.
2. Our AMA will continue its strong leadership role in automating, standardizing and simplifying all administrative actions required for transactions between payers and providers.
3. Our AMA will continue its strong leadership role in automating, standardizing, and simplifying the claims revenue cycle for physicians in all specialties and modes of practice with all their trading partners, including, but not limited to, public and private payers, vendors, and clearinghouses.
4. Our AMA will prioritize efforts to automate, standardize and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care, especially for patients in high-deductible health plans.
5. Our AMA will continue to use its strong leadership role to support state and specialty society initiatives to simplify administrative functions.
6. Our AMA will continue its efforts to ensure that physicians are aware of the value of automating their claims cycle.

Administrative Costs and Access to Health Care H-155.976

Our American Medical Association supports accurate calculations of the **administrative** costs of government programs (Medicare, Medicaid, TRICARE, etc.) and private health insurance plans. It is the policy of the AMA:

(1) to begin immediately to seek comprehensive reforms to reduce the **administrative** inefficiencies, burdens and expenses involved in paying for health care services and to urge that proposals to increase access to health care also address the need to reduce **administrative** costs and burdens;

(2) that state and county medical societies and national medical specialty societies be urged to utilize the joint Guidelines for Health Benefits Administration in discussions with health care payers directed toward improving the efficiency of utilization management programs and minimizing the **administrative** burdens they impose on physicians and hospitals;

(3) that the AMA strongly encourage further study of the cost-effectiveness of all types of utilization management systems and programs and report further results of such study to the Federation as they become available;

(4) that state medical societies be urged to work for enactment of the AMA model state legislation governing: (a) clarity and readability of contract language and uniform policy provisions; (b) liability of review entities for injury to beneficiaries; (c) physician involvement in the review process; and (d) confidentiality of medical information requested by review entities; and

(5) that this information be conveyed to the American public through appropriate mechanisms.

Refinement of Medicare Physician Payment System H-400.990

1. Our American Medical Association reaffirms its support for development and implementation of a Medicare indemnity **payment** schedule according to the policies established in Policy 400.991.

2. Our AMA supports reasonable attempts to remedy geographic Medicare physician **payment** inequities that do not substantially interfere with the AMA's support for an RBRVS-based indemnity **payment** system.
3. Our AMA supports continued efforts to ensure that implementation of an RBRVS-based Medicare **payment** schedule occurs upon the expansion, correction, and refinement of the Harvard RBRVS study and data as called for in Board Report AA (I-88), and upon AMA review and approval of the relevant proposed enabling legislation.
4. Our AMA continues to oppose any effort to link the acceptance of an RBRVS with any proposal that is counter to AMA policy, such as expenditure targets or mandatory assignment.

Reducing MIPS Reporting Burden D-395.999
Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to advocate for improvements to Merit-Based Incentive Payment System (MIPS) that have significant input from practicing physicians and reduce regulatory and paperwork burdens on physicians. In the interim, our AMA will work with CMS to shorten the yearly MIPS data reporting period from one-year to a minimum of 90-days (of the physician's choosing) within the calendar year.

Prior Authorization and Utilization Management Reform H-320.939
1. Our American Medical Association 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.

Physician Payment Reform H-390.849
1. Our American Medical Association will advocate for the development and adoption of physician **payment** reforms that adhere to the following principles:
    a. Promote improved patient access to high-quality, cost-effective care.
    b. Be designed with input from the physician community.
    c. Ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions.
    d. Not require budget neutrality within Medicare Part B.
    e. Be based on **payment** rates that are sufficient to cover the full cost of sustainable medical practice.
    f. Ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process.
    g. Make participation options available for varying practice sizes, patient mixes, specialties, and locales.
    h. Use adequate risk adjustment methodologies.
    i. Incorporate incentives large enough to merit additional investments by physicians.
    j. Provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols.
    k. Provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization.
    l. Attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary.

m. Include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.

2. Our AMA opposes bundling of payments in ways that limit medically necessary care, including institutional post-acute care, or otherwise interfere with a physician's ability to provide high quality care to patients.
3. Our AMA supports **payment** methodologies that redistribute Medicare payments among providers based on outcomes (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, reliable, and consistent with national medical specialty society- developed clinical guidelines/standards.
4. Our AMA will continue to monitor health care delivery and physician **payment** reform activities and provide resources to help physicians understand and participate in these initiatives.
5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

Unfunded Mandates H-270.962
Our AMA vigorously opposes any unfunded mandates on physicians.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 803
(I-24)

Introduced by: New England

Subject: Healthcare Savings Account Reform

Referred to: Reference Committee J

Whereas, individually owned retirements savings plans that grow tax free, e.g. 401k, 403b, and IRAs, have assisted and encouraged financial security in retirement[1]; and

Whereas, individually owned educational savings plans that grow tax free, i.e. 529 plans, have assisted and encouraged people to save for educational expenses[2]; and

Whereas, many people would be able and willing to put money into an account dedicated to healthcare expenses in anticipation of healthcare expenses when they are unable to work; and

Whereas, contributions to healthcare savings accounts (HSAs) could start in childhood with contributions from others; and

Whereas, HSAs could be used as a bridge to cover healthcare expenses when people are between jobs, thereby decreasing limits on job mobility due to gaps in healthcare insurance coverage; and

Whereas, HSAs contributions from direct donations and HSA transfers could be used by a community to assist those most in need, while ensuring that the funds are used exclusively for healthcare needs; and

Whereas, HSAs could be redirected to others in a will or estate plan to ensure that the funds are used only for healthcare needs by the recipient; and

Whereas, allowing people more control over their healthcare dollar could facilitate meaningful healthcare system improvement; therefore be it

RESOLVED, that our American Medical Association advocate for revision of Health Savings Accounts to:

1. Permit contributions from family members, employers, or other designated individuals, not limiting contributions to only those on high deductible health insurance plans;
2. Permit contributions to the accounts of dependents, including children and spouses;
3. Permit contributions from Medicare and Medicaid enrollees;
4. Permit the payment of health, dental, and vision insurance premiums from Health Savings Accounts;
5. Permit the money spent by an employer on health insurance to be directed, in part, into an employee HSA, at the employee's discretion;
6. Prioritize permitting the transfer of funds between HSAs, including between spouses and family members; and
7. Ensure that the expansion of the role and functions of Health Savings Accounts is complementary to, and does not replace, health insurance. (Modify Current HOD Policy)

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

Received: 9/19/2024

REFERENCES

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RELEVANT AMA POLICY

Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans D-165.954
Our AMA will:
(1) educate physicians about health insurance plan practices that may impact physician billing and collection of payment from patients with health savings accounts (HSAs), health reimbursement arrangements (HRAs), and other forms of consumer-driven health care; and
(2) monitor and support rigorous research on the impact of HSAs and HRAs on physician practices, and on levels and appropriateness of utilization, including preventive care, costs, and account savings.

Health Savings Accounts for Older Americans D-165.962
Our AMA will monitor pending regulations and take appropriate steps to ensure access to Health Savings Accounts by all Medicare eligible individuals.

Flexible Spending Accounts (FSAs) H-165.863
1. Along with other efforts to liberalize the Health Savings Account rules, our AMA places a top priority on allowing employees to roll-over any unexpended funds in a Flexible Spending Account into a Health Savings Account.
2. Our AMA will advocate for a reasonable increase in Section 125 Flex Spending accounts.

Health Savings Accounts H-165.852
It is the policy of the AMA that:
(1) high-deductible health insurance plans issued to families in conjunction with Health Savings Accounts (HSAs) be allowed to apply lower, per-person deductibles to individual family members with the permitted levels for per-person deductibles being the same as permitted levels for individual deductibles, and with the annual HSA account contribution limit being determined by the full family deductible or the dollar-limit for family policies;
(2) contributions to HSAs should be allowed to continue to be tax deductible until legislation is enacted to replace the present exclusion from employees' taxable income of employer-provided health expense coverage with tax credits for individuals and families;
(3) advocacy of HSAs continues to be incorporated prominently in its campaign for health insurance market reform;
(4) activities to educate patients about the advantages and opportunities of HSAs be enhanced;
(5) efforts by companies to develop, package, and market innovative products built around HSAs continue to be monitored and encouraged;
(6) HSAs continue to be promoted and offered to AMA physicians through its own medical insurance programs; and
(7) legislation promoting the establishment and use of HSAs and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, be strongly supported as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance.

