AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 815
(I-13)

Introduced by: Georgia

Subject: Vulnerable Patient Access and Protection

Referred to: Reference Committee J
(Dolleen M. Licciardi, Chair)

Whereas, Patients with chronic diseases need primary and specialty care; and

Whereas, Lack of access to physician expertise in complicated diseases leads to patient vulnerability; and

Whereas, Not all physicians, specialists, and sub-specialists have expertise in all diseases; and

Whereas, Lack of access to proper care subjects patients to risk of early disease progression and disability; and

Whereas, The Patient Protection and Affordable Care Act promotes care under health insurance exchanges and accountable care organizations (ACOs); and

Whereas, Exchanges and ACOs have defined care providers and restricted networks; and

Whereas, Exchanges and ACOs may be organized with a list of providers that may not be adequate for certain patient populations without intent to harm; therefore be it

RESOLVED, That our American Medical Association promote access to appropriate care for all patients (New HOD Policy); and be it further

RESOLVED, That our AMA promote special access for vulnerable patients if appropriate care cannot be provided within a patient’s insurance provider network (New HOD Policy); and be it further

RESOLVED, That our AMA oppose any health care delivery model, public or private, that restricts patient access to physicians adequately experienced in their disease. (New HOD Policy)

Fiscal Note: Not yet determined

Received: 10/25/13
RELEVANT AMA POLICY

E-8.13 Managed Care - The expansion of managed care has brought a variety of changes to medicine including new and different reimbursement systems for physicians with complex referral restrictions and benefits packages for patients. Some of these changes have raised concerns that a physician’s ability to practice ethical medicine will be adversely affected by the modifications in the system. In response to these concerns, the following points were developed to provide physicians with general guidelines that will assist them in fulfilling their ethical responsibilities to patients given the changes heralded by managed care. (1) The duty of patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the system of health care delivery. Physicians must continue to place the interests of their patients first. (2) When health care plans place restrictions on the care that physicians in the plan may provide to their patients, physicians should insist that the following principles be followed: (a) Any broad allocation guidelines that restrict care and choices—which go beyond the cost/benefit judgments made by physicians as a part of their normal professional responsibilities—should be established at a policy-making level so that individual physicians are not asked to engage in bedside rationing. (b) Regardless of any allocation guidelines or gatekeeper directives, physicians must advocate for any care they believe will materially benefit their patients. (c) Physicians should be given an active role in contributing their expertise to any allocation process and should advocate for guidelines that are sensitive to differences among patients. Health care plans should create structures similar to hospital medical staffs that allow physicians to have meaningful input into the plan’s development of allocation guidelines. Guidelines for allocating health care should be reviewed on a regular basis and updated to reflect advances in medical knowledge and changes in relative costs. (d) Adequate appellate mechanisms for both patients and physicians should be in place to address disputes regarding medically necessary care. In some circumstances, physicians have an obligation to initiate appeals on behalf of their patients. Cases may arise in which a health plan has an allocation guideline that is generally fair but in particular circumstances results in unfair denials of care, ie, denial of care that, in the physician’s judgment, would materially benefit the patient. In such cases, the physician’s duty as patient advocate requires that the physician challenge the denial and argue for the provision of treatment in the specific case. Cases may also arise when a health plan has an allocation guideline that is generally unfair in its operations. In such cases, the physician’s duty as patient advocate requires not only a challenge to any denials of treatment from the guideline but also advocacy at the health plan’s policy-making level to seek an elimination or modification of the guideline. Physicians should assist patients who wish to seek additional, appropriate care outside the plan when the physician believes the care is in the patient’s best interests. (e) Health care plans must adhere to the requirement of informed consent that patients be given full disclosure of material information. Full disclosure requires that health care plans inform potential subscribers of limitations or restrictions on the benefits package when they are considering entering the plan. (f) Physicians also should continue to promote full disclosure to patients enrolled in health care plans. The physician’s obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patient’s health care plan. Full disclosure includes informing patients of all of their treatment options, even those that may not be covered under the terms of the health care plan. Patients may then determine whether an appeal is appropriate, or whether they wish to seek care outside the plan for treatment alternatives that are not covered. (g) Physicians should not participate in any plan that encourages or requires care below minimum professional standards. (3) When physicians are employed or reimbursed by health care plans that offer financial incentives to limit care, serious potential conflicts are created between the physicians’ personal financial interests and the needs of their patients. Efforts to contain health care costs should not place patient welfare at risk. Thus, physicians should accept only those financial incentives that promote the cost-effective delivery of health care and not the withholding of
medically necessary care. (a) Physicians should insist that any incentives to limit care must be disclosed fully to patients by plan administrators upon enrollment and at least annually thereafter. (b) Physicians should advocate that limits be placed on the magnitude of fee withholds, bonuses, and other financial incentives to limit care and that incentive payments be calculated according to the performance of a sizable group of physicians rather than on an individual basis. (c) Physicians should advocate that health care plans or other groups develop financial incentives based on quality of care. Such incentives should complement those based on the quantity of services used. (4) Physicians should encourage both that patients be aware of the benefits and limitations of their health care coverage and that they exercise their autonomy by public participation in the formulation of benefits packages and by prudent selection of health care coverage that best suits their needs. (I, II, III, V) Issued June 1996 based on the report "Ethical Issues in Managed Care," adopted June 1994 (JAMA. 1995; 273: 330-35); Updated June 2002.

