RESOLUTION 17-401

(Referred to Reference Committee D)

Subject: Eliminate the Preferential Treatment of Physicians with Hospital Privileges in Pennsylvania

Introduced by: Sandeep K. Kakaria, MD, on behalf of the Cumberland County Medical Society

Author: Sandeep K. Kakaria, MD, Cumberland County Medical Society

WHEREAS, hospitals place unpaid requirements on physicians including, but not limited to, on-call coverage, electronic records training, and staff meetings; and

WHEREAS, hospital-owned practices directly compete with private practices for outpatient care; and

WHEREAS, two of the nation’s largest insurers, Medicare and Medicaid, do not require hospital privileges; and

WHEREAS, patients pay additional fees and lose access to qualified doctors when insurance companies grant preferred status to one group of physicians over another; therefore, be it

RESOLVED, that the Pennsylvania Medical Society work with the Pennsylvania Legislature, the Pennsylvania Department of Health, the Pennsylvania Insurance Department, and other appropriate agencies to establish legislation or regulation that any physician who is not practicing in a hospital may not be required to maintain hospital privileges by any entity including, but not limited to, a health insurance company, malpractice insurance company, surgery center, or outpatient facility; and, be it further

RESOLVED, that the Pennsylvania Medical Society work with the Pennsylvania Legislature, the Pennsylvania Department of Health, the Pennsylvania Insurance Department, and other appropriate agencies to establish legislation or regulation that no insurance company may grant or deny preferred or in-network status to physicians according to the presence or absence of their hospital privileges.

Fiscal Note: $_______

Relevance to Strategic Plan

401
RESOLUTION 17-402

(Referred to Reference Committee D)

Subject: CPR Training

Introduced by: Pennsylvania College of Emergency Physicians (PACEP) and Allegheny County Medical Society (ACMS)

Author: Ankur A. Doshi, MD, FACEP

WHEREAS, over 300,000 Americans die from sudden cardiac arrest each year; and

WHEREAS, bystander cardiopulmonary resuscitation (CPR), also known as layperson CPR, is an important intervention that can double the chances for patients to be discharged to home neurologically intact; and

WHEREAS, less than 20% of Americans feel that they are adequately trained in CPR; and

WHEREAS, an increase in the rate of CPR training is associated with an increase in survival for sudden cardiac arrest; and

WHEREAS, 37 states and the District of Columbia have some CPR mandate in schools; and

WHEREAS, the American Medical Association’s “Cardiopulmonary Resuscitation (CPR) and Defibrillation” Policy (H-130.938) states that the AMA “encourages the American public to become trained in CPR and the use of automated external defibrillators” and “supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated defibrillator use”; therefore, be it

RESOLVED, that the Pennsylvania Medical Society support state legislation advocating for mandatory CPR training in schools; and, be it further


RESOLVED, that the Pennsylvania Medical Society work with other stakeholder organizations, including the American Heart Association, the American Red Cross, and county medical societies to advocate for increased CPR training for laypersons.

Fiscal Note: $______________

Relevance to Strategic Plan

402
RESOLUTION 17-403

(Referred to Reference Committee D)

Subject: Defending the Physician-Patient Relationship
Introduced by: Pennsylvania Society of Anesthesiologists
Author: Shannon Grap, MD, Pennsylvania Society of Anesthesiologists

WHEREAS, one of the tenets of the Pennsylvania Medical Society is to uphold the Physician-Patient Relationship as noted in Policy Number 35.986 (“Supporting the Need for Physician Oversight”) which in its opening line states: “The Society recognizes, supports and lobbies for the need for physician oversight, whether by direct supervision or a written collaborative agreement...”; and

WHEREAS, legislation pending in both Chambers of the Pennsylvania General Assembly, with strong support of mid-level providers, the Pennsylvania Hospital Association, and many legislators, would grant full independent practice to Nurse Practitioners; and

WHEREAS, independent practice for mid-level providers contradicts and expressly violates the tenet of preserving the Physician-Patient Relationship; and

WHEREAS, removal, in any way, of the collaborative agreement, even in a time-defined fashion for Nurse Practitioners, would provide independent practice for these mid-level providers; and

WHEREAS, the current legislation pending in the Pennsylvania General Assembly would authorize independent practice for Nurse Practitioners; and

WHEREAS, the leadership of the Pennsylvania Medical Society has been asked by some members of the Pennsylvania Legislature and others to compromise to eventually remove the collaborative agreement for Nurse Practitioners; therefore, be it

RESOLVED, that the Pennsylvania Medical Society strongly and unequivocally oppose Senate Bill 25 and House Bill 100, which would establish independent practice for Nurse Practitioners; and, be it further

RESOLVED, that the Pennsylvania Medical Society strongly oppose any effort to grant independent practice to Nurse Practitioners as an unacceptable disruption of the Physician-Patient Relationship; and, be it further

RESOLVED, that the Pennsylvania Medical Society direct all Society Leadership to forcefully and unequivocally oppose this and any future expansion of Nurse Practitioners’ scope of practice leading to independent practice, which would disrupt the Physician-Patient Relationship; and, be it further

RESOLVED, that the Pennsylvania Medical Society reaffirm Policy Number 35.986, and opposes any legislation, regulation, or negotiation which would permit Nurse Practitioners and all other non-physicians to practice medicine independently without licensed medical supervision or a written collaborative agreement.