Health Savings Accounts in the Medicaid Program H-290.972
It is the policy of our AMA that states offering Medicaid beneficiaries Health Savings Accounts (HSAs) should adhere to the following principles:

A. Make beneficiary participation voluntary;
B. Provide first-dollar coverage of preventive services regardless of whether the beneficiary has met the deductible;
C. Offer positive incentives to reward healthy behavior and offset beneficiary cost-sharing, provided that such incentives do not result in punitive cuts in standard benefits or increased cost-sharing to enrollees who are unable to achieve improvements in personal behavior affecting their health;
D. Set deductibles at 100% of account contributions, but no higher;
E. Allow payments to non-Medicaid providers by beneficiaries to count toward deductibles and out-of-pocket spending limits;
F. Allow the deductible limits for families to be the lower of either the individual or family combined deductible;
G. Ensure that enrollees are protected by standard Medicaid maximum out-of-pocket spending limits;
H. Provide outreach, information, and decision-support that is readily accessible through a variety of formats (e.g., written, telephone, online), and in multiple languages;
I. Encourage HSA enrollees to establish a medical home, in order to assure provision of preventive care services, coordination of care and continuity of care;
J. Prohibit use of HSA funds for non-medical purposes, but consider allowing HSA balances of enrollees who lose Medicaid coverage to be used to purchase private insurance, including the employee share of premium for employer-sponsored coverage;
K. Monitor the impact on utilization and beneficiary financial burden;
L. Test broadening of eligibility to include currently ineligible beneficiary groups; and
M. Ensure that physicians and other providers of health care services have access to up-to-date information verifying beneficiary enrollment and covered benefits, and are paid at point-of-service, or are allowed to use their standard billing procedures to obtain payment from the insurer or account custodian.

Health Insurance Affordability H-165.828
7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.

Direct Primary Care H-385.912
1. Our AMA supports:
(a) inclusion of Direct Primary Care as a qualified medical expense by the Internal Revenue Service; and
(b) efforts to ensure that patients in Direct Primary Care practices have access to specialty care, including efforts to oppose payer policies that prevent referrals to in-network specialists.
2. AMA policy is that the use of a health savings account (HSA) to access direct primary care providers and/or to receive care from a direct primary care medical home constitutes a bona fide medical expense, and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for direct primary care and direct primary care medical home models as a qualified medical expense.
3. Our AMA will seek federal legislation or regulation, as necessary, to amend appropriate sections of the IRS code to specify that direct primary care access or direct primary care medical homes are not health “plans” and that the use of HSA funds to pay for direct primary care provider services in such settings constitutes a qualified medical expense, enabling patients to use HSAs to help pay for Direct Primary Care and to enter DPC periodic-fee agreements without IRS interference or penalty.

Principles for Structuring a Health Insurance Tax Credit H-165.865
(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 not afford the monthly out-of-pocket premium costs.

Aligning Clinical and Financial Incentives for High-Value Care D-185.979
1. Our American Medical Association supports Value-Based Insurance Design (VBID) plans designed in accordance with the tenets of “clinical nuance,” recognizing that
a. medical services may differ in the amount of health produced.
b. the clinical benefit derived from a specific service depends on the person receiving it, as well as when, where, and by whom the service is provided.
...
7. Our AMA supports legislative and regulatory flexibility to accommodate VBID that
a. preserves health plan coverage without patient cost-sharing for evidence-based preventive services.
b. allows innovations that expand access to affordable care, including changes needed to allow High Deductible Health Plans paired with Health Savings Accounts to provide pre-deductible coverage for preventive and chronic care management services.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 804
(I-24)

Introduced by: New England

Subject: Improving Public Assistance for People with Disabilities

Referred to: Reference Committee J

Whereas, Supplemental Security Income (SSI) helps meet basic needs for 7.5 million low-income people, 85% of whom have severe disabilities[1,2]; and

Whereas, SSI's asset limit has not been updated since 1989 and under current inflation now reflects 20% of its original 1972 value[4-5];

Whereas, SSI's asset limit is $2000 for individuals but $3000 for couples (only 50% more) unfairly creating a "marriage penalty"[4]; and

Whereas, similarly, SSI's monthly pre-tax income cutoff is $1971 for individuals but $2915 for couples (only 47% more), and monthly benefits are $841 for individuals but $1261 for couples (only 50% more), extending the "marriage penalty" across the program[3-7]; and

Whereas, 45% of couples with SSI are in poverty, compared to only 9.8% for individuals[7]; and

Whereas, the SSI Savings Penalty Elimination Act would adjust asset limits for inflation and eliminate the marriage penalty, increasing program costs by only 1% over 10 years[8-10]; and

Whereas, SSI eligibility often automatically makes beneficiaries eligible for Medicaid, even in non-expansion states, improving access to care for patients with disabilities[11]; therefore be it

RESOLVED, that our American Medical Association support appropriate increased asset limits, income cutoffs, and benefits that are indexed to increase at least by inflation for public assistance programs such as Supplemental Security Income (SSI) (New HOD Policy); and be it further

RESOLVED, that our AMA support eliminating the marriage penalty for SSI benefits, such that married couples do not receive fewer benefits or have more restrictive eligibility requirements than they would have as individuals. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/19/2024

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RELEVANT AMA POLICY

SSI Benefits for Children with Disabilities H-90.986
The AMA will use all appropriate means to inform members about national outreach efforts to find and refer children who may qualify for Supplemental Security Income benefits to the Social Security Administration and promote and publicize the new rules for determining disability. [Res. 420, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13; Reaffirmed: CMS Rep. 01, A-23]

Increase Employment Services Funding for People with Disabilities H-90.964
Our AMA supports increased resources for employment services to reduce health disparities for people with disabilities. [Res. 406, A-23]

Medicaid Expansion D-290.979
(1) Our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133% (138% FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded.
(2) Our AMA will: (a) continue to advocate strongly for expansion of the Medicaid program to all states and reaffirm existing policies D-290.979, H 290.965 and H-165.823; and (b) work with interested state medical associations and national medical specialty societies to provide AMA resources on Medicaid expansion and covering the uninsured to health care professionals to inform the public of the importance of expanded health insurance coverage to all. [Res. 809, I-12; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: CMS Rep. 9, A-21; Reaffirmed: CMS Rep. 3, I-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21; Appended: Res. 122, A-22]

Recognizing Child Poverty and the Racial Wealth Gap as Public Health Issues and Extending the Child Tax Credit for Families in Need D-60.965
(1) Our AMA recognizes: (1) child poverty as a public health issue and a crucial social determinant of health across the life course; and (2) that the disproportionate concentration of child poverty and generational wealth gaps experienced by Black, American Indian or Alaska Native, and Hispanic families are a consequence of structural racism and a barrier to achieving racial health equity.
(2) Our AMA will advocate for fully refundable, expanded child tax credit and other evidence-based cash assistance programs to alleviate child poverty, ameliorate the racial wealth gap, and advance health equity for families in need. [Res. 247, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 805
(I-24)

Introduced by: Women Physicians Section

Subject: Coverage for Care for Sexual Assault Survivors

Referred to: Reference Committee J

Whereas, one in five women in the United States report having been raped at some time in their life, yet only 20% of these women will seek medical care, often in emergency departments[1,2]; and

Whereas, the Violence Against Women Act of 1994 prohibits charging patients for the cost of evidence collection as part of a medical forensic exam, yet patients are often charged for treatment of their physical injuries, post-exposure prophylaxis treatment and testing for sexually transmitted disease (STIs), counseling, and emergency contraception[3,4]; and

Whereas, in 2019, almost 18,000 sexual assault survivors who sought care in emergency departments were charged $3,673 on average, and survivors who were abused during pregnancy were charged $4,553 on average[5]; and

