AMERICAN MEDICAL ASSOCIATION ORGANIZED MEDICAL STAFF SECTION

Resolution: 6
(I-24)

Introduced by: Daniel Gold, MD, and Matthew D. Gold, MD

Subject: Transparency of Facility Fees for Hospital Outpatient Department Visits

Referred to: OMSS Reference Committee
(xxxx, MD, Chair)

Whereas, transparency in healthcare costs is essential for empowering patients to make informed decisions regarding their medical care; and

Whereas, many patients are often unaware of the additional costs associated with services rendered at hospital outpatient department designated clinics, particularly regarding facility fees that can significantly impact their overall financial responsibility; and

Whereas, the lack of clarity around facility fees and professional service charges contributes to surprise billing and financial hardship for consumers, undermining trust in the healthcare system; and

Whereas, the current lack of transparency causes a burden on hospital employed physicians who are then asked to justify to their patients the higher cost of care; and

Whereas, the American Medical Association has a long-standing commitment to advocating for fair and transparent healthcare practices that prioritize patient welfare; therefore be it

RESOLVED, that our American Medical Association advocate for legislation or regulation that mandates the proactive transparency of the added costs to the consumer for health care services rendered at hospital outpatient department designated clinics (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate the additional costs of facility fees over professional services be states upon scheduling of such services, noting the two are separate and additive charges, as well as prominently displayed at the point of service (Directive to Take Action).

Fiscal Note: (Assigned by HOD)

Received: 9/23/2024

RELEVANT AMA POLICY

Price Transparency D-155.987

1. Our American Medical Association encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.

2. Our AMA advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.

3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.

4. Our AMA will work with states and the federal government to support and strengthen the development of all-payer claims databases.

5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.

6. Our AMA encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving.

7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.

Citation: CMS Rep. 4, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed in lieu of: Res 213, I-17; Reaffirmed: BOT Rep. 14, A-18; Reaffirmed in lieu of: Res. 112, A-19

Addressing Financial Incentives to Shop for Lower-Cost Health Care H-185.920

1. Our AMA supports the following continuity of care principles for any financial incentive program (FIP):
a. Collaborate with the physician community in the development and implementation of patient incentives.
b. Collaborate with the physician community to identify high-value referral options based on both quality and cost of care.
c. Provide treating physicians with access to patients' FIP benefits information in real-time during patient consultations, allowing patients and physicians to work together to select appropriate referral options.
d. Inform referring and/or primary care physicians when their patients have selected an FIP service prior to the provision of that service.
e. Provide referring and/or primary care physicians with the full record of the service encounter.
f. Never interfere with a patient-physician relationship (eg, by proactively suggesting health care items or services that may or may not become part of a future care plan).

g. Inform patients that only treating physicians can determine whether a lower-cost care option is medically appropriate in their case and encourage patients to consult with their physicians prior to making changes to established care plans.

2. Our AMA supports the following quality and cost principles for any FIP:
a. Remind patients that they can receive care from the physician or facility of their choice consistent with their health plan benefits.
b. Provide publicly available information regarding the metrics used to identify, and quality scores associated with, lower and higher-cost health care items, services, physicians and facilities.
c. Provide patients and physicians with the quality scores associated with both lower and higher-cost physicians and facilities, as well as information regarding the methods used to determine quality scores. Differences in cost due to specialty or sub-specialty focus should be explicitly stated and clearly explained if data is made public.
d. Respond within a reasonable timeframe to inquiries of whether the physician is among the preferred lower-cost physicians; the physician's quality scores and those of lower-cost physicians; and directions for how to appeal exclusion from lists of preferred lower-cost physicians.
e. Provide a process through which patients and physicians can report unsatisfactory care experiences when referred to lower-cost physicians or facilities. The reporting process should be easily accessible by patients and physicians participating in the program.
f. Provide meaningful transparency of prices and vendors.
g. Inform patients of the health plan cost-sharing and any financial incentives associated with receiving care from FIP-preferred, other in-network, and out-of-network physicians and facilities.
h. Inform patients that pursuing lower-cost and/or incentivized care, including FIP incentives, may require them to undertake some burden, such as traveling to a lower-cost site of service or complying with a more complex dosing regimen for lower-cost prescription drugs.
i. Methods of cost attribution to a physician or facility must be transparent, and the assumptions underlying cost attributions must be publicly available if cost is a factor used to stratify physicians or facilities.

3. Our AMA supports requiring health insurers to indemnify patients for any additional medical expenses resulting from needed services following inadequate FIP-recommended services.

4. Our AMA opposes FIPs that effectively limit patient choice by making alternatives other than the FIP-preferred choice so expensive, onerous and inconvenient that patients effectively must choose the FIP choice.

5. Our AMA encourages state medical associations and national medical specialty societies to apply these principles in seeking opportunities to collaborate in the design and implementation of FIPs, with the goal of empowering physicians and patients to make high-value referral choices.

6. Our AMA encourages objective studies of the impact of FIPs that include data collection on dimensions such as:
a. Patient outcomes/the quality of care provided with shopped services;
b. Patient utilization of shopped services;
c. Patient satisfaction with care for shopped services;
d. Patient choice of health care provider;
e. Impact on physician administrative burden; and

f. Overall/systemic impact on health care costs and care fragmentation.

Citation: CMS Rep. 2, I-19

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.

Citation: Sub. Res. 724, A-14; Appended: Res. 701, A-16; Appended: Alt. Res. 806, I-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: BOT Rep. 20, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 2, A-21; Reaffirmed: CMS Rep. 06, A-24