

REFERENCE COMMITTEE G (Medical Practice)
SUMMARY REPORT FOR THE NEW ENGLAND DELEGATION
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Please list two questions for the Candidate Interviews based on the topics represented within your reference committee.

1. Given the emphasis on transparency of costs by the current administration, the effects it has had on hospital charge lists, and our policy on medication pricing, how will the AMA address the same with insurance products purchased by employers to help reduce the economic burden of high deductible and co-pay plans to the employees?

CONSENT CALENDAR FOR APPROVAL

- BOT 1 3** **Employed Physician Bill of Rights and Basic Practice Professional Standards**
 This report recommends adoption of new policy addressing themes not previously included in the Employed Physician Bill of Rights. These include academic freedom to pursue clinical research and other academic pursuits; as well as providing sufficient administrative and clinical support for appropriate patient care.
- BOT 1 5** **Physician Burnout and Wellness Challenges; Physician and Physician Assistant Safety Net; Identification and Reduction of Physician Demoralization**
 This report discusses the efforts that the AMA has undertaken to provide solutions and presents recommendations to existing HOD policy on the issue of Physician Burnout and Wellness Challenges. Please see p. 10 -11 for recommendations and policy changes.
- BOT 3 1** **Non-Payment and Audit Takebacks by CMS**
 Resolution 704-A-18 called for our AMA to “seek through legislation and/or regulation” - Need flexibility in addressing this issue and not be limited to those, but also seek reform through sub-regulatory guidance and other payer policies. Already have strong existing policy regarding the opposing of claim nonpayment for inadvertent, unintentional, or clerical errors, and already working to reduce administrative burden through regulatory relief efforts involving them (the other requests in original resolution). Recommendation in lieu of 704-A-18: That our AMA advocate to oppose claim nonpayment, extrapolation of overpayments, and bundled payment denials based on minor wording or clinically insignificant documentation inconsistencies.
- BOT 3 2** **Impact of High Capital Costs of Hospital EHRs on the Medical Staff**
 At A-18, D-225.974, “Impact of the High Capital Cost of Hospital EHRs on the Medical Staff,” asked the AMA to study the long-term economic impact for physicians and hospitals of EHR system procurement. This report provides the requested study of documented examples of economic and financial impacts of procuring electronic health record systems. Costs can include financial, productivity, workforce/personnel, and clinician and patient satisfaction. These impacts, and the long-term economic and financial costs, are not widely studied or discussed, and generalizations are limited by the variation in practice characteristics. Evidence points to the benefit of fully engaging and optimizing the EHR in order to realize full ROI. With this study, the directive in D-225.974 has been fulfilled.
- CMS Report 0 1** **Council on Medical Service Sunset Review of 2009 AMA House Policies**
 Summary of policies reviewed and allowed to sunset, or be retained as is or amended based on superseded policies.

CMS Report 0 7**Hospital Consolidation**

This CMS report reviews AMA policy on hospital consolidations, their potential impact on physicians and patients and recommends policy and process priorities. Pages 8-9 provide a summary of recommendations including new and reaffirmed HOD policies.

CMS Report 0 8**Group Purchasing Organizations and Pharmacy Benefit Manager Safe Harbor**

This CMS report the potential effects of repealing the 1987 Safe Harbor exemption for Group Purchasing Organizations and Pharmacy Benefit Managers. Conclusion is that, as things currently stand, repeal could create widespread disruption of the supply chain urges instead greater transparency and accountability efforts as well as supporting efforts to update relevant laws and regulations and their impact on drug pricing and shortages.

CMS Report 1 1**Corporate Investors**

This report describes physician practice consolidation with corporate investors, including private equity investment in physician practices with examples; discusses the corporate practice of medicine, risks and benefits, legal issues; summarizes relevant AMA policy. Recommendations include reaffirmation of policies related to AMA being involved and helping guide the corporate practice of medicine and its effects, physicians' right to enter contracts, though being aware of conflicts of interest and primary responsibility to patient. New policy offers 9 guidelines to physicians contemplating corporate investor partnerships. AMA supports improved transparency in subsequent changes in health care prices and encourages medical specialty societies to research and develop tools on the impact on patients and physicians in that specialty. Worth a read for anyone considering such a practice.

701(DE)**Coding for Prior Authorization Obstacles**

This resolution calls for establishing ICD codes that cover and describe the Prior Authorization process to reduce delay in testing and treatment which can act as obstacles to patient health and well-being.