Whereas, privately-insured sexual assault survivors pay 14% of emergency department costs, averaging $497 out-of-pocket[5,6]; and

Whereas, medical costs particularly burden low-income women and girls, who are disproportionately sexual assault survivors, and fear of high costs deters survivors from seeking care in emergency departments[7-9]; and

Whereas, many survivors of sexual assault endure short and long term sequelae requiring care and therapeutic services, which are not currently covered by the Violence Against Women Act and may impose significant financial hardship on survivors[10,11]; and

Whereas, survivors of sexual assault and intimate partner violence who seek mental health counseling pay 32-36% of costs out of pocket on average[12]; and

Whereas, under the Illinois law, The Sexual Assault Survivors Emergency Treatment Act (SASETA), sexual assault survivors who are not covered by private insurance or Medicaid may not be billed directly for costs of services or any out-of-pocket expenses, and healthcare providers are reimbursed for services provided to uninsured and underinsured patients[13,14]; and

Whereas, all 50 states have Crime Victim Compensation (CVC) programs that directly reimburse certain eligible sexual assault survivors[15,16]; therefore be it

RESOLVED, that our American Medical Association amend policy H-80.999 “Sexual Assault Survivors” by addition as follows:

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing and prevention, drug testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.
3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.
4. Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.
5. Our AMA will advocate at the state and federal level for (a) the timely processing of all sexual examination kits upon patient consent; (b) timely processing of "backlogged" sexual assault examination kits with patient consent; and (c) additional funding to facilitate the timely testing of sexual assault evidence kits.
6. Our AMA supports the implementation of a national database of Sexual Assault Nurse Examiner and Sexual Assault Forensic Examiner providers (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA advocate for federal and state efforts to reduce financial barriers that limit sexual assault survivors' ability to seek physical and mental health care and social services after sexual assault. (Directive to Take Action)

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

Submitted: 09/19/2024

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RELEVANT AMA POLICY

Sexual Assault Survivors H-80.999

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.
3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.
4. Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.
5. Our AMA will advocate at the state and federal level for (a) the timely processing of all sexual examination kits upon patient consent; (b) timely processing of "backlogged" sexual assault examination kits with patient consent; and (c) additional funding to facilitate the timely testing of sexual assault evidence kits.
6. Our AMA supports the implementation of a national database of Sexual Assault Nurse Examiner and Sexual Assault Forensic Examiner providers.

[Sub. Res. 101, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: Res. 202, I-17; Appended: Res. 902, I-18; Appended: Res. 210, A-22; Modified: Res. 211, A-23]

HIV, Sexual Assault, and Violence H-20.900
Our AMA: (1) believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all survivors of sexual assault who present within 72 hours of a substantial exposure risk, that these survivors should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained; and (2) supports: (a) education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines, and (b) increased access to, and coverage for, PEP for HIV, as well as enhanced public education on its effective use. [CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13; Modified: Res. 905, I-18]

Access to Emergency Contraception H-75.985
It is the policy of our AMA: (1) that physicians and other health care professionals should be encouraged to play a more active role in providing education about emergency contraception, including access and informed consent issues, by discussing it as part of routine family planning and contraceptive counseling; (2) to enhance efforts to expand access to emergency contraception, including making emergency contraception pills more readily available through pharmacies, hospitals, clinics, emergency rooms, acute care centers, and physicians' offices; (3) to recognize that information about emergency contraception is part of the comprehensive information to be provided as part of the emergency treatment of sexual assault victims; (4) to support educational programs for physicians and patients regarding treatment options for the emergency treatment of sexual assault victims, including information about emergency contraception; and (5) to encourage writing advance prescriptions for these pills as requested by their patients until the pills are available over-the-counter. [CMS Rep. 1, I-00; Appended: Res. 408, A-02; Modified: Res. 443, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Modified: CSAPH Rep. 01, A-24]

Addressing Sexual Violence and Improving American Indian and Alaska Native Women's Health Outcomes D-350.985
(1) Our AMA advocates for mitigation of the critical issues of American Indian/Alaska Native women's health that place Native women at increased risk for sexual violence, and encourages allocation of sufficient resources to the clinics serving this population to facilitate health care delivery commensurate with the current epidemic of violence against Native women. (2) Our AMA will collaborate with the Indian Health Service, Centers for Disease Control and Prevention (CDC), Tribal authorities, community organizations, and other interested stakeholders to develop programs to educate physicians and other health care professionals about the legal and cultural contexts of their American Indian and Alaska Native female patients as well as the current epidemic of violence against Native women and the pursuant medical needs of this population. (3) Our AMA will collaborate with the Indian Health Service, CDC, Tribal authorities, and community organizations to obtain or develop appropriate American Indian and Alaska Native women's health materials for distribution to patients in the spirit of self-determination to improve responses to sexual violence and overall health outcomes. [Res. 208, I-15]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 807
(I-24)

Introduced by: Louisiana

Subject: Expanded Pluralism in Medicaid

Referred to: Reference Committee J

Whereas, Medicaid beneficiaries have very limited choice of plan design; and

Whereas, Medicaid beneficiaries have little or no opportunity to directly benefit from utilizing our healthcare system in a more cost-effective way; and

Whereas, the typical Medicaid beneficiary has limited or no ability to create generational wealth; therefore be it

RESOLVED, that our American Medical Association suggest Medicaid reform that introduces more pluralism for Medicaid beneficiaries (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for inclusion of choices of plan that allow Medicaid beneficiaries to directly benefit financially from using our healthcare system in a more cost-effective way (Directive to Take Action); and be it further

RESOLVED, that our AMA investigate whether the Health Savings Account (HSA) model could be adapted as one option in an expanded pluralistic system that would enable Medicaid beneficiaries to directly benefit from utilizing the healthcare system in a more cost-effective manner and, in doing so, offer Medicaid beneficiaries an opportunity to create generational wealth. (Directive to Take Action)

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

Received: 9/23/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 808
(I-24)

Introduced by: Mississippi

Subject: Requirement to Communicate Covered Alternatives for Denied Medications

Referred to: Reference Committee J

Whereas, healthcare is a vital component of wellbeing; and

Whereas, the healthcare system is increasingly complicated, expensive, and difficult for the average adult to navigate in their favor; and

Whereas, health insurance is, for most Americans currently, necessary to access standard of care treatment and prevention for acute and chronic diseases; and

Whereas, health insurance costs and coverage options vary greatly, even within the same company; and

Whereas**,** medication formularies greatly influence which medications can be accessed by patients; and

Whereas**,** medication formularies change at various times of the year for each patient and those changes are unpredictable for the physician or the patient; and

Whereas**,** the harm to patients caused by these changes are not simply or consistently remedied; therefore be it

RESOLVED, that our American Medical Association advocate that Medicare, Medicaid, and all other insurers provide covered alternatives to the patient and the patient's prescribing physician at the time that coverage for a medication is denied. (Directive to Take Action)

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

Received: 9/23/2024

RELEVANT AMA POLICY

Private Health Insurance Formulary Transparency H-125.979

1. Our American Medical Association 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.
    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.
    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.