Fiscal Note: $____________

Relevance to Strategic Plan: Goals 1.1, 1.5, and 2
RESOLUTION 17-404

(Referred to Reference Committee D)

Subject: Oversight of the PA Board of Medicine & PA Board of Osteopathic Medicine

Introduced by: Winslow W. Murdoch, MD, Chester County Medical Society

Authors: Board of Directors, Chester County Medical Society

WHEREAS, the Pennsylvania State Boards of Medicine and Osteopathic Medicine have absolute authority over physicians practicing medicine in Pennsylvania; and

WHEREAS, the Boards are permitted by statute to remove or restrict a physician’s license and ability to practice in cases where a physician has been accused of a wrongdoing but has not had the opportunity to have the matter addressed and appropriately adjudicated; and

WHEREAS, the Boards report actions taken against a physician’s license to the National Practitioner’s Data Bank but do not follow up expediently and amend or update their reports to the Data Bank; and

WHEREAS, the Boards are permitted to issue restricted licenses when they determine that a physician may be a risk to public safety; and

WHEREAS, physicians with a restricted license are not able to obtain professional liability insurance or to be credentialled by third-party payers; and

WHEREAS, physicians without enormous financial resources have little or no recourse to challenge the decisions and actions taken by the licensing boards; and

WHEREAS, PAMED has a longstanding policy (275.995) calling for the state boards to permit physicians to practice until a final decision is rendered; therefore, be it

RESOLVED, that PAMED seek legislative oversight of the Boards of Medicine to instill accountability of the Boards to all those involved in cases where a physician’s license is suspended or restricted; and, be it further

RESOLVED, that PAMED develop channels of communication with the PA Board(s) of Medicine and Osteopathic Medicine to provide advocacy on behalf of practicing physicians who may face some jeopardy due to a Board action.

Fiscal Note: $

Relevance to Strategic Plan

404
RESOLUTION 17-405

(Referred to Reference Committee D)

Subject: Requirement of Formulary Equivalent Alternatives from Denying Insurers

Introduced by: Stephen T. Olin, MD, Lancaster City & County Medical Society

Author: Stephen T. Olin, MD, Lancaster City & County Medical Society

WHEREAS, patients experiencing symptoms of an illness present at physician offices and hospital emergency departments; and

WHEREAS, patients are treated for their reported symptoms with a prescription for medication; and

WHEREAS, patients’ insurers make a determination that the prescription provided to the patient is not included in the patients’ health plan formulary; and

WHEREAS, the prescription drug has been determined medically necessary for the treatment of the indicated condition as recommended and prescribed; and

WHEREAS, every carrier uses different criteria that changes frequently; and

WHEREAS, patients may experience a delay in receiving the necessary, prescribed medication; and

WHEREAS, this can result in significant and unexpected financial expenses to patients and/or potential negative impacts on their health; therefore, be it

RESOLVED, that the Pennsylvania Medical Society seek through enactment of legislation or regulation the requirement that all insurers or their agents provide formulary alternates if a prescription drug has been denied due to the fact that it is not included in the health plans’ formulary; and, be it further

RESOLVED, that an alternate and equivalent formulary recommendation be made by the insurer to the prescribing physician within 24 hours following the denial of the prescription; and, be it further

RESOLVED, that the Pennsylvania Medical Society work to compel insurers to provide physicians with a clear and rapid process of review that includes alternate recommendations for prescription drug treatment.

Fiscal Note: $__________

Relevance to Strategic Plan

405
RESOLUTION 17-406

(Referred to Reference Committee D)

Subject: Fixing Informed Consent

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

Authors: Enrique Hernandez, MD and Kurt Miceli, MD, Philadelphia County Medical Society

WHEREAS, the Pennsylvania Supreme Court has ruled that only physicians who will perform a procedure can obtain informed consent for that procedure; and

WHEREAS, there are many situations when it is impractical to prohibit other competent members of the health care team (residents, nurses, physician assistants) to participate in the informed consent process; and

WHEREAS, allowing other qualified members of the health care team to participate in the informed care process may provide the patient with more information, more opportunities to ask questions and, ultimately, to be able to make an informed decision; therefore, be it

RESOLVED, that the Pennsylvania Medical Society (PAMED) work with members of the Pennsylvania Assembly to introduce legislation to amend the MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) ACT of Mar. 20, 2002, P.L. 154, No. 13, specifically, Section 504, to allow other qualified health professionals (e.g. residents, fellows, nurses, physician assistants and/or other Allied Health Professionals) to obtain informed consent for procedures about which they are knowledgeable and qualified, whenever they are delegated to do so by the health care practitioner who will perform any procedure that requires consent under the MCARE ACT; and, be it further

RESOLVED, that if the informed consent has been obtained by a qualified health care practitioner, the patient will still have the opportunity to participate in informed consent discussions with the practitioner performing the procedure prior to the procedure, except in the case of an emergency; and, be it further

RESOLVED, that whenever alleged failure to obtain informed consent claims are made, all information exchanged between the patient and the physician and/or the physician’s qualified delegate shall be admissible in court; and, be it further

RESOLVED, that such legislation fully ensures a physician has satisfied the duty of disclosure and that the patient’s consent is truly informed when either the physician, or the physician’s qualified staff, have obtained informed consent for a surgery or treatment provided by the physician.