706 (WI)**Hospital Falls and "Never Events" - A Need for More in Depth Study**

This resolution seeks to study whether health care setting falls that results in a serious injury or death should be removed from a list of "Never Events" effecting reimbursement or accreditation. And to study the merits of recommending it as a pay-for-performance measure. Suspect that the fiscal note will be greater than the \$5,000 mentioned. Suspect that funding more PT and OT to facilitate patient mobility is the better approach. Some of the references are more viewpoints and opinions and concepts quoted like "keeping score" and "driving in fear" are not supported by multiple quality studies. Also the same authors keep appearing in the bibliography. Suggest listening for unintended consequences of support.

707 (IL)**Cost of Unpaid Patient Deductibles on Physician Staff Time**

This resolution advocates for legislation that terminates the practice of insurance plans that make it the physician's responsibility to recoup patient out-of-pocket costs and deductible expenses due to the contractual relationship created by the insurance company. Despite no provided references suggest support as a good start in the effort.

708# (Ger. Psych/APA) Access to Psychiatric Treatment in Long Term Care

This resolution seeks to support advocacy for the support of psychotropic medications and their use in long term care facilities and to discontinue their use in Nursing Home Compare rankings when used appropriately in the mentally ill. Some policy exists already such as D-120.951 that addresses the last resolve and H-280.963 that addresses resolves 1 and 3. Suspect that the reaffirmation of these policies will be included in the Committee's report.

712# (Critical Care Med) Promotion of Early Recognition and Treatment of Sepsis by Out-of-Hospital Healthcare Providers to Save Lives

That AMA collaborate with interested medical orgs such as CDC and the Society of Critical Care Medicine to promote the importance of early detection and expedited intervention of sepsis by healthcare providers who work in outpatient settings. Sounds good as we're not carrying the whole burden and it's not mandated, though is this reaffirmation?

713* (Rheum, Ophtho, Endo, Onc) Selective Application of Prior Authorization

That AMA support policies such that prior auth requirements will not be applied to items or services ordered by physicians whose prescribing or ordering practices align with an evidence-based guideline established or approved by a national professional medical association; or who meet quality criteria; or whose orders or prescriptions are routinely approved; or who adhere to a high quality clinical care pathway; or who participate in an alternative payment model or care delivery model that aims to improve health care quality. Seeing this with some specialties (oncology) and negotiated contracts with health systems – anything that reduces the burden would be welcome

716* (TX)

Health Plan Claim Auditing Programs

That our AMA oppose exclusive use of software or other methodologies, without review of the medical record, to determine payment/denial of a claim based solely on the CPT codes, ICD-10 codes, and modifiers submitted. That our AMA oppose the exclusive use of the patient's medical claim history, without review of the patient's medical record, as a tool to deny or pay a claim. That our AMA support the use of coding methods that adhere to CPT guidelines, rules, and conventions. At the risk of sounding less than enthusiastic, could do without "vigorously" in each resolved clause. 3rd resolved may be reaffirmation.

RESOLUTIONS FOR DISCUSSION

CMS Report 0 9

Health Plan Payment of Patient Cost-Sharing

Resolution 707-A-18 asked: That our AMA urge health plans and insurers to bear the responsibility of ensuring physicians promptly receive full payment for patient copayments, coinsurance and deductibles. Report's recommendations reaffirm policies to support business freedom of physician practices, continue discussions with insurers on difficulty of collecting copayments, encourage demonstration projects for patients to access partially funded HSAs and educate them on deductibles and cost-sharing. New policy has the AMA support development of IT systems to help physicians and patients better understand financial obligations and encourage states and other stakeholders to monitor HDHPs and other forms of cost-sharing to assess impact on access, outcomes, medical debt, and practice sustainability. While these recommendations may not go as far as some want, they raised the specter of unintended consequences if insurers were to bear the full cost/responsibility, such as losing autonomy for those practices that want to control their own billing practices (ability to write off or give discounts). CSMS is pushing for a task force to look at this issue with HDHPs on a state level. Overall support this report – actively speak to it?

CMS Report 1 0**Alternative Payment Models and Vulnerable Populations**

Resolution 712-A-18 introduced by NE Del asked our AMA study the impact of current advanced APMs and risk adjustment on providers caring for vulnerable populations; and advocate legislatively that advanced APMs examine the evaluation of quality performance (for bonus/incentive payment) of providers caring for vulnerable populations in reference to peer group (similarities in SES, disability, percent of dual eligible population). This report gives an overview of vulnerable populations and the emergence of APMs, highlights APMs and value-based care initiatives incorporating social determinants of health into their models, summarizes relevant AMA policy and advocacy activities. New policies recommended to encourage the development of APMs that serve vulnerable populations while protecting physicians with appropriate risk adjustments from being financially penalized. They seem to capture the desires of the original intent, so if we feel that it supports what we wanted, we should speak to it.