Value-Based Management of Drug Formularies H-110.979

Our AMA: (1) will advocate that pharmacy benefit managers (PBMs) and health plans use a transparent process in formulary development and administration, and include practicing network physicians from the appropriate medical specialty when making determinations regarding formulary inclusion or placement for a particular drug class; (2) will advocate that any refunds or rebates received by a health plan or PBM from a pharmaceutical manufacturer under an outcomes-based contract be shared with impacted patients; and (3) opposes indication-based formularies in order to protect the ability of patients to access and afford the prescription drugs they need, and physicians to make the best prescribing decisions for their patients.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 809
(I-24)

Introduced by: Mississippi

Subject: Minimum Requirements for Medication Formularies

Referred to: Reference Committee J

Whereas, healthcare is a vital component of wellbeing; and

Whereas, the healthcare system is increasingly complicated, expensive, and difficult for the average adult to navigate in their favor; and

Whereas, health insurance is assumed by most patients to offer them the lowest price point for a given product or service; and

Whereas, health insurance costs and coverage options vary greatly, even within the same company, and certainly across companies; and

Whereas, many generic medications are inexpensive when paid for with cash or via a non-manufacturer's discount card (like GoodRx); and

Whereas, health insurers commonly request prior authorizations or outright deny coverage for many inexpensive generic medications; and

Whereas, this practice causes harm to patients and physicians by decreasing access to low cost generic medications and increasing administrative burden and physician burnout; and

Whereas, this practice imposes unnecessary costs and burdens to the healthcare system; therefore be it

RESOLVED, that our American Medical Association advocate that Medicare, Medicaid, and all other insurers create, maintain, and enforce a minimum formulary for all beneficiaries, regardless of their specific plan, that includes all commonly prescribed, inexpensive, generic medications unless there are reasonable safety or economic concerns regarding the medication. (Directive to Take Action)

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

Received: 9/23/2024

RELEVANT AMA POLICY

Private Health Insurance Formulary Transparency H-125.979

1. Our American Medical Association 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.
    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.
    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.

Value-Based Management of Drug Formularies H-110.979

Our AMA: (1) will advocate that pharmacy benefit managers (PBMs) and health plans use a transparent process in formulary development and administration, and include practicing network physicians from the appropriate medical specialty when making determinations regarding formulary inclusion or placement for a particular drug class; (2) will advocate that any refunds or rebates received by a health plan or PBM from a pharmaceutical manufacturer under an outcomes-based contract be shared with impacted patients; and (3) opposes indication-based formularies in order to protect the ability of patients to access and afford the prescription drugs they need, and physicians to make the best prescribing decisions for their patients.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 810
(I-24)

Introduced by: Mississippi

Subject: Immediate Digital Access to Updated Medication Formulary for Patients and Their Physicians

Referred to: Reference Committee J

Whereas, there is wide variation in the compilation of medication formularies among health insurance companies; and

Whereas, medication formularies among health insurance companies change on a regular basis; and

Whereas, there are often multiple appropriate drugs within a medication class from which a physician may choose to prescribe to a patient; and

Whereas, physicians often prescribe one medication to a patient only to find out at a later time that the medication was not taken due to a lack of coverage which contributes to poor outcomes as well as a delay in treatment; and

Whereas, once the lack of medication coverage is discovered, there is often no information easily accessible to inform the physician, the physician's staff, or the patient what medication (if any) has preferred coverage by the insurance company; therefore be it

RESOLVED, that our American Medical Association advocate for the Centers for Medicare & Medicaid Services to provide (or cause their associated carriers to provide) a hyperlink (such as a QR code) to a digital, well-organized, and searchable formulary located on the insured's insurance card to all Medicare patients in such a manner that the patient can easily share and discuss covered medications with their prescribing physician during office appointments or other encounters. (Directive To Take Action)

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

Received: 9/23/2024

RELEVANT AMA POLICY

Private Health Insurance Formulary Transparency H-125.979

1. Our American Medical Association 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.
    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.
    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.

Value-Based Management of Drug Formularies H-110.979
Our AMA: (1) will advocate that pharmacy benefit managers (PBMs) and health plans use a transparent process in formulary development and administration, and include practicing network physicians from the appropriate medical specialty when making determinations regarding formulary inclusion or placement for a particular drug class; (2) will advocate that any refunds or rebates received by a health plan or PBM from a pharmaceutical manufacturer under an outcomes-based contract be shared with impacted patients; and (3) opposes indication-based formularies in order to protect the ability of patients to access and afford the prescription drugs they need, and physicians to make the best prescribing decisions for their patients.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 811
(I-24)

Introduced by: Iowa

Subject: AMA Practice Expense Survey Geographic Analysis

Referred to: Reference Committee J

Whereas, the American Medical Association (AMA) has sponsored a new physician practice expense survey to update the Medical Economic Index and Resource Based Relative Value Scale, representing 250,000 physicians (including sites of service), because the last national Physician Practice Information (PPI) survey was in 2006-2007– and the latest PPI survey was reportedly finished in June 2024; and

Whereas, AMA leadership has shown that over the last 23 years, physician practice expenses have grown 54% and with medical inflation increasing, the net result has been a 30% drop in Centers for Medicare and Medicaid Services (CMS) physician payment; and

Whereas, the AMA analyzed the 2006-2007 PPI survey in 2009 and found no differences in non-metro (rural and micropolitan) vs. metro locations, or other geographic differences (except for slightly lower expenses in the North East) in physician practice expenses (published as "Policy Research Perspectives"*); and

Whereas, AMA leadership has emphasized the shortage of physicians in rural America is contributing to significant health inequities in rural America; and

Whereas, rural Americans' health disparities are significant and unacceptable, with mortality rates 23% higher, and preventable hospitalizations 40% higher—across all racial and age groups; and

Whereas, the percent of physicians who practice in rural areas is about 10%, despite 20% of Americans living in rural America; and

Whereas, health care research (Johnston et al**) has shown that the biggest reason for worse rural mortality and preventable hospitalization rates is the shortage in "local-area supply of specialists, which explained 55% of the differences in hospitalization rates and 40% of the difference in mortality rates"; and

Whereas, another research group (Probst et al***) wrote that "rural health disparities are due in part to declining healthcare provider availability and accessibility in rural communities" and "these problems are exacerbated by structural urbanism"... a bias which "systematically shortchanges rural areas"... They also suggested that "current models of health care funding... are innately biased in favor of large populations" and "Until this bias is recognized, the development of viable models of care across the rural-urban continuum cannot move forward"; and

Whereas, rural and many geographic regions have been systematically subjected since 1992 to arbitrary estimates of practice expenses [that used incongruous data from various sources such

as U.S. Department of Housing and Urban Development (HUD) apartment rents, American Community Survey (ACS), Bureau of Labor Statistics (BLS), Occupational Employment and Wage Statistics (OES), Bureau of Labor Statistics Online (BLSO), Occupational Employment and Wage Statistics Online (OEWS), and 1990 or 2000 census data] and therefore have resulted in chronic large downward adjustments in their Medicare payments, called Geographic Practice Cost Indexes (GPCIs); and

Whereas, GPCIs were developed by the Urban Institute in 1992, and these Medicare payment adjustments have never been accurately determined from national practice expense surveys, despite many expense surveys including the 2009 AMA analysis of the PPI survey that showed no difference in rural vs urban or geographic physician practice expenses; and

Whereas, the Medicare GPCI adjustments result in as much as 25-30% lower Evaluation and Management (E&M) and 50-60% lower imaging and lab diagnostic testing fees for service in rural vs. metro areas despite the lack of evidence of a significant difference in physician practice expenses; therefore be it

RESOLVED, that our American Medical Association formally recognize that systemic bias in healthcare financing called “Structural Urbanism”, has been a factor in leading to rural health disparities (New HOD Policy); and be it further

RESOLVED, that our AMA in advocating for health equity for all Americans, point out that Medicare payment policies have played a role in the shortage of rural physicians and the poorer health outcomes in rural America (Directive to Take Action); and be it further

RESOLVED, that our AMA review the results from its 2023-2024 Physician Practice Information Survey to determine whether the data can be used to estimate differences in physician practice expenses across practice geography (e.g., urban vs. rural, or region) (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the Centers for Medicare and Medicaid Services use evidence rather than bias to determine if Geographic Practice Cost Indexes should continue to adjust physician payment regionally. (Directive to Take Action)

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

Received: 9/23/2024

REFERENCES

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2. **Johnston K, Wen H, Maddox KEJ. Lack of Access to Specialists Associated with Mortality and Preventable Hospitalizations of Rural Medicare Beneficiaries. Health Aff (Millwood) 2019; 38(12): 1993-2002
3. ***Probst J, Eberth JM, Crouch E. Structural Urbanism Contributes to Poorer Health Outcomes for Rural America. Health Aff (Millwood) 2019; 38(12): 1976-1984

RELEVANT AMA POLICY

Transparency, Participation, and Accountability in CMS' Payment Determination Process D-400.984

1. Our American Medical Association will urgently advocate for the Centers for Medicare and Medicaid Services (CMS) to improve its rate-setting processes by first publishing modifications to Medicare physician fees that result from CMS' misvalued codes initiative in the Medicare Physician Fee Schedule proposed rule instead of the final rule to afford adequate time for providers, professional medical societies and other stakeholders to review and comment on such changes before they take effect.
2. Our AMA will demand that CMS be transparent in its processes and methodologies for establishing physician work values and allow adequate opportunity for public comment on its methodologies before changes in physician work values take effect.

