RESOLUTION 17-301

(Referred to Reference Committee C)

Subject: Medicaid Reform

Introduced by: Marion E. Mass, MD, Bucks County Medical Society

Author: Arvind R. Cavale, MD, Bucks County Medical Society

WHEREAS, Medicaid expansion costs continue to rise way above predicted levels ($7,436 per enrollee versus $4875), accounting for nearly 40% of Pennsylvania’s annual budget as of 2015, while failing to fulfill its stated goal of improving access to timely and personal health care for the indigent and disabled, resulting in second-class medical care for Medicaid recipients; and

WHEREAS, the current Medicaid program relegates its enrollees to a system where they have no recourse to challenge inequalities in the medical care they receive; and

WHEREAS, the current Center for Medicare and Medicaid Services is highly inclined to offer waivers to States “to pursue innovative strategies for providing their residents with access to high quality, affordable health coverage”; therefore, be it

RESOLVED, that PAMED designate its Executive Vice President or other staff member to begin working immediately with the PA Insurance Department to simplify regulatory language regarding Medicaid services to encourage the offering of innovative insurance products by current and/or new insurance companies, including the option of Medicaid patients accessing timely, comprehensive, and personal services provided by Direct Care practices; and, be it further

RESOLVED, that PAMED immediately engage with the Governor’s office and State House & Senate leadership to assist in applying for Section 1332 State Innovation Waiver with the concept of allocating $5000 per Medicaid enrollee to a Health Savings Account, through which the enrollee can purchase innovative private health insurance (with the default being the State Employee Benefits Plan) and/or purchase care directly (coupled with a catastrophic insurance plan), and promote this concept via County Medical Societies; and, be it further

RESOLVED, that PAMED formulate a plan to form an independent organization, funded equally by PAMED and insurance companies, that serves as an impartial adjudicator of complaints by Medicaid enrollees, and to encourage the PA Insurance Department to be responsive to the remedial actions suggested by this organization.

LINKS TO SUPPORTING DOCUMENTATION:

https://www.wsj.com/articles/medicaids-potemkin-health-coverage-1500419200?mg=prod/accounts-wsj
https://ballotpedia.org/Medicaid_spending_in_Pennsylvania
Fiscal Note: $________

Relevance to Strategic Plan

301
RESOLUTION 17-302

(Referred to Reference Committee C)

Subject: PAMED Support of Direct Primary Care
Introduced by: Marion E. Mass, MD, Bucks County Medical Society
Author: Kimberly Legg Corba, DO, Lehigh County Medical Society

WHEREAS, Direct Primary Care is a new system of health care delivery; and

WHEREAS, our health care system, in its current state of exorbitant cost and unaffordability, is making it
difficult for patients to access basic affordable primary care; and

WHEREAS, Direct Primary Care works in the following manner:
1) Direct Primary Care physicians do not participate with insurers and may or may not opt
out of Medicare/Medicaid;
2) Charges patient member a monthly membership fee often graduated based on age;
3) Monthly membership fee covers many, if not most in-office primary care services with
any exceptions being transparently demonstrated to the patient at extremely affordable
cost, does not charge co-pays or co-insurance;
4) Provides access to a Direct Primary Care physician via unrestricted office visits,
text/email/phone availability after hours and weekends/holidays for acute issues;
5) Provides same day/next day acute visits;
6) Provides prolonged visits of 30-60 minutes;
7) Provides value-added benefits of wholesale generic medications dispensed from in-house
dispensary, deeply discounted imaging and laboratory services; and
8) Provides extensive coordination of care for complex medical issues; and

WHEREAS, Direct Primary Care will improve our health care system for primary care services with better
access, affordability and attention through all the above listed benefits; and

WHEREAS, Direct Primary Care will allow physicians to care for patients without the intrusions and
restrictions of insurers and government; and

WHEREAS, Direct Primary Care is gaining national recognition and as the model grows across this state
and the country; and

WHEREAS, physicians and the public need to become educated about the Direct Primary Care model; and

WHEREAS, draft legislation defining Direct Primary Care as an entity that will not fall under insurance
regulation is being sponsored by Representative Matt Baker and Senator Pat Browne in Pennsylvania and
endorsement of the model by the Pennsylvania Medical Society would aid in the passage of these bills;
therefore, be it

RESOLVED, that the Pennsylvania Medical Society (PAMED) support the Direct Primary Care model by
producing a written document endorsing Direct Primary Care and publishing said endorsement in
PAMED newsletter and on the PAMED website; and, be it further
RESOLVED, that PAMED support the Direct Primary Care model by writing a press release outlining PAMED’s endorsement of the model and publishing said press release outlining PAMED’s endorsement of the model.