Fiscal Note: $10,000-25,000

Relevance to Strategic Plan

406
RESOLUTION 17-407

(Referred to Reference Committee D)

Subject: Freedom from Government Forced Mandates in Physician Practice

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

Author: Kurt Miceli, MD, Philadelphia County Medical Society

WHEREAS, in 2017, Senate Bill No. 655 was introduced to the General Assembly of Pennsylvania and proposed mandating the state’s opioid prescribing guidelines as written by a government formed Advisory Council; and

WHEREAS, similar legislation mandating guidelines took effect as law last year under Act 87, which requires every individual born between 1945 and 1965 who receives health services as an inpatient in a hospital or who receives primary care services in an outpatient department of a hospital, health care facility, or physician’s office, to be offered a hepatitis C screening test or hepatitis C diagnostic test; and

WHEREAS, it is unclear what legal ramifications, either intentional or unintentional, violation of Act 87 may have; and

WHEREAS, Act 87 and Senate Bill No. 655 subvert clinical judgment by imposing a blanket mandate on physicians; and

WHEREAS, the Hippocratic Oath states that a physician “will use treatment to help the sick according to [the physician’s] ability and judgment,” not according to government mandate; and

WHEREAS, the continued intrusion of government into the doctor-patient relationship erodes the professional bond which exists between the two; and

WHEREAS, in medicine, there is no one-size-fits-all, cookie-cutter approach to care; and

WHEREAS, each individual is unique and should be treated as such; and

WHEREAS, guidelines can inform care, but they should not govern it; and;

WHEREAS, a treatment protocol or clinical guideline may not be appropriate and effective for all patients; and

WHEREAS, forcing a physician, either through statute or regulation, to treat each patient the same without regard for clinical flexibility can be dangerous, ineffective, and detrimental to a patient’s well-being; and

WHEREAS, physicians should not be put in the position of breaking the law when they are seeking to provide care in the best interests of their patients; therefore, be it

RESOLVED, that the Pennsylvania Medical Society (PAMED) continue to oppose legislation that would mandate the state’s opioid prescribing guidelines; and, be it further
RESOLVED, that PAMED actively oppose any further legislation seeking to mandate clinical guidelines upon the physician; and, be it further

RESOLVED, that PAMED notify its membership in a timely manner of any new legislation from the Pennsylvania General Assembly that seeks to mandate clinical guidelines; and, be it further

RESOLVED, that PAMED—should it be unsuccessful in its opposition to future legislation seeking to mandate clinical guidelines—will, at a minimum, ensure that such legislation does not impose any liability, criminal or civil penalty, or licensure sanctions before any applicable State board for failure by a physician to comply.

Fiscal Note: $2500-5000

Relevance to Strategic Plan

407
RESOLUTION 17-408

(Referred to Reference Committee D)

Subject: Providing Immunity for Healthcare Providers of Free or Low-Cost or Emergent Healthcare

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

Author: Michael A. DellaVecchia, MD, PhD, Philadelphia County Medical Society

WHEREAS, there is a great source of active physicians, physicians in training, and physicians who are in retirement in the State of Pennsylvania; and

WHEREAS, such physicians are a great resource to the healthcare of the people of the State of Pennsylvania; and

WHEREAS, there is a need for the services of such physicians to people who may not have healthcare access due to economics, availability, de facto, or emergent causes; and

WHEREAS, a great hindrance to physicians volunteering to fulfill such a healthcare void is exposure to liability; and

WHEREAS, liability insurance coverage usually does not extend to physicians who volunteer to fill such a need; and

WHEREAS, approximately 2/3 of the physicians of Pennsylvania are employees and employers of these physicians do not extend liability coverage of such employees who volunteer to fill such a need; and

WHEREAS, the State of Pennsylvania has on many occasions neglected such needy populace of the state by failing to pass legislation that grants immunity for healthcare providers of free or low-cost health or emergent care, such as with 2015 bill SB 1102; therefore, be it

RESOLVED, that the Pennsylvania Medical Society be required to petition the legislature of the State of Pennsylvania to provide immunity for healthcare providers of free or low-cost health or emergent care.

Fiscal note: $5,000--$8,000

Relevance to Strategic Plan

408
Resolution 17-409
(Referred to Reference Committee D)

Subject: Informed Consent

Introduced by: Andrew R. Waxler, MD, FACC, on behalf of the Pennsylvania Chapter of the American College of Cardiology

Author: Andrew R. Waxler, MD FACC

WHEREAS, the process of witnessed informed consent is a vital prerequisite to any invasive procedure or treatment, and constitutes a detailed back-and-forth discussion between the physician and the patient regarding specific risks, benefits, indications and alternatives of that particular procedure or treatment; and

WHEREAS, many physician groups and departments of physicians (particularly, specialists and subspecialists) frequently work as a well-organized "team" in order to better care for the patient and to improve the efficiency of patient care; and

WHEREAS, a 2017 Pennsylvania Supreme Court ruling mandated that a physician may not delegate to others his or her obligation to provide sufficient information to obtain a patient’s informed consent; and

WHEREAS, the high court further stated that the duty of informed consent is a non-delegable duty owed by the physician conducting the surgery or treatment; and

WHEREAS, the court’s decision may lead to potentially devastating and adverse unintended consequences to patient health by causing unnecessary and potentially harmful delays; therefore, be it

RESOLVED, that the Pennsylvania Medical Society continue to support laws that promote physician-led, team-based care, to ensure efficiency, patient safety, and quality of care; and be it further

RESOLVED, that the Pennsylvania Medical Society advocate for informed consent laws that acknowledge and support the use of a well-organized team in providing patients with information sufficient to obtain their informed consent; and be it further

RESOLVED, that the Pennsylvania Medical Society advocate for laws that allow the physician conducting the surgery or treatment to delegate his or her duty to obtain informed consent to another qualified physician (including, residents and fellows) of the same specialty or subspecialty, within the same physician group or department. The physician to whom informed consent is delegated must have knowledge of the patient, the patient’s condition, and the procedures to be performed on the patient.