Geographic Practice Cost Index D-400.985
Our American Medical Association will provide annual updates on the Centers for Medicare and Medicaid Services efforts to improve the accuracy of Medicare Economic Index weights and geographic adjustments and their impact on the physician payment schedule, and AMA advocacy efforts on these issues.

Update Practice Expense Component of Relative Value Units D-406.992
Our American Medical Association will conduct a pilot study to determine the best mechanism for gathering physician practice expense data, including the feasibility of fielding a new physician practice expense survey, and work with the Centers for Medicare & Medicaid Services (CMS) to update the resource-based relative value practice expense methodology.

Enhancing Rural Physician Practices H-465.981
1. Our American Medical Association supports legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' Health Professional Shortage Area (HPSA) status.
2. Our AMA encourages federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements.
3. Our AMA will explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result.
4. Our AMA supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders.
5. Our AMA will undertake a study of structural urbanism, federal payment polices, and the impact on rural workforce disparities.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 812
(I-24)

Introduced by: Michigan, American Academy of Physical Medicine and Rehabilitation, American Academy of Orthopaedic Surgeons

Subject: Advocate for Therapy Cap Exception Process

Referred to: Reference Committee J

Whereas, the current annual incidence of spinal cord injuries in the United States is estimated to be 54 per million, which translates to 17,800 new injuries per year; and

Whereas, the current annual incidence of stroke in the United States is 795,000; and

Whereas, the current annual incidence of brain injury in the United States is 2.8 million; and

Whereas, outcomes following neurologic and orthopedic injuries improve with appropriate physical rehabilitation; and

Whereas, arbitrary therapy caps restrict access to care regardless of an individual's medical history or complex medical conditions; and

Whereas, patients often ration or forgo care as they near the cap to avoid exhausting their benefits, which often results in the need for higher-cost interventions in the future to remain functional, and

Whereas, AMA policy D-330.941, "Medicare Outpatient Therapy Caps," takes a position against Medicare Outpatient Therapy Caps; and

Whereas, in 2018, Section 50202 of the Bipartisan Budget Act of 2018 repealed application of Medicare's "hard" outpatient therapy caps, and instead retained the cap amounts as annual thresholds with an exception process for patients that require additional visits to reach their full potential; and

Whereas, this process allows for the thresholds to be exceeded when claims are appended with the KX modifier for medically necessary services as justified by appropriate documentation in the medical record; and

Whereas, virtually all commercial health plans continue to impose arbitrary therapy caps without an exception process; therefore be it

RESOLVED, that our American Medical Association actively advocate for all health plans with therapy caps or thresholds to include an exception process. This process should, at a minimum, follow the Medicare standard for therapy cap exceptions, ensuring that patients can access the necessary services to restore functional abilities and enhance quality of life. (Directive to Take Action)

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

Received: 9/23/2024

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RELEVANT AMA POLICY

Medicare Outpatient Therapy Caps D-330.941
Our American Medical Association will not support medicare outpatient rehabilitation therapy caps.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 813
(I-24)

Introduced by: American Academy of Physical Medicine & Rehabilitation, American Association of Neuromuscular & Electrodiagnostic Medicine, Association of Academic Physiatrists

Subject: Insurance Coverage for Pediatric Positioning Chairs

Referred to: Reference Committee J

Whereas, children with cerebral palsy, traumatic brain injury (TBI) and other neuromuscular conditions that affect sitting balance and ambulation, require the support of a custom wheelchair for sitting upright due to weakness of the trunk muscles, spasticity, and poor balance; and

Whereas, adaptive seating systems may be associated with gains in body function including oro-motor skills, vocalization, improvement in seating posture, activity and participation; and

Whereas, many payors refuse to pay for children to have both a custom wheelchair for use for mobility outside of the home and a positioning chair for use inside the home; and

Whereas, due to lack of funding, children who need support sitting for daily activities including feeding and play, have only a wheelchair to use in the home; and

Whereas, without a positioning chair, the same wheelchair that is used in the home and in the community, is the only option that can be used in the home for any upright positioning and for feeding; and

Whereas, depending on the home environment, for some families there is an extra burden of care moving the wheelchair in/out of a small home or apartment or upstairs for a second or third floor apartment; and

Whereas, the wheelchair is a relatively large footprint item that has to "fit" in the home setting, which is challenging in small areas; and

Whereas, the size of the wheelchair is also not conducive to inclusion of the child at the family table or in family activities in the home; and

Whereas, many families find the burden of care such that they forego using the wheelchair in the home and therefore prop the child poorly on a couch and forego all the advantages that proper trunk and body support offers; and

Whereas, thankfully, most people don't have to be relegated to a singular seat/chair all day; therefore be it

RESOLVED, that our American Medical Association advocate that private and public insurance companies pay for a physician prescribed positioning chair for children who need support for sitting for daily activities in the home, in addition to the wheelchair that the patient uses for all mobility in the home and community. (Directive to Take Action)

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

Received: 9/23/2024

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RELEVANT AMA POLICY

D-330.907 Our AMA strongly encourages the Centers for Medicare and Medicaid Services (CMS) to refrain from implementing policies on January 1, 2016 that would curtail access to complex rehabilitation technology (CRT) wheelchairs and accessories by applying competitively bid prices to these specialized devices. In the event that CMS does not refrain from implementing policies limiting access to CRT wheelchairs, our AMA will encourage Congress to support legislation (e.g. H.R. 3229) that would provide a technical correction to federal law to clarify that CMS cannot apply Medicare competitive bidding pricing to CRT wheelchairs.

H-185.91 Our American Medical Association supports health insurance coverage to eliminate barriers for patients to obtain wheelchair repair; ensure that repairs and services are safe, affordable, timely, and support mobility and independence for those who utilize power and manual wheelchairs; eliminate unnecessary paperwork and prior authorization requirements for basic repairs, including proof of continuous need; cover temporary rental of a substitute wheelchair when repairs require the primary wheelchair to be taken out of the home; and would include preventive maintenance and transporting the wheelchair between the patient’s home and the repair facility.

Our AMA will identify procedures for obtaining changes to Medicare and other payers’ current policies on repairing wheelchairs.

Our AMA supports suppliers of power and manual wheelchairs providing preventive maintenance and repair services for wheelchairs they supply to patients and permits consumers to perform self-repairs as permitted by the manufacturer and when it does not void the warranty.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 814
(I-24)

Introduced by: American Association of Clinical Urologists

Subject: Legislation for Physician Payment for Prior Authorization

Referred to: Reference Committee J

Whereas, policy H-385.951 Remuneration for Physician Services supports that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work; and

Whereas, nearly 15 percent of all claims submitted to private payers for reimbursement are initially denied, including many that were pre-approved to move forward through the prior authorization process; and

Whereas, over half (54.3%) of denials by private payers were ultimately overturned and the claims paid, but only after multiple, costly rounds of provider appeals; and

Whereas, the average cost incurred by providers fighting denials is $43.84 per claim – meaning that providers spend $19.7 billion a year just to adjudicate with payers; therefore be it

RESOLVED, that our American Medical Association initiates prior authorization legislation aimed at Medicare Advantage plans, state Medicaid programs as well as commercial payers, via model legislation, that allows for fair reimbursement for physician's time and that of their office staff when dealing with prior authorization. (Directive to Take Action)