Fiscal Note: $0

Relevance to Strategic Plan

302
RESOLUTION 17-303

(Referred to Reference Committee C)

Subject: Air Ambulance Regulations and Reimbursements

Introduced by: Natalia Ortiz, MD, on behalf of the Philadelphia County Medical Society

Author: Elisa Giusto, Philadelphia College of Osteopathic Medicine

WHEREAS, emergent air medical services are provided to critically-ill or injured patients to the closest appropriate hospital via air ambulances when requested by third-party medical professionals or first responders;¹ and

WHEREAS, air ambulances improve access to level 1 trauma centers for 87 million Americans who would not otherwise be able to receive emergent care in a timely manner with 86.4% of the U.S. population living within a 15- to 20-minute response area of an air ambulance;¹ and

WHEREAS, the American College of Surgeons has published field triage guidelines, yet 59% of patients transported by air ambulance had minor injuries, as defined by an Injury Severity Score of less than 15;² and

WHEREAS, the Airline Deregulation Act of 1978 prohibits states from regulating the price, route, or service of an air carrier, including air ambulances, for the purposes of increasing competition, reducing rates, and improving airline passenger service;³ and

WHEREAS, since Medicare created a national fee schedule for air ambulances in 2002, more than half of the air ambulance industry is now controlled by 4 for-profit operators with an increase in air ambulances from 545 in 2002 to 1,045 in 2015;⁴ and

WHEREAS, Air Methods, the nation’s largest air ambulance operator, has seen an increase in their average bill from $17,262 in 2009 to $50,199 in 2016, far more than the actual cost for a flight of only $10,199;¹,⁴ and

WHEREAS, Air Methods has resorted to hundreds of lawsuits against individuals throughout the country seeking salary garnishment and other forms of debt collection;⁵,⁶ and

WHEREAS, Medicare only reimburses 59% of air ambulance costs, adding an average of $15,984 to the cost of self-pay or privately insured patients as air ambulance operators recoup what they lose on below-cost transports funded by the government;¹ and

WHEREAS, private insurance companies that offer ambulance coverage only cover an average of 36.5% of the air ambulance’s bill and, unlike Medicare and Medicaid, there are no regulations preventing them from balance billing patients for charges after coverage has been applied; for example, Blue Cross Blue Shield pays air ambulance companies $13,780 plus $89.72 per mile and “balance bill” patients if the air ambulance company is out of network;⁷,⁹ and

WHEREAS, between 2013 and 2016, insurance departments from nine states reviewed 55 incidences in which consumers complained of $3.8 million in combined charges, an average charge of $70,000 per trip;¹⁰ and

...
WHEREAS, in 2015, the Maryland Insurance Administration held hearings to investigate a string of consumer complaints regarding air ambulance bills ranging from $20,000 to over $40,000;\textsuperscript{11} and
\textbf{WHEREAS}, laws from Wyoming seeking to cap air ambulance fees and North Dakota forcing air ambulance companies to become participating providers by joining major insurance company networks have been struck down in federal courts;\textsuperscript{12} therefore, be it

\textbf{RESOLVED,} that the Pennsylvania Delegation to the American Medical Association (AMA) present this resolution for national adoption to direct that the AMA, and appropriate stakeholders identified by the AMA, study the role, clinical efficacy, and cost-effectiveness of air ambulance services, including barriers to adequate competition, reimbursement, quality improvement and other areas identified by the AMA and its stakeholders, and provide appropriate recommendations addressing the areas to be studied.

\textbf{Fiscal Note: $1500-2000}

\textbf{Relevance to Strategic Plan}

303

\textbf{References:}

10. Peterson, Eric and Brian Maffly. Sky’s the Limit for What Utah Air Ambulances Can Charge -- the $46K Bill This Man Received for a 50-mile Trip. The Salt Lake Tribune. August 2016.
RESOLUTION 17-304

(Referred to Reference Committee C)

Subject: Patient Protection from Surprise Out-of-Network Costs

Introduced by: Natalia Ortiz, MD, on behalf of the Philadelphia County Medical Society

Author: Ludwig Koeneke-Hernandez, MS, Sidney Kimmel College of Medicine

WHEREAS, patients obtain services from in-network facilities and hospitals expecting to have their treatments covered by insurance; and

WHEREAS, patients receiving care at an in-network facility can receive treatment from out-of-network providers resulting in higher fees for the patient that are often undisclosed at the time of treatment and they end up receiving “surprise billing” after services are rendered; and

WHEREAS, current AMA policy (H-285.908), designed to protect patients from low-quality networks, does not suffice in protecting patients from receiving out-of-network treatment unless the patient’s network is deemed “inadequate”; and

WHEREAS, current AMA policy (H-285.904) demands insurers to provide access to in-network physicians but does not go so far as to demand access to in-network facilities and consultants within the same in-network facility; therefore, be it

RESOLVED, that the Pennsylvania Medical Society (PAMED) work with the Pennsylvania Insurance Department to ensure access to high-quality, in-network providers located at in-network institutions so as to decrease high cost out-of-network billing; and, be it further

RESOLVED, that PAMED advocate for the expansion of AMA policy H-285.904 to mandate insurers to provide networks providing patient access to an in-network facility with in-network physicians and consultants.