Fiscal Note: $5000

Relevance to Strategic Plan:
Goal 1: Improve the health of patients, families, and communities as we advocate for physicians and their patients
Objective 1.1. Develop and advocate for policies and programs that promote the appropriate patient-centered, physician-led team-based care as determined by patient need and available resources, and position physicians as the ultimate champions of safety, quality and value in patient care.

PAMED Policy:
35.991 - Physician Delegation Regulations
The Society continues to support the State Board of Medicine physician delegation regulations. The Society shall assist in the education of physicians as to their responsibilities as they relate to the delegation, supervision and direction of non-physician health care services.

References:

\[\text{(1) Shinal v. Toms, 2017 WL 2655387, at *17 (Pa. June 20, 2017).}\]
\[\text{(2) Id. at *16.}\]
RESOLUTION 17-410
(Referred to Reference Committee D)

Subject: Protection for Pennsylvania DACA Students, Physicians, and Patients

Introduced by: Gillian Naro, Penn State College of Medicine, on behalf of the Medical Students Section

Authors: Daniel Kim, Gillian Naro, and John Muller, Penn State College of Medicine

WHEREAS, 113 students with Deferred Action for Childhood Arrivals (DACA) status applied to US medical schools, with 65 matriculating in the 2016-2017 academic year alone; and

WHEREAS, to be eligible for DACA protections to stay and work in the US, these youths must prove that they arrived in the United States prior to turning 16; were under the age of 31 in June 2012; have continuously resided in the United States since June 15, 2007; are currently in school, graduated from high school, or obtained a general education development certificate (GED); and have not been convicted of a felony, a significant misdemeanor, or three or more other misdemeanors; and

WHEREAS, an undocumented student network called Pre-Health Dreamers reports that it currently has over 215 prehealth undocumented students in 27 states in its network; and

WHEREAS, one social mission of medical education is to increase the number of primary care physicians in health professional shortage areas, especially those populated by underrepresented minorities. DACA students demonstrate characteristics likely to contribute directly to this social mission. DACA students are largely underrepresented minorities themselves, and such physicians are likely to return to and serve their communities, which are often low-income, health professional shortage areas; and

WHEREAS, DACA medical students are legally excluded from receiving federal financial aid, and many have already taken on this debt with the intention of living and working in the US; and

WHEREAS, DACA status medical students enrolled in school will now face uncertainty about completing their degrees, paying their student loans, and serving patients. Furthermore, if DACA residents are unable to complete their training, this will result in wasted graduate medical education funds, unfilled training slots, and generally exacerbate the physician shortage our country is facing, especially for our most vulnerable patients; and

WHEREAS, our nation’s health care workforce depends on the care provided by international medical graduates (IMGs)—one out of every four physicians practicing in the United States is an IMG. These individuals include many with DACA status who are filling gaps in care; and

WHEREAS, the Health Resources and Services Administration reported that there is a current shortage of over 8,200 primary care physicians. Likewise, an independent study by the Association of American Medical Colleges has projected that the total physician deficit will grow to between 61,700 and 94,700 physicians by 2025. Estimates have shown that the DACA initiative could help introduce 5,400 previously ineligible physicians into the U.S. health care system in the coming decades to help address these shortages and ensure patient access to care; and

WHEREAS, in Pennsylvania, DACA has allowed nearly 5,900 young people to come forward, pass background checks, and live and work legally; and
WHEREAS, ending DACA would cost Pennsylvania nearly $357.1 million in annual GDP losses;¹¹ and

WHEREAS, AAMC (Association of American Medical Colleges) President and CEO Darrell G. Kirch, MD, issued the following statement to “strongly urge [Trump] to not revoke the current DACA executive action until a permanent pathway to a lawful immigration status for DACA participants is approved by Congress.;¹²and

WHEREAS, the AAMC is dedicated to promoting a culturally competent, diverse, and prepared health and biomedical workforce that leads to improved health.;¹²and

WHEREAS, the AAMC also supports work underway on Capitol Hill to craft a potential legislative solution that would ensure a temporary stay of deportation for students with DACA status until such time that Congress approves a permanent fix, such as the Development, Relief, and Education for Alien Minors (DREAM) Act. Further, the AAMC encourages lawmakers to grant DREAMers eligibility for federal student loans since financing medical education is often cited as the biggest barrier for aspiring physicians.;¹²and

WHEREAS, medical students and residents with DACA status and DREAMers represent a small but important segment of the U.S. population, and their participation in our health care workforce will benefit all U.S. patients.;¹²and

WHEREAS, the American Medical Association (AMA), has publically urged Congress to take prompt action to protect and provide stability for individuals with DACA status.;¹³ therefore, be it

RESOLVED, that the Pennsylvania Medical Society (PAMED) will study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates; and, be it further

RESOLVED, that PAMED support legislative efforts to protect DACA status medical students, physicians, and patients; and, be it further

RESOLVED, that PAMED issue a statement in support of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients in the Commonwealth of Pennsylvania.