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

Received: 9/24/2024

REFERENCES

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RELEVANT AMA POLICY

H-385.951 Remuneration for Physician Services

1. Our American Medical Association actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.

2. It is our AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.
[Sub. Res. 814, A-96; Reaffirmation A-02; Reaffirmation I-08; Reaffirmation I-09 Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmation A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14; Reaffirmed: Res. 811, I-19; Reaffirmation: A-22; Reaffirmed: BOT Rep. 30, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 815
(I-24)

Introduced by: Society of Critical Care Medicine, American Academy of Pediatrics

Subject: Addressing the Crisis of Pediatric Hospital Closures and Impact on Care

Referred to: Reference Committee J

Whereas, there has been a concerning trend of pediatric hospital and unit closures across the United States, with inpatient pediatric units decreasing by 19.1% from 2008 to 2018, leading to reduced access to pediatric care, especially in rural areas[1,2]; and

Whereas, financial pressures, including low Medicaid reimbursement rates that vary by state, are putting many pediatric hospitals and units in financial distress, leading to consolidation and closures[3,4]; and

Whereas, the closure of pediatric units and hospitals has resulted in increased distances to care for nearly a quarter of U.S. children, potentially delaying critical care and worsening health outcomes[5]; and

Whereas, the consolidation of pediatric care into fewer, larger centers may improve care for some specialized conditions but can also create access barriers, increase costs, and disrupt established patient-provider relationships[6]; and

Whereas, the COVID-19 pandemic has exacerbated financial pressures on hospitals and highlighted the need for maintained pediatric inpatient and critical care capacity[7]; and

Whereas, the American Hospital Association has not taken a strong public stance on this critical issue affecting children's health care access; therefore be it

RESOLVED, that our American Medical Association recognize the closure of pediatric hospitals and units as a critical threat to children's health care access and quality (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for federal and state policies to support the financial viability and access to pediatric care delivery organizations, particularly inpatient care units (Directive to Take Action); and be it further

RESOLVED, that our AMA work with relevant organizations, for example the American Academy of Pediatrics, American Hospital Association, Children’s Hospital Association, and National Rural Health Association, to study the current and future projected impact of pediatric hospital and unit closures on health outcomes, access to care, and health disparities (Directive to Take Action); and be it further

RESOLVED, that our AMA build a national coalition with the American Hospital Association and other like-minded organizations to increase awareness on the issue of pediatric hospital closures and to develop strategies to preserve access to high-quality pediatric inpatient and critical care. (Directive to Take Action)

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

Received: 9/24/2024

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RELEVANT AMA POLICY

Expanding AMA Payment Reform Work and Advocacy to Medicaid and Other Non-Medicare Payment Models for Pediatric Health Care and Specialty Populations (H-385.901)

1. Our American Medical Association supports appropriate demonstration projects, carve outs, and adjustments for pediatric patients and services provided to pediatric patients within the payment reform arena.
2. Our AMA will extend ongoing payment reform research, education, and advocacy to address the needs of specialties and patient populations not served by current CMMI models or other Medicare-focused payment reform efforts.
3. Our AMA will support and work with national medical specialty societies that are developing alternative payment models for specific conditions or episodes, target patient populations including pediatric populations, and medical and surgical specialties and continue to advocate that the Centers for Medicare and Medicaid Services, including the Center for Medicare and Medicaid Innovation; state Medicaid agencies; and other payers implement physician-developed payment models.
4. Our AMA will consider improved Medicaid payment rates to be a priority given the critical impact these payment rates have on patient care and patient access to care.
5. Our AMA will support and collaborate with state and national medical specialty societies and other interested parties on the development and adoption of physician-developed alternative payment models for pediatric health care that address the distinct prevention and health needs of children and take long-term, life-course impact into account. *Policy Timeline | Res. 817, I-23*

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 817
(I-24)

Introduced by: Minority Affairs Section

Subject: ACA Subsidies for Undocumented Immigrants

Referred to: Reference Committee J

Whereas, the uninsurance rate among undocumented immigrants is approximately 50% compared to 7.7% for U.S. residents, meaning that approximately 5 million undocumented immigrants are uninsured, which can lead to decreased access to care and poorer health outcomes[1-5]; and

Whereas, expanding health insurance coverage to undocumented immigrants improves access to care and health outcomes[6,7]; and

Whereas, undocumented immigrants may file federal taxes through the use of an Individual Taxpayer Identification Number (ITIN), but are not eligible for a Social Security Number, meaning that undocumented immigrants collectively pay billions into the tax system[8,9]; and

Whereas, the reporting of income to the federal government through ITINs may render undocumented immigrants ineligible for means-tested insurance programs like Medicaid based on their income, even if their state permits undocumented immigrants to enroll in Medicaid[1,10,11]; and

Whereas, undocumented immigrants are currently prohibited from purchasing insurance through the Affordable Care Act (ACA) marketplaces and are ineligible for premium tax credit and cost-sharing reduction subsidies[12-15]; and

Whereas, in order to fully realize the benefits of extending eligibility to purchase plans on the ACA marketplaces, undocumented immigrants would also need to be made eligible to receive premium tax credits and cost-sharing reductions, but are currently prohibited from receiving these subsidies[12]; and

Whereas, states including Colorado and Washington have implemented programs to provide state subsidies for undocumented immigrants to purchase health insurance on state exchanges, leading to 11,000 immigrants enrolling in subsidized coverage in Colorado in 2024[16]; and

Whereas, pending state and federal legislation would expand ACA premium tax credit and cost sharing reduction eligibility to undocumented immigrants, in addition to allowing them to purchase coverage through ACA marketplaces[17, 18]; and

Whereas, the American Medical Association “advocates for the removal of eligibility criteria based on immigration status from Medicaid and CHIP” (D-440.911) and should similarly support removing this criteria for premium tax credits and cost-sharing reductions; therefore be it

RESOLVED, that our American Medical Association support federal and state efforts to provide subsidies for undocumented immigrants to purchase health insurance, including by extending

eligibility for premium tax credits and cost-sharing reductions to purchase Affordable Care Act (ACA) plans. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/24/2024

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18. S.2646 - HEAL for Immigrant Families Act of 2023. Congress.Gov. July 27, 2023. https://www.congress.gov/bill/118th-congress/senate-bill/2226.

RELEVANT AMA POLICY

Options to Maximize Coverage under the AMA Proposal for Reform H-165.823

1. That our AMA advocate for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians.
2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.

c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
e. The public option is financially self-sustaining and has uniform solvency requirements.
f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
g. The public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.
3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:
a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage.
c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.
4. Our AMA: (a) will advocate that any federal approach to cover uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status. [CMS Rep. 1, I-20; Appended: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22; Reaffirmed: Res. 122, A-22; Modified: Res. 813, I-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 818
(I-24)

Introduced by: New York

Subject: Payment for pre-certified/preauthorized procedures

Referred to: Reference Committee J

Whereas, many insurers require pre-certification/preauthorization for diagnostic and surgical procedures; and

Whereas, many insurers require extensive pre-approval/preauthorization documentation submission and approval process, and have ample opportunities to consider and request additional documentation to decide on approval or denial of the pre-certification request; and

Whereas, Current Procedural Terminology (CPT) codes defining the procedures/testing to be performed are routinely required under pre-certification/preauthorization process; and

Whereas, pre-certification/preauthorization process is both time and labor intensive; and

Whereas, certain Gold Card program waiving pre-certification/preauthorization requirement is under consideration by the NY State legislature; and

Whereas, insurers not infrequently deny payments for such pre-certified/preauthorized procedures; and

Whereas, such pre-certification/preauthorization process and post-procedure claim denial cause significant administrative burden on physician practice; therefore be it

RESOLVED, that our American Medical Association support the position that the practice of retrospective denial of payment for care which has been pre-certified by an insurer should be banned, except when false or fraudulent information has knowingly been given to the insurer by the physician, hospital or ancillary service provider to obtain pre-certification (New HOD Policy); and be it further

RESOLVED, that our AMA continue to advocate for legislation, regulation, or other appropriate means to ensure that all health plans including those regulated by ERISA, pay for services that are pre-authorized, or pre-certified by such health plan, including services that are deemed pre-authorized or pre-certified because the physician participates in a “Gold Card” program operated by that health plan. (Directive to Take Action)

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

Received: 9/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 819
(I-24)

Introduced by: Society for Cardiovascular Angiography and Interventions; Outpatient Endovascular and Interventional Society; the American College of Radiation Oncology

Subject: Establishing a New Office-Based Facility Setting to Pay Separately from the Medicare Physician Fee Schedule for the Technical Reimbursement of Physician Services Using High-Cost Supplies.