Fiscal Note: $3,000-5,000

Relevance to Strategic Plan

304

References:

1. Court, Emma. This increasingly common hidden fee is a nasty surprise on medical bills. Marketwatch. June 3, 2017.


Relevant AMA and AMA-MSS Policy:

Network Adequacy [H-285.908]

1. Our AMA supports state regulators as the primary enforcer of network adequacy requirements.
2. Our AMA supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. Physicians may be added to the network at any time.
3. Our AMA supports requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy, including the number and type of providers that have joined or left the network; the number and type of specialists and subspecialists that have left or joined the network; the number and types of providers who have filed an in-network claim within the calendar year; total number of claims by provider type made on an out-of-network basis; data that indicate the provision of Essential Health Benefits; and consumer complaints received.
4. Our AMA supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
5. Our AMA advocates for regulation and legislation to require that out-of-network expenses count toward a participant's annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies.
6. Our AMA supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
7. Our AMA supports health insurers paying out-of-network physicians fairly and equitably for emergency and out-of-network bills in a hospital. AMA policy is that any legislation which addresses this issue should assure that insurer payment for such care be based upon a number of factors, including the physicians' usual charge, the usual and customary charge for such service, the circumstances of the care and the expertise of the particular physician.
8. Our AMA provides assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure physicians and patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks.
9. Our AMA supports the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities.
10. Our AMA advocates for legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited.
11. Our AMA advocates that health plans should be required to document to regulators that they have met requisite standards of network adequacy including hospital-based physician specialties (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible.
Out-of-Network Care  

Our AMA adopts the following principles related to unanticipated out-of-network care:

1. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
2. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
3. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
4. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
5. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
6. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
7. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
8. Mediation should be permitted in those instances where a physician's unique background or skills (e.g. the Gould Criteria) are not accounted for within a minimum coverage standard.

Price Transparency  

1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.
2. Our AMA advocates that health plans provide 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 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.
RESOLUTION 17-305

(Referred to Reference Committee C)

**Subject:** Medicaid Physician Reimbursement for Translation and Interpretation Services

**Introduced by:** Natalia Ortiz, MD, on behalf of the Philadelphia County Medical Society

**Authors:** Rachel Thomas, MPH, and Jarett Beaudoin, MD, Sidney Kimmel Medical College

**WHEREAS**, refusal of medical interpretation for Limited English Proficient (LEP) patients during any medical encounter is considered discrimination due to country of origin under Title IV of the Civil Rights Act of 1964; and

**WHEREAS**, physicians and medical providers, consequently, must bear the burden of finding, contracting with, and paying for medical interpreters to adhere to the law; and

**WHEREAS**, Pennsylvania census data from 2011 shows more than 219,000 Pennsylvanians who designated that they speak English “Not Well” or “Not At All”, this includes both patients and parents/caregivers of patients; and

**WHEREAS**, medical interpretation is shown to increase positive health outcomes for LEP individuals by both the Institute of Medicine (IOM) and the joint commission, and results in patients who make more outpatient visits, receive and fill more prescriptions, do not differ from English-proficient patients in test costs or receipt of intravenous hydration, have outcomes among those with diabetes that are superior or equivalent to those of English-proficient patients, and have high satisfaction with care and is widely accepted to be essential for the delivery of quality care to patients; and

**WHEREAS**, LEP patients who are not provided interpretation have increased chances of negative health outcomes such as defer needed medical care, leave the hospital against medical advice, miss follow-up appointments, or experience drug complications; and

**WHEREAS**, the use of family members and friends as medical interpreters has been shown to be ineffective and harmful (i.e. interpreters omitting questions about drug allergies or instructions on prescription dose, frequency, and duration); and

**WHEREAS**, Medicaid reimbursement for interpretation and translation services during medical encounters has historically been regulated at the state level; and

**WHEREAS**, ten states pay for interpreter services under Medicaid or SCHIP. With varying approaches are used (ex: Some states authorize reimbursement for interpreter services, while others contract with specific organizations to provide interpretation); therefore, be it

**RESOLVED**, that the Pennsylvania Medical Society (PAMED) work to obtain state Medicaid funding for medical interpretive services; and, be it further

**RESOLVED**, that PAMED urge the Pennsylvania General Assembly to pass legislation that installs a system of reimbursement for interpretation and translation services accrued during medical encounters.
RELEVANT AMA AND AMA-MSS POLICY:

Language Interpreters D-385.978
Our AMA will: (1) continue to work to obtain federal funding for medical interpretive services; (2) redouble its efforts to remove the financial burden of medical interpretive services from physicians; (3) urge the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement; (4) consider the feasibility of a legal solution to the problem of funding medical interpretive services; and (5) work with governmental officials and other organizations to make language interpretive services a covered benefit for all health plans inasmuch as health plans are in a superior position to pass on the cost of these federally mandated services as a business expense.

Availability and Payment for Medical Interpreters Services in Medical Practices H-385.929
It is the policy of our AMA to: (1) the fullest extent appropriate, to actively oppose the inappropriate extension of the OCR LEP guidelines to physicians in private practice; and (2) continue our proactive, ongoing efforts to correct the problems imposed on physicians in private practice by the OCR language interpretation requirements.