Fiscal Note:

Relevance to Strategic Plan

410

References:


RELEVANT AMA AND AMA-MSS POLICY:

Res. 305, A-15 Appended: Late Res. 1001, I-16
Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages D-350.986
RESOLUTION 17-411

(Referred to Reference Committee D)

Subject: The Pennsylvania Medical Society (PAMED) Support and Lobby State Legislators to Support HB 17, Introduced by State Representative Marcia Hahn (138th District), to Amend Sections 8 and 12 of the Act of April 14, 1972 (P.L. 221, No. 63), known as the Pennsylvania Drug and Alcohol Abuse Control Act

Introduced by: Ziba Rahjoi-Monfared, MD, on behalf of the Northampton County Medical Society

Author: Ziba Rahjoi-Monfared, MD, Northampton County Medical Society

WHEREAS, current law does not allow for a parent or legal guardian to consent for medical treatment of a minor over the legal age of 14; and

WHEREAS, the intent of this bill is to allow for a parent or legal guardian to authorize medical treatment for an individual who might otherwise not seek treatment for a substance abuse or mental health issue; and

WHEREAS, opioid and substance abuse, as well as mental health issues, have touched and affected children and families of many Pennsylvanians; and

WHEREAS, substance abuse and mental health treatment of individuals over the age 14 can only be applied by a physician upon the consent of the individual; and

WHEREAS, parents of children above the age of 14 have no legal authority to mandate or seek treatment for their children without the child’s consent above legal age; and

WHEREAS, 14- to 18-year-old children have not yet reached an age of what might be considered maturity or have the ability to define what might be in their own best interest in respect to substance abuse or mental health issues; and

WHEREAS, many parents seek to have their children treated for substance abuse and mental health issues before they become addicted or a mental health condition worsens; and

WHEREAS, physicians do not have the ability to order treatment for individuals between the ages of 14 and 18, without that individuals consent, regardless of parental consent or wishes; therefore, be it

RESOLVED, that the Pennsylvania Medical Society (PAMED) support and use lobbying efforts to support passage of this bill; and, be it further

RESOLVED, that PAMED add HB 17 to its list of legislative priorities and seek passage of this bill through its lobbying efforts.

Fiscal Note:

Relevance to Strategic Plan

411
Attached: House Bill 17

HB_17.pdf
RESOLUTION 17-412

(Referred to Reference Committee D)

Subject: The Pennsylvania Medical Society (PAMED) Support and Provide Financing to Develop and Execute a Physician Survey Assessing Patterns of Healthcare Financial Spending and Its Effect by Consolidation of Hospital and Hospital Network Systems, Monopolies of Healthcare Facilities, and Excluding Private Practice Physicians from Caring for Their Patients that have a History of Treatment by the Physician in Local Healthcare Facilities

Introduced by: Manny S. Iyer, MD, FACS, Northampton County Medical Society

Author: Chand Rohatgi, MD, Northampton County Medical Society

WHEREAS, the current healthcare marketplace has empowered hospital consolidation; and

WHEREAS, hospitals that dominate the marketplace have excluded private practice physicians being granted staff hospital privileges and practicing in “Not for Profit” institutions; and

WHEREAS, this is a violation of the IRS “Community Benefit Standard” - Rev. Rul. 56-185, 1956-1 C.B. 202, modified Rev. Rul. 69-545, 1969-2 C.B. 117; and

WHEREAS, the ruling states: In order for a hospital to establish that it is exempt as a public charitable organization within the contemplation of section 501(c)(3), it must, among other things, show that it meets the following general requirements: #3: It must not restrict the use of its facilities to a particular group of physicians and surgeons, such as a medical partnership or association, to the exclusion of all other qualified doctors; and

WHEREAS, consolidation of Network Healthcare systems has impacted small groups and solo private practices; and

WHEREAS, insurance carriers collaborate with hospitals and network systems to narrow healthcare networks and select products that exclude private practice participation and hospital physician domination of the marketplace; and

WHEREAS, healthcare facility monopolies have driven up the cost of healthcare; and

WHEREAS, consolidation of healthcare facilities raises costs, decreases and limits patient access to healthcare; and

WHEREAS, patients of private practice physicians who request their current physicians in hospital settings are redirected to employed healthcare system physicians. Private practice physicians are not contacted even when a patient requests “their own” doctor; and

WHEREAS, the above factors limit a physician’s ability to care for their patients and sever the patient/physician relationship; therefore, be it

RESOLVED, that the Pennsylvania Medical Society (PAMED) provide financing to develop and execute a physician survey to assess the patterns of how healthcare is being affected in Pennsylvania, by consolidation of hospitals and healthcare network systems; and, be it further
RESOLVED, that PAMED provide financing to develop and execute a physician survey to assess the patterns of insurance carriers creating narrow physician networks; and, be it further RESOLVED, that PAMED investigate and lobby federal legislators to enforce the regulations contained in the IRS’ “Community Benefit Standard” - Rev. Rul. 56-185, 1956-1 C.B. 202, modified Rev. Rul. 69-545, 1969-2 C.B.117 - for “Non-Profit” Healthcare systems using the results of these surveys.

Fiscal Note:

Relevance to Strategic Plan


HealthcareFacilities Act_79_P.L.130_No48
RESOLUTION 17-413

(Referred to Reference Committee D)

Subject: Oppose Measures That Erode Physician Supervision of Physician Assistants

Introduced by: Early Career Physicians Section

Author: Joseph W. Laskas, DO, Delaware County

WHEREAS, physician assistants are a valuable member of the physician-led team; and

WHEREAS, there are substantial differences in the education of physician assistants and physicians, both in depth of knowledge and length of training; and

WHEREAS, new health care models, including accountable care organizations, require increased teamwork among physicians, nurse practitioners, physician assistants, and other providers of care; and

WHEREAS, efforts to disassemble the physician-physician assistant relationship would further compartmentalize the delivery of health care; and

WHEREAS, the American Academy of Physician Assistant’s (AAPA) House of Delegates approved the “Optimal Team Practice” policy, which supports the removal of state laws requiring a formal supervisory relationship between physicians and physician assistants; establishment of autonomous state licensing boards with a majority of physician assistants as voting members or for physician assistants to be full voting members of medical boards; and ensures that physician assistants are eligible to be reimbursed directly by public and private insurance; and