Referred to: Reference Committee J

Whereas, Medicare Physician Fee Schedule (MPFS) reimbursement cuts have become so severe for certain non-facility services that, in 2024, 195 non-facility services are paid at rates less than the direct costs associated with those procedures, according to data from the Centers for Medicare and Medicaid Services (CMS)[1]; and

Whereas, in the 2025 PFS Proposed Rule, the number of non-facility services paid less than direct costs will grow to 300, a 50% increase[2]; and

Whereas, because these data do not account for other costs, including indirect costs and physician work, the number of services under the MPFS for which reimbursement does not even cover cost likely is much higher than 300 services; and

Whereas, non-facility services are increasingly unsustainable under the MPFS, which is a catalyst for (1) private practice closure[3], (2) site-of-service reimbursement disparities[4], (3) higher Medicare spending and beneficiary coinsurance as services migrate to high-cost sites of service[5], (4) reduced rural access to important specialty care services[6]; and

Whereas, non-facility services are critical to the MPFS (1) as a lowest cost option to Medicare beneficiaries[7], (2) for rural access where ambulatory surgical centers are not typically present[8], and (3) as an option during pandemics so hospitals can focus on the most vulnerable patients; and

Whereas, the migration of non-facility care to higher cost settings results in higher Medicare spending, higher Medicare beneficiary coinsurance, and reduced access to care[9]; and

Whereas, in many states, certificate of need laws and cost considerations are a barrier to ambulatory surgical centers, thus making hospitals the only site-of-service option outside of a non-facility setting[10]; and

Whereas, office-based services under the MPFS for which reimbursement does not cover cost predominantly utilize high-cost supplies and equipment; and

Whereas, the decades-long migration of high-cost supplies and equipment from the Hospital Outpatient Prospective Payment System to the PFS has not been accompanied by corresponding funding allocations and has contributed to the dilution of the MPFS; and

Whereas, in 2010, CMS removed high-cost Part B drugs from the PFS in 2010 due to similar concerns relating to the impact on the MPFS[11]; and

Whereas, the AMA RUC has recommended for many years that CMS separately identify and pay for high-cost disposable supplies priced more than $500[12]; and

Whereas, removing high-cost supplies from the PFS would (1) help to address the ongoing closures of non-facility centers, (2) bolster resources available for the PFS, and (3) meaningfully addresses site-of-service reimbursement differences; therefore be it

RESOLVED, that our American Medical Association study options to reform the Medicare Physician Fee Schedule by (1) removing high-cost supplies from the Medicare Physician Fee Schedule by establishing a new office-based facility setting to pay separately for the technical reimbursement of physician services using high-cost supplies (2) removing high-cost radiation therapy equipment from the Medicare Physician Fee Schedule by establishing a new case rate model for radiation oncology. (Directive to Take Action)

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

Received: 9/24/2024

REFERENCES

1. Data is based on 2024 Physician Fee Schedule Final Rule Total Non-Facility Reimbursement and Total Direct Costs
2. Data is based on 2025 Physician Fee Schedule Proposed Rule Total Non-Facility Reimbursement and Total Direct Costs
3. American Medical Association, Carol Kane, PhD, Recent Changes in Physicain Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022
4. Medicare Payment Advisory Commission, June 2024 Report to the Congress: Medicare and the Health Care Delivery System, 13 June 2024 Report
5. Ibid
6. Medicare Payment Advisory Commission, Ambulatory surgical center services: Status report, 11 January 2024
7. Medicare Payment Advisory Commission, June 2024 Report to the Congress: Medicare and the Health Care Delivery System, 13 June 2024 Report
8. Medicare Payment Advisory Commission, Ambulatory surgical center services: Status report, 11 January 2024
9. Medicare Payment Advisory Commission, March 2020 Report to the Congress: Medicare Payment Policy, 13 March 2020
10. National Conference of State Legislatures, Certificate of Need State Laws, 26 February 2024
11. CY 2010 PFS Proposed and Final Rules. 74 FR 33650 and 74 FR 61965
12. American Medical Association, February 2024 Recommendations

RELEVANT AMA POLICY

H-330.925 Appropriate Payment Level Differences by Place and Type of Service
Our AMA (1) encourages CMS to adopt policy and establish mechanisms to fairly reimburse physicians for office-based procedures; (2) encourages CMS to adopt a site neutral payment policy for hospital outpatient departments and ambulatory surgical centers; (3) advocates for the use of valid and reliable data in the development of any payment methodology for the provision of ambulatory services; (4) advocates that in place of the Consumer Price Index for all Urban Consumers (CPI-U), CMS use the hospital market basket index to annually update ambulatory surgical center payment rates; (5) encourages the use of CPT codes across all sites-of-service as the only acceptable approach to payment methodology; and (6) will join other interested organizations and lobby for any needed changes in existing and proposed regulations affecting payment for ambulatory surgical centers to assure a fair rate of reimbursement for ambulatory surgery. [Sub. Res. 104, A-98Reaffirmation I-98Appended: CMS Rep. 7, A-99Reaffirmation A-00Reaffirmation I-03Reaffirmation A-11Reaffirmed: CMS Rep. 3, A-13Reaffirmed: Sub. Res. 104, A-14Reaffirmed: Res. 116, A-14Modified: CMS Rep. 3, A-14Reaffirmation A-14 Reaffirmation A-15Reaffirmation: I-17]

D-330.902 The Site-of-Service Differential

1. Our American Medical Association supports Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments.

2. Our AMA supports Medicare payments for the same service routinely and safely provided in multiple outpatient settings (eg, physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting.

3. Our AMA will urge CMS to update the data used to calculate the practice expense component of the Medicare physician fee schedule by administering a physician practice survey (similar to the Physician Practice Information Survey administered in 2007-2008) every five years, and that this survey collect data to ensure that all physician practice costs are captured.

4. Our AMA encourages CMS to both:
a. Base disproportionate share hospital payments and uncompensated care payments to hospitals on actual uncompensated care data.
b. Study the costs to independent physician practices of providing uncompensated care.

5. Our AMA will collect data and conduct research both:
a. to document the role that physicians have played in reducing Medicare spending.
b. to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery.

6. Our AMA will produce a graphic report illustrating the fiscal losses and inequities that practices without facility fees have endured for decades as a result of the site of service differential factoring in inflation.

7. Our AMA will consider disseminating the resulting educational materials and graphics.
[CMS Rep. 04, I-18Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19Appended: Res. 826, I-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 820
(I-24)

Introduced by: American Thoracic Society

Subject: State Medicaid Coverage of Home Sleep Testing

Referred to: Reference Committee J

Whereas, sleep disordered breathing, most commonly obstructive sleep apnea, is a chronic health concern for millions of Americans; and

Whereas, there are effective interventions to treat patients with sleep disordered breathing that reduces risk of death and cardiopulmonary disease while improving overall well-being, alertness and reductions in daytime fatigue; and

Whereas, home-based sleep testing is an effective and inexpensive way to detect sleep disordered breathing in patients suspected of sleep disordered breathing; and

Whereas, prior to the development of home testing, patients were required to undergo facility-based polysomnography to confirm the diagnosis of sleep disordered breathing; and

Whereas, facility base polysomnography is effective, it added costs and inconvenience for patients seeking to confirm a diagnosis of sleep disordered breathing; and

Whereas. Medicare has covered home sleep apnea testing for several years; and

Whereas, very few state Medicaid programs have allowed home sleep testing for sleep apnea and instead require facility-based polysomnography to confirm the diagnosis of sleep disordered breathing; and

Whereas, the requirement of facility-based polysomnography is a barrier to care for many Medicaid beneficiaries, leading to undertreatment of sleep disordered breathing in the Medicare population; therefore be it

