REPORT 8 OF THE COUNCIL ON MEDICAL SERVICE (A-24)
Sustainable Payment for Community Practices
(Resolution 108-A-23)
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the House of Delegates referred Resolution 108-A-23, which asked the American Medical Association (AMA) to assess the prevalence of insurance payments to small medical practices that are below Medicare rates and the impact of these payment levels on the ability of practices to provide care. The resolution also asked the AMA to consider the impact on small and medium-sized practices of being excluded from population health management, outcome evidence-based care, and value-based purchasing arrangements, as well as to consider model legislation to address payment rates below the cost of practicing. Council on Medical Service Report 7-I-23 was referred back to the Council to allow reconsideration of a) non-Medicare benchmarks for private payers; b) a minimum government rate, including Medicaid; and c) the impact that rates below these benchmarks have on small community practices.

Despite the current trend toward larger practices, more than half of physicians still work in small practices of 10 or fewer physicians, a percentage that has fallen continuously since 2012. While small practices have some advantages that cannot be matched by larger practices, they are not necessarily well equipped to succeed in value-based purchasing arrangements, which require financial investment and regulatory, technological, and analytic expertise. Given that the single most important factor in ensuring a sustainable level of payment for small practices is leverage, collaboration to form alliances may provide the scale needed to negotiate value-based contracts and to spread the risk across multiple practices. Strong network adequacy requirements and fair out-of-network rules are also essential for the sustainability of small practices.

While research shows that private insurance payment rates are, on average, higher than Medicare payment rates for the same medical services, it also indicates that Medicaid payment rates are substantially below Medicare payment rates. Small practices have a higher percentage of private health insurance patients than larger practices, which should benefit them. However, not all private insurance payments are reflective of the full cost of practice, the value of the care provided, or include inflation-based updates. These inadequate payment levels are exacerbated by the fact that in 2019, Medicaid fee-for-service payments for physician services were nearly 30 percent below Medicare payment levels, with an even larger differential for primary care physician services.

While AMA policy does not endorse a specific payment mechanism such as the Medicare Resource-Based Relative Value Scale (RBRVS), it does support payment at no less than 100 percent of RBRVS Medicare allowable as one option that could provide the basis for both public and private physician payment systems.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 8-A-24

Subject: Sustainable Payment for Community Practices (Resolution 108-A-23)

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee A

At the 2023 Annual Meeting, the House of Delegates (HOD) referred Resolution 108, which was sponsored by the District of Columbia Delegation. Resolution 108-A-23 asked for the American Medical Association (AMA) to:

> "(1) study small medical practices to assess the prevalence of insurance payments to these practices that are below Medicare rates and to assess the effects of these payment levels on practices' ability to provide care, and report back by the 2024 Annual Meeting; (2) study and report back on remedies for such reimbursement rates for physician practices; (3) study the impact on small and medium-sized physician practices of being excluded from population health management, outcome evidence-based care, and value-based purchasing arrangements; and study and report back to the House of Delegates options for model legislation for states and municipalities seeking to correct reimbursement rates for medical practices that are below those required to meet fixed costs."

The Council on Medical Service developed Report 7-I-23, Sustainable Payment for Community Practices, which was referred to allow reconsideration of a) non-Medicare benchmarks for private payers; b) a minimum government rate, including Medicaid; and c) the impact that rates below these benchmarks have on small community practices.

In this report, the Council expands on the discussion included in Council Report 7-I-23 to include Medicaid payment schedules and how they compare to Medicare and private insurance payment rates, while acknowledging the costs of providing care to the Medicaid population as well as the challenges of tying payment schedules to a Medicare benchmark. Our focus is on non-hospital owned small practices, which are typically not eligible for facility fees nor possess the market power inherent in larger, hospital-owned practices. We compare Medicare, Medicaid, and private insurance payment rates, outline collaborative and negotiating resources available to small practices, highlight essential AMA policy and resources, and present new policy recommendations.

BACKGROUND

Despite the current trend toward larger practices, more than half of physicians (51.8 percent) still work in small practices of 10 or fewer physicians, a percentage that has fallen continuously from 61.4 percent in 2012.[1] Contributing factors to the shift include mergers and acquisitions, practice closures, physician job changes, and the different practice settings chosen by younger physicians compared to those of retiring physicians. The "cohort effect"[2] demonstrates that younger

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physicians appear to prefer larger practices for the more predictable income and work-life balance they can offer.[3] They also may be hesitant to assume the business and entrepreneurial responsibilities demanded by smaller practices.[4]