WHEREAS, AAPA model legislation removes language stipulating that the physician assistant scope of practice must not exceed the supervisory physician scope of practice and instead permits the physician assistant to provide any medical service within the physician assistant’s education, training, and experience; and

WHEREAS, in Pennsylvania the scope of practice of the physician assistant is reviewed by the state board of medicine prior to approval; and

WHEREAS, in Pennsylvania there is a law in place to reduce the requirement for countersignatures for physician assistants after a brief period of practice that requires review by the state board of medicine; and

WHEREAS, Senate Bill 895 has been introduced amending the Medical Practice Act, which if enacted would seriously cause harm to patients by removing important safety regulations present in the existing Medical Practice Act: and

WHEREAS, physician-led team based care is a priority of the Pennsylvania Medical Society as a means to provide the highest level of patient safety; and

WHEREAS, the AMA recently adopted policy in supporting the ability of medical boards to regulate the practice of physician assistants; therefore be it
RESOLVED, that the Pennsylvania Medical Society oppose any legislation that eliminates the requirement for physician scope of practice to be reviewed by the state board of medicine; and be it further

RESOLVED, that the Pennsylvania Medical Society oppose legislation that eliminates any oversight for the requirement for physician countersignature; and be it further

RESOLVED, that the Pennsylvania Medical Society oppose legislation that establishes a permanent seat for a Physician Assistant on the State Medical Board and State Osteopathic Board; and be it further

RESOLVED, that the Pennsylvania Medical Society oppose legislation that promotes physician assistant independent practice.

Fiscal Note: $______

Attached:

Document A - PA SB 895 - SENATE MEMORANDUM.pdf

Document B - Senate Bill 895 - text of bill document.pdf

Document C - Bill General Information - Senate Bill 895.pdf
Resolution 16-406: Hepatitis C Screening Act and Discretion of Physician Practice – Resolution 16-406, introduced at the 2016 annual meeting and referred for study to the Board of Trustees, called on the Society to seek legislative amendment to Act 87-2016 to prohibit the imposition of any liability, criminal or civil penalty, or licensure sanctions before any applicable State board for failure by a physician, health care practitioner, health care provider, hospital, health care facility, or physician’s office to comply with Act 87.

BACKGROUND ON HOUSE BILL 59

Act 87, the Hepatitis C Screening Act, was introduced as HB 59 by Representative Matthew E. Baker (R-68). Representative Baker serves as the Chairperson of the House Health Committee. In his co-sponsorship memo outlining his goals for passage of this act, Representative Baker highlighted that Pennsylvania has one of the highest rates of Hepatitis C in the nation and that Hepatitis C is the leading cause of liver cancer and liver transplantation. Due to the high rates of Hepatitis C, the U.S. Centers for Disease Control and Prevention (CDC) released guidelines in 2012 recommending anyone born between 1945 through 1965 get tested for Hepatitis C.

Representative Baker introduced HB 59 on January 21, 2015. His legislation required individuals born between 1945 and 1965 to be offered Hepatitis C testing when receiving health services as an inpatient in a hospital or when receiving primary care services in an outpatient department of a hospital, health care facility or physician’s office. There were three exceptions placed within this bill where the offering of Hepatitis C screening or diagnostic tests were not required when the health care practitioner providing services reasonably believed at least one of the following: 1) the individual is being treated for a life-threatening emergency; 2) the individual has previously been offered or has been the subject of a Hepatitis C screening test; or 3) the individual lacks capacity to consent to a Hepatitis C screening test.

HB 59 did not mandate that an individual take the test; it only required the offering of the test. If the individual accepted the offer of the test and the screening was reactive, HB 59 required the health care provider to either offer the individual follow-up care or refer the individual to a health care provider who was able to provide follow-up health care.

HB 59 was signed into law as Act 87-2016 on July 20, 2016 and became effective on September 18, 2016.

PAMED’S CORRESPONDENCE WITH THE DEPARTMENT OF HEALTH

Due to various questions that it received from members soon after PAMED published an article on this law in August 2016, PAMED staff drafted a letter to the Department of Health (DOH) dated August 31, 2016. Within that letter, PAMED sought answers to several questions, including:

- What is considered “primary care services” under Act 87, and specifically, whether OB-GYN services met that definition?

http://www.legis.state.pa.us//cfdocs/Legis/CSM/showMemoPublic.cfm?chamber=H&SPick=20150&cosponId=15893
• Whether there is a timeframe for individuals that have previously been offered Hepatitis C screening tests, thus negating the requirement to offer another test?
• What constitutes “culturally and linguistically” appropriate Hepatitis C screening tests given that DOH has not yet issued regulations on this issue?
• Whether physicians are required to explain to patients that their insurance may not cover the test?
• Whether the requirement for the “offering” of a Hepatitis C screening test is met if a physician writes an order or prescription for a patient to go to another facility for the test?

DOH did not respond to PAMED’s letter and it is unlikely that regulations will be promulgated by DOH any time soon under this law.

CURRENT STATUS

PAMED’s legal staff has not received inquiries on this bill since the Fall of 2016, soon after PAMED published its article in August 2016. PAMED is also unaware of any physician that has been sanctioned by the State Board of Medicine or State Board of Osteopathic Medicine for a violation of this act.

POLITICAL CLIMATE

Revisiting recently passed legislation that would, in essence, negate the bill’s original intent would be a heavy lift and would likely not be successful. However, approaching the legislature and the author of the enabling legislation with a proposal to enhance the existing law would be a more advisable pathway forward.