H-465.980 Rural Community Health Networks - AMA policy is that development of rural community health networks be organized using the following principles: (1) Local delivery systems should be organized around the physical, mental and social needs of the community; (2) Clinical decision-making and financial management should reside within the community health network whenever feasible with physicians retaining responsibility for a network's medical, quality and utilization management; (3) Savings generated by community health networks should be reinvested in the local health care delivery system, rather than redirected elsewhere, since rural health systems and economies are fundamentally intertwined; (4) Patients should retain access to the spectrum of local health services, thereby preserving patient-physician relationships and continuity of care; and (5) Participation in rural community health networks should be voluntary, but open to all qualified rural physicians and other health care providers wishing to participate. (Sub. Res. 721, I-97; Reaffirmed: CMS Rep. 9, A-07)

H-450.941 Pay-For-Performance, Physician Economic Profiling, and Tiered and Narrow Networks - 1. Our AMA will collaborate with interested parties to develop quality initiatives that exclusively benefit patients, protect patient access, do not contain requirements that permit third party interference in the patient-physician relationship, and are consistent with AMA policy and Code of Medical Ethics, including Policy H-450.947, which establishes the AMA’s Principles and Guidelines for Pay-for-Performance and Policy H-406.994, which establishes principles for organizations to follow when developing physician profiles, and that our AMA actively oppose any pay-for-performance program that does not meet all the principles set forth in Policy H-450.947. 2. Our AMA strongly opposes the use of tiered and narrow physician networks that deny patient access to, or attempt to steer patients towards, certain physicians primarily based on cost of care factors. 3. Our AMA pledges an unshakable and uncompromising commitment to the welfare of our patients, the health of our nation and the primacy of the patient-physician relationship free from intrusion from third parties. 4. Because there are reports that pay-for-performance programs may pose more risks to patients than benefits, our AMA will prepare an annual report on the risks and benefits of pay-for-performance programs, in general and specifically the largest programs in the country including Medicare, for the House of Delegates over the next three years, beginning at the 2007 Interim Meeting. This report should shall clearly delineate between private pay-for-performance programs and voluntary public pay-for-reporting and other related quality initiatives. 5. Our AMA will continue to work with other medical and specialty associations to develop effective means of maintaining high quality medical care which may include physician accountability to robust, effective, fair peer review programs, and use of specialty-based clinical data registries. 6. As a step toward providing the Centers for Medicare and Medicaid Services (CMS) with data on special populations with higher health risk levels and developing variable incentives in achieving quality, our AMA will continue to work with CMS to encourage and support pilot projects, such as the Physician Quality Reporting Initiative (PQRI),
by state and specialty medical societies that are developed collaboratively to demonstrate effective incentives for improving quality, cost-effectiveness, and appropriateness of care. 7. Our AMA will advocate that physicians be allowed to review and correct inaccuracies in their patient specific data well in advance of any public release, decreased payments, or forfeiture of opportunity for additional compensation. (BOT Rep. 18, A-07; Reaffirmed in lieu of Res. 729, A-08; Reaffirmation A-09; Reaffirmed: BOT Rep. 18, A-09; Reaffirmation I-10; Reaffirmed in lieu of Res. 808, I-10; Reaffirmed in lieu of Res. 824, I-10)

H-165.997 Prioritization of Health Care Services - (1) Our AMA urges the medical profession to develop and pursue an initiative for improvement in the systems design for medical and health care plans. (2) Our AMA opposes rationing of health and medical care services. (3) In developing its initiative to contribute responsibly to improvements in the systems design of health and medical care plans, our AMA urges the medical profession to support efforts to evaluate all mechanisms for financing, provision of care and reimbursement in light of their impact on access to care, quality of care and affordability. (4) Our AMA will develop additional clinically based criteria by which benefits desirable under both private and publicly funded health plans can be identified, and will use these criteria in further refining AMA policy in this area. (5) These criteria will be used to evaluate any benefit package developed by any source. (6) Our AMA continues to support the allocation of health services through a decentralized working of the market, coupled with incentives for effective individual choices, as the preferred alternative to centralized prioritization of services or decisions about coverage for such services. (7) Our AMA urges that physicians work to assist society, including legislatures, whenever discussion regarding prioritization of resources take place. (8) Our AMA will assist medical societies in those states considering or undertaking prioritization to develop processes and criteria for such prioritization that best serve the needs of patients. (9) Our AMA will study and take the lead in stimulating discussion among all concerned sectors of society about the implications of limited and limiting health care resources, current experimental programs for centralized allocation, and the processes and criteria to be used in any such allocation. (10) Our AMA will continue to assign a high priority to the problem of the medically uninsured and underinsured and continue working toward national consensus on providing access to adequate health care coverage for all Americans. (Res. 88, A-84; BOT Rep. EE, I-92; CLRPD Rep. 3 - I-94; Appended: Sub. Res. 109, I-98; Reaffirmed: Res. 808, I-02; Reaffirmed: CMS Rep. 5, A-04; Consolidated: CMS Rep. 7, I-05)