However, small practices have some advantages that cannot be matched by larger practices, most notably patients of small practices have lower rates of preventable readmissions than those in larger practices.[5] The autonomy of small practices and preservation of the traditional patient-physician relationship provide reassurance to patients that the physician is acting in their best interests. It is thought that the patient-physician bond generates trust, which leads to better adherence to a treatment plan.[6] As small practices become patient-centered medical homes, their decisions can control downstream costs, highlighting the importance of trusted, engaged, and financially aligned physicians in value-based payment systems. Although the medical home model suggests that physicians in small practices are uniquely positioned to succeed in value-based purchasing arrangements, they are not necessarily well equipped to do so given the financial investment and regulatory, technological, and analytic expertise necessary to enter these arrangements. In addition to these inherent limitations of small practices, extrinsic factors can play a role in creating an uneven playing field, including the fact that independent primary care physicians more often fill gaps in care in low-income, rural, and other underserved communities.[7]

Assessing the current level of sustainability for small community practices requires appreciating the current limitations of governmental authority, understanding the impact of Medicare, Medicaid, and private insurance payment rates, acknowledging relevant AMA policy and advocacy, and exploring the resources available for small practices that want to engage more fully in an evolving value-based health care system.

FAIR LABOR STANDARDS ACT OF 1938

The Fair Labor Standards Act of 1938 (FLSA) protects workers against unfair employment practices. FLSA rules specify when workers are considered "on the clock" and when they should be paid overtime, along with a minimum wage. Employees are deemed either exempt or nonexempt under the FLSA.

Resolution 108-A-23 postulates that the FLSA confers governmental authority to establish minimum levels of payment for medical practices. However, Section 13(a)(1) of the FLSA provides an exemption from both minimum wage and overtime pay for employees employed as "bona fide executive, administrative, professional, and outside sales employees." Physicians are exempted from FLSA protection since they are considered "Learned Professionals," as their primary duty requires advanced knowledge, defined as work that is predominantly intellectual in character and that includes work requiring the consistent exercise of discretion and judgment, in a field of science or learning; and customarily acquired by a prolonged course of specialized intellectual instruction.[8] As such, the FLSA cannot provide protection for small medical practices regarding minimum levels of payment.

MEDICARE PHYSICIAN PAYMENT SCHEDULE

Medicare is a federal insurance program where coverage is generally offered to individuals who are 65 years or older, have certain disabilities, or suffer from end-stage renal disease or amyotrophic lateral sclerosis. In 1992, the federal government established a standardized Medicare Physician Payment Schedule (MPPS) based on a resource-based relative value scale (RBRVS). Prior to that, the federal government paid physicians using a system of "customary, prevailing, and reasonable" (CPR) charges, which was based on the "usual, customary, and reasonable" system used by many

private insurers. The Medicare CPR system allowed for wide variation in the amount paid for the same service, resulting in unfounded discrepancies in Medicare payment levels among geographic service areas and physician specialties.

In an RBRVS system, payments for services are determined by the standardized resource costs needed to provide them, which are then adjusted to account for differences in work, practice expense, and professional liability insurance costs across national geographic service areas. The RBRVS publishes relative value units (RVUs) for each service, which are then converted to a payment amount using geographical practice cost indices and an annually updated Medicare Conversion Factor to establish the MPPS. The AMA/Specialty Society Relative Value Scale Update Committee (RUC) identifies the resources required to provide physician services, which the Centers for Medicare & Medicaid Services (CMS) then considers in developing RBRVS RVUs. While, historically, 90 percent or more of RUC recommendations have been accepted,[9] CMS makes all final Medicare payment decisions.

MEDICAID PAYMENT SCHEDULES

The Department of Health and Human Services describes Medicare as an insurance program, whereas Medicaid is an assistance program. Medicaid is a federal and state-sponsored program that assists low-income individuals with paying for their health care costs. Each state defines who is eligible for Medicaid coverage, but the program generally covers individuals who have limited income, including:

- Individuals 65 years or older
- Children under 19 years old
- Pregnant women
- Individuals living with a disability
- Parents or adults caring for a child
- Adults without dependent children
- Eligible immigrants

States have the option to charge premiums and determine cost sharing requirements for Medicaid beneficiaries. While maximum out-of-pocket costs are limited, states can impose higher charges for targeted groups of somewhat higher income individuals. Certain vulnerable groups, such as children and pregnant women, are exempt from most out-of-pocket costs and copayments and coinsurance cannot be charged for some services. The federal government funds a percentage of the operating costs for each state through the federal medical assistance percentage (FMAP). The FMAP varies from state to state and is inversely related to state per capita income. The matching rate for a state can range from 50 percent to 83 percent. On average, the federal government nominally pays 57 percent of the cost of the program.[10] Medicaid payment rates are determined by the state for each service in accordance with its approved Medicaid state plan.

PRIVATE INSURANCE PAYMENT SCHEDULES

For small community practices, payment schedules are typically negotiated between the payer and the practice as part of a network of preferred physicians. Practices agree to these payment schedules to permit inclusion in the network, since being in-network is generally more appealing to patients, allows access to in-network referrals, and reduces the chance of unexpectedly low payment