RECOMMENDATION

It is unlikely that PAMED will be able to successfully get an amendment enacted that basically exempts physicians from the requirements of this act. This act is specific to physicians and other health care practitioners in that it requires the offering of a Hepatitis C screening test if certain parameters are met. PAMED should not spend political capital attempting to seek an amendment that in essence allows physicians to ignore the mandates of this bill and face no penalties for doing so.

However, there are issues with the law that could be addressed with a possible amendment, among them the following:

• A better definition of “primary care services” and what services are specifically exempt from this definition.
• A timeframe for when the offering of a Hepatitis C screening test negates the requirement to offer another test.
• Clarification on whether physicians are required to discuss insurance/payment-related issues with patients.
• Clarification on whether physicians may write an order for a Hepatitis C screening test that allows a patient to go elsewhere for the test or whether the test has to be given in the office of the physician.

Discussing these issues with members of the legislature, and specifically Rep. Baker, may open up the possibility of amending Act 87 and better clarifying what a physician must do under this law.

CONCLUSION

Given the political climate, the unlikely success in getting this type of amendment enacted, while at the same time recognizing that there are issues with this law, it is recommended that PAMED does not seek
an amendment to Act 87 that essentially exempts physicians from having to comply with the law. In the alternative, it is recommended that PAMED seek to work with the legislature to draft an amendment to Act 87 that clarifies the issues that were highlighted by PAMED in its letter to DOH. By seeking this type of amendment, physicians will have a better understanding of when they must offer a Hepatitis C screening test and under what circumstances.

RECOMMENDATION

1. The Board of Trustees recommends that this report be adopted in lieu of Resolution 16-406.

David A. Talenti, MD
Chair
Resolution 16-408: Address and Petition CMS and Legislators to Allow for a Process of Appeal to Negative Statements and Reports to the National Practitioner Data Bank – Resolution 16-408, introduced at the 2016 annual meeting and referred for study to the Board of Trustees, called on the Society to:

1. Adopt a position on and defend physicians against those who use the National Practitioner Data Bank to ruin their reputations in an effort to manipulate and dissuade them from application and/or participation on their medical staffs.

2. Take action through its delegation to the AMA to address and petition CMS and legislators to allow for a process of appeal to negative statements and reports to the data bank.

3. Pursue avenues legal and political to guarantee due process and to protect physicians from abuse of the NPDB.

RESOLVED STATEMENT 1
Resolved Statement 1 calls on PAMED to adopt a position on and defend physicians against those who use the National Practitioner Data Bank to ruin their reputations in an effort to manipulate and dissuade them from application and/or participation on their medical staffs.

An NPDB report can have detrimental consequences for the subject physician. As a result of an NPDB report, a physician might find their employment opportunities diminished and ability to obtain malpractice insurance hindered. Regardless of whether the report adequately reflects their competence, it is difficult for a physician’s career and reputation to ever fully recover from a negative report. Considering the serious ramifications, it is imperative that only reports related to physician competence or conduct, which have adverse patient care outcomes, are promulgated to the NPDB.

Although PAMED cannot offer financial assistance or legal defense to physicians challenging NPDB reports, PAMED can provide physicians with pertinent information and resources to assist with their defense. PAMED can also refer physicians to organizations that specialize in peer review and NPDB appeal.

RESOLVED STATEMENT 2
Resolved Statement 2 calls on PAMED to take action through its delegation to the AMA to address and petition CMS and legislators to allow for a process of appeal to negative statements and reports to the data bank.

The AMA has recently adopted policy, advanced by the Medical Society of New Jersey that opposes medical staff appointment denial for any other purpose besides competency or conduct.
issues. The AMA is finalizing the official language of this policy, which should be published shortly. This policy is as follows:

“RESOLVED that our AMA formally request that the Health Resources and Services Administration (HRSA) clarify that reports of medical staff appointment denial by physicians are contingent upon competency or conduct issues related to the physicians’ provision of or failure to provide healthcare services that adversely affect the health or welfare of a result in patient harm and (2) only based on a professional review action and not for administrative or eligibility reasons; and be it further

RESOLVED that our AMA advocate that formally petition the Secretary of HHS to direct the HRSA to remove the name of any physician from the NPDB reported for reasons not related to competence or conduct patient care that adversely affected the health or welfare of a result in patient harm. (Directive to Take Action).”

First, although the AMA policy does not specifically direct the AMA to address and petition for a NPDB appeals process, it does identify a remedy that gets at the heart of what Resolution 16-408 seeks to accomplish: it advocates for (1) the proper use of the NPDB and (2) a mechanism for removing names/reports when the report is not related to competence or conduct that has adverse patient care outcomes.

Second, it appears that the author of the resolution believes that an appeals process for the NPDB does not currently exist. Contrary to this belief, the subject of an NPDB report may appeal a decision of the reporting entity, which was subsequently reported to the NPDB. The reporting entity’s appeals process should be part of the due process rights afforded the subject of the report.

Although the NPDB does not have an “appeals process” per se, it does have a dispute resolution process. This process allows a subject to dispute (1) whether a report was submitted in accordance with NPDB reporting requirement or (2) the factual accuracy of the information. It is the expectation of the NPDB that all appeals are handled at the level of the reporting entity.

Entering a report into Dispute Status does not trigger an automatic review by the NPDB. Once entered into Dispute Status, the subject must attempt to resolve their issue(s) with the report with the reporting entity. There is no formal process for how reporting entities are to handle report disputes with physicians. Unless modified or removed by the reporting entity, NPDB reports are permanent. Confronted with a dispute, the reporting entity may choose to: void, revise, or correct the report. The reporting entity may also choose to keep the report as is. If the subject has not received a response from the reporting entity in 60 days, or is unsatisfied with the response they received, the subject can elevate the dispute to Dispute Resolution. Dispute Resolution triggers a review of the report by the Secretary of HHS.