702 (YPS)**Peer Support Groups for Second Victims**

This resolution from the Young Physicians section seeks to encourage institutional, State, and local physician wellness programs to consider developing peer support groups to address second victim phenomenon defined as being a health care provider involved in an unanticipated medical error and/or patient-related injury that results in the sense that they are traumatized by the event. It also seeks to develop a survey of all US physicians, at a cost of \$465,000, to quantify the effects of stress and burnout and its impact on the physician workforce. Some of the goals of this resolution may be met by existing policy H-295.993 and H-295.858 that address facilitating access to counseling services for trainees as well as include resident physicians and medical students in State physician health and wellness programs. Also policy D-310.968 addressing burnout in physicians and medical students.

703 (OMSS)**Preservation of the Patient-Physician Relationship**

This resolution seeks to support a study on identifying perceived barriers, to the patient-physician relationship, by the presence of electronic devices and scribes. Suspect the cost will be greater than the estimated \$5,000. Part of this resolution will help explore the already existing policy D-478.967 seeking to identify important trends in the medical scribe industry. Little policy exists on the effect of electronic devices during the clinical encounter.

704 (DE)**Prior Authorization Reform**

This resolution seeks to advocate exploring emerging technologies that would automate the Prior Authorization process, and evaluate the efficiency and scalability of these technologies, to ensure access and reduce administrative burdens. Suspect the cost will be greater than the estimated \$5,000.

705 (Madejski)**Physician Requirements for Comprehensive Stroke Center Designation**

This resolution advocates for changing the provision by the Joint Commission that establishes significant limitations in the ability of most physicians who specialize in mechanical thrombectomies in acute strokes from performing this service. Time sensitive patient care could then be compromised. Ideally it would be nice if this resolution provided footnotes as to the efficacy comparing mechanical to thrombolytic thrombectomies as well as to ask for funding a study to establish if, and at what point, a volume-outcome relationship exists.

709# (Neurosurgeons) Promoting Accountability in Prior Authorization

Asks that Policy H-320.968 be amended to be more active in seeking draft legislation, that utilization review entity or health plan physicians have the expertise to treat the medical condition or disease they are reviewing. Asks AMA and CEJA to discuss ethical and medicolegal responsibilities of physicians who participate in prior auth processes and medical necessity determinations, asks for report back with guidance. See CEJA Code 11.2.3-Contracts to Deliver Health Care Services. Code 11.1.2, 11.1.3, and 11.2.1 also relevant. Code 11.2.3 may benefit from more explicit exploration of when a physician is directly employed by/has a fiduciary relationship to health insurance company yet making decisions that affect patient care. If a delay in care from prior auth process results in an adverse outcome- who is responsible?

710# (MI)**Council for Affordable Quality Healthcare Attestation**

That AMA work with CAQH and any other relevant organizations to reduce the frequency of required CAQH reporting to 12 months or longer unless the physician has a change in relevant information to be updated. Sounds like a reasonable request to a burdensome process. Possibly advocate for option to reconfirm rather than resubmit in the resolved as well?

711# (OMSS)**Impact on the Medical Staff of the Success or Failure in Generating Savings of Hospital Integrated System ACOs**

Asks the AMA to study how hospital integrated system ACOs' failure to generate savings affects medical staff downsizing and further consolidation of medical practices; and the root causes for failure to generate savings in hospital integrated ACOs compared to physician-owned ACOs, and report back at the 2019 Interim Meeting. Seems like a bit much to address in a short time, unless the data is already out there

714* (Rheum, Ophtho, Endo, Onc) Medicare Advantage Step Therapy

That AMA work with CMS to immediately publish guidance to plans that lays out patient safeguards proposed/finalized in the Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out-of-Pocket Expenses proposed rule so beneficiaries have some protections in 2019, as well as additional clarifying language on exceptions. Provides guidance on principles. If CMS doesn't respond, asks AMA to advance Congressional action to provide patient safeguards in the 2019 plan year. Laudable goal and principles, though specific reference to legislation and short timeframe raise question of how feasible this is. Perhaps better addressed through another mechanism if we pass the principles?

715* (TX)**Managing Patient-Physician Relations Within Medicare Advantage Plans**

That AMA advocate that Medicare Advantage plans allow a PCP to remove assigned patients from their panel if the physician has proven they have been unable to establish a patient-physician relationship, despite multiple documented attempts, and that effectiveness and other quality scores and ratings not be affected by these patients. Can see this being an issue with noncompliant patients, though may need clarification regarding legal ramifications, how much outreach is necessary (phone, letter, visit to home)?

Contained in the Handbook Addendum