RESOLVED, that our American Medical Association support efforts to expand access to and insurance coverage of home sleep testing, including for Medicaid beneficiaries, for the purpose of identifying sleep apnea and related sleep conditions. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Late Resolution: 821
(I-24)

Introduced by: American Thoracic Society
American Academy of Allergy Asthma and Immunology

Subject: Patient Access to Asthma Medications

Referred to: Reference Committee J

Whereas, for children with asthma, inhaled corticosteroids (ICS) are an essential intervention to help patients control their asthma

Whereas, for young children, inhaled corticosteroids in metered dose inhaler (MDI) format, with a spacer and mask, are the most effective way to deliver inhaled asthma medications; and

Whereas, in the US there are a limited number of FDA approved inhaled corticosteroids in MDI formulation on the market; and

Whereas, fluticasone HFA is currently the most widely used ICS to treat pediatric asthma; and

Whereas, the transition of fluticasone HFA from a branded product to a generic product has caused significant disruption in Medicaid coverage for fluticasone HFA with some states having no ICS in MDI formulation on the preferred drug list while other states only cover ICS in MDI formulation with prior authorization; and

Whereas, the disruption in Medicare beneficiary access to appropriate asthma medication has led to anecdotal reports of avoidable asthma exacerbations and significant frustration for patients and physicians; and

Whereas, pulmonary and allergy medical professional societies have contacted state Medicaid programs to urge changes in Medicaid coverage policy to ensure appropriate access to a least one ICS in MDI formulation for young patients with asthma; therefore be it

RESOLVED, that our American Medical Association supports efforts to ensure access to and insurance coverage, including Medicaid coverage, for metered-dose inhaler formulations for children and others who require it for optimal medication administration. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 822
(I-24)

Introduced by: Renal Physicians Association

Subject: Resolution on Medicare Coverage for Non-Emergent Dialysis Transport

Referred to: Reference Committee J

Whereas, access to dialysis is critical for patients with end-stage renal disease (ESRD), ensuring they receive life-saving treatments multiple times a week[11]; and

Whereas, studies have shown that barriers to transportation are a determinant of healthcare access and patient outcomes[10]; and

Whereas, non-emergent medical transportation (NEMT) is essential for many dialysis patients who are unable to transport themselves due to medical or financial constraints[8]; and

Whereas, according to the United States Department of Transportation, 66% of rural Americans live in an area where there is no access to public transportation, or public transportation is negligible[4]; and

Whereas, many dialysis patients are elderly or have comorbid conditions that limit their ability to use public or personal transportation[6]; and

Whereas, at least 22% of missed dialysis appointments can be attributed to lack of transportation[9]; and

Whereas, 84% of nephrology social workers state that patients' dialysis treatments are not completed due to public transportation, and 72% of nephrology social workers state that patients miss dialysis completely due to unreliability of public transportation[4]; and

Whereas, when dialysis access was compared across countries, shortened or missed dialysis treatments as a result of transportation disproportionately impacted patients in the United States4; and

Whereas, shortened or missed dialysis appointments as a result of transportation disproportionately impacted minority populations in the United States[4]; and

Whereas, reliable transportation to dialysis treatments is crucial for maintaining patients' health and preventing complications associated with missed dialysis sessions[4]; and

Whereas, emergency dialysis services cost the health system nearly $72,000 more per person annually than scheduled dialysis appointments[5]; and

Whereas, non-emergent dialysis transport can reduce the burden on emergency medical services and emergency departments by preventing avoidable crisis[1]; and

Whereas, the Centers for Medicare & Medicaid Services (CMS) currently does not cover non-emergent dialysis transport under Medicare[3]; and

Whereas, over 80% of Americans living with ESRD are enrolled in Medicare[6]; and

Whereas, Providing Medicare coverage for non-emergent dialysis transport can reduce healthcare costs by preventing missed dialysis sessions and subsequent hospitalizations, and alleviate the burden on primary care providers by eliminating unnecessary paperwork for ambulance transfers[1,7]; and

Whereas, ensuring access to regular dialysis treatments through adequate transportation can improve the quality of life and support better long-term health outcomes for ESRD patients[2]; and

Whereas, non-emergent dialysis transport coverage could align with broader efforts promote health equity[4]; therefore be it

RESOLVED, that our American Medical Association advocate for Medicare coverage of non-emergent medical transportation specifically for patients requiring dialysis treatment (Directive to Take Action); and be it further

RESOLVED, that our AMA partner with Center for Medicare and Medicaid Services (CMS) to develop policies to ensure financial assistance for non-emergent medical transportation for dialysis treatments and to transplant centers for kidney transplant evaluation and related care for Medicare beneficiaries. (Directive to Take Action)

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

Received: 9/24/2024

References:

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9. Transportation Issues and Their Impact upon In-Center Hemodialysis. National Kidney Foundation. https://www.kidney.org/sites/default/files/v23_a6.pdf

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 823
(I-24)

Introduced by: Louisiana

Subject: Reigning in Medicare Advantage - Institutional Special Needs Plans

Referred to: Reference Committee J

Whereas, addressing the many issues plaguing Medicare Advantage plans is one of the top advocacy priorities for the AMA; and

Whereas, to date these advocacy efforts have been contained, for the most part, to traditional Medicare Advantage plans; and

Whereas, Institutional Special Needs Plans or I-SNPs were designed as a subset of traditional Medicare Advantage plans to serve the ever-growing frail, disabled, and chronically ill population within a nursing facility; and

Whereas, federal regulations within the Centers for Medicare and Medicaid (CMS) provide little to no oversight over I-SNPs, allowing nursing facilities to own and operate their own I-SNPs; and

Whereas, when an I-SNP is owned by the nursing facility, there is an inherent conflict of interest because the plan, acting as an insurer, can deny coverage for care, even care within its own skilled nursing facility; and

Whereas, these I-SNPs typically utilize nurse practitioners to manage their patient populations, even when the patients already have a primary care physician who has no relationship with the ISNP nor a collaborative practice agreement with the ISNP nurse practitioner; and

Whereas, these conflicts of interest, and lack of physician participation or supervision, place our most vulnerable elderly patients at risk based on health care decisions being made for profits over outcomes, and/or without physician involvement; therefore be it

RESOLVED, that our American Medical Association add I-SNPs to its advocacy efforts related to Medicare Advantage plans (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for increased policies, rules, and general oversight over I-SNPs (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for an overall ban on facility-owned I-SNPs. (Directive to Take Action)

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

Received: 9/23/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 824
(I-24)

Introduced by: American Academy of Ophthalmology

Subject: Ophthalmologists Required to Be Available for Level I & II Trauma Centers

Referred to: Reference Committee J

Whereas, the Level of Hospital Trauma Centers (I – V) are designated at the State and Local Levels but are verified by the American College; and

Whereas, Level I & II require coverage by medical and surgical specialists where Ophthalmology is not specifically listed; and

Whereas, the Level of Hospital Trauma Centers (I -V) are designated at the State and Local Levels but are verified by the American College of Surgeons; and

Whereas, Level I & II require coverage by medical and surgical specialists where Ophthalmology is not specifically listed; and

Whereas, the second largest University Hospital in New Jersey which is a Level I Trauma Center is permitting optometrists to take first call in the ER; and

Whereas, optometrists do not have the education or training to care for severe ocular or periocular trauma; and

Whereas, designation of a Level Trauma Center identifies that Hospital as the place that treats severe trauma including eye trauma; and

Whereas, having optometrists providing first call in a designated Trauma Center creates a huge advocacy problem for our Scope of Practice Partnership, preventing optometric surgery; therefore be it

RESOLVED, that our American Medical Association work with the American College of Surgeons and the American Trauma Society to specifically name Ophthalmology as a requirement for Level I & II Trauma Centers (Directive to Take Action); and be it further

RESOLVED, that our AMA work with the American College of Surgeons and the American Trauma Society to ensure that during the verification process it has to be insisted that there is availability of Ophthalmology Trauma coverage. (Directive to Take Action)

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

Received: 9/24/2024