Secretarial review of NPDB information is limited in scope. The Secretary will only review a report for factual accuracy or to determine whether the report was submitted in accordance with NPDB reporting requirements. Dispute Resolution is not the proper venue for a physician to
appeal the underlying reasons of an adverse action. Secretarial review is not a mechanism for physicians to protest malpractice payments, challenge the allegations concerning their conduct, or question the merit of the underlying action.

Upon review of the dispute, the Secretary will issue one of the following decisions.

1. Conclude that the report is accurate. The Secretary will remove the report from disputed status and the report will stay the same in the NPDB. Subject may request reconsideration.
2. Conclude that the report is inaccurate. The Secretary will direct the reporting entity to either void the report or submit a corrected report.
3. Conclude that the action was not reportable. Report is voided.
4. Conclude that the disputed issue is outside the scope of departmental review. The Secretary will remove the report from disputed status and the report will stay the same in the NPDB.

There is no formal process to appeal a Dispute Resolution decision. However, reconsideration of the decision may be requested by the subject. When reconsidering a Dispute Resolution decision, the Secretary will either affirm the previous decision or issue a revised final decision. Subjects of reports may also challenge Dispute Resolutions in federal courts. The Administrative Process Act (APA) provides a remedy for individuals who have suffered a legal wrong because of an agency action. Under the APA, individuals who have suffered such a wrong are entitled to judicial review of the agency’s action. The wronged party must demonstrate that the agency action was arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.

In addition to the dispute process, subjects may also add Subject Statements. Subject Statements do not void, correct, amend, or otherwise alter NPDB reports. Unless removed or edited by the subject, Subject Statements become permanent parts of the report. Reports need not be in the dispute process for a subject to add a Subject Statement. Subject Statements provide an opportunity for subjects to rebut reports by explaining their conduct, listing relevant external factors, and offering clarifications. Subject Statements are left to the discretion of the subject and may be added at any time.

The existence of an appeals process at the reporting entity level and a regulatory process to challenge NPDB information would significantly minimize the efficacy of any effort initiated by PAMED. The aforementioned AMA policy is also relevant to this discussion as it provides a mechanism to remove reports not related to competence or conduct that has adverse patient care outcomes.

PAMED will provide members with education on the NPDB. This education will involve developing a module and primer on the NPDB. PAMED will instruct members on: what actions are reportable to the NPDB, due process, who can disseminate information to the NPDB, who can query the NPDB, and the NPDB dispute process. Additionally, PAMED will also educate members on how to ensure and utilize due process procedures during peer review proceedings and steps that can be taken to mitigate the damage of an NPDB report.
Resolved Statement 3 calls on PAMED to pursue legal and political avenues to guarantee due process and to protect physicians from abuses of the NPDB.

As briefly mentioned above, many of the disciplinary actions that culminate in NPDB reports include inherent guarantees of due process and procedural fairness. Reporting entities—hospitals, health plans, professional organizations, and licensing authorities, to name a few—generally accord physicians due process protections in peer review, credentialing, and disciplinary actions.

The AMA has enacted a number of policies concerning the protection of due process in peer review. Although universal guidelines for due process have not been promulgated, the AMA has issued general guidelines to be adopted as necessary to suit the circumstances and conditions of health care organizations. These guidelines include provisions to ensure a fair, objective, expeditious and independent hearing.

PAMED has also adopted numerous policies concerning the due process protection for physicians interacting with health care plans and hospitals. For example:

PAMED Policy No. 225.992(h) on medical staff development states: “Staff privileges for physicians should be based only on training, experience, demonstrated competence, and adherence to medical staff bylaws…there shall be a requirement in hospital bylaws for an appropriate appeal and due process mechanism.”

PAMED Policy No. 225.997 states: “The Society holds…that appropriate due process rights be assured to a physician who has received an adverse recommendation regarding medical staff membership or privileges.” Policy No. 225.997 further clarifies that these due process rights shall include an appeal conducted by an impartial body consisting of physicians who did not participate in the previous recommendation, and if a negative action is taken by the physician hearing committee, a hearing be held by a committee of the hospital governing body.

PAMED Policy No, 285.992(4) states: “[PAMED] will advocate in those cases in which economic issues may be used for consideration of sanction or dismissal, the physician participating in the plan should have the right to receive profile information and education, in a due process manner, before action of any kind is taken”

PAMED’s existing policies demonstrate PAMED’s commitment to guaranteeing and protecting due process for physicians.

As a result of the existing due process measures and the extensive number of policies from PAMED and other physician organizations concerning the protection of due process rights, it is recommended that this third resolved statement not be approved. As resolved above, PAMED is also committed to protecting physicians from those who abuse the NPDB for purposes of manipulation and dissuasion.
Conclusion
Given the potential harm of a NPDB report on a subject physician’s reputation, PAMED vehemently opposes any use of the NPDB to ruin a physician’s reputation in an attempt to manipulate or dissuade said physician from application and participation on a medical staff. Accordingly, The Board of Trustees recommends that the Society:

1. Oppose the use of the National Practitioner Data Bank to manipulate or dissuade physicians from application and participation on medical staffs; and

2. Provide members with education on the National Practitioner Data Bank and the National Practitioner Data Bank’s dispute process.

Recommendation
1. The Board of Trustees recommends that this report be adopted in lieu of Resolution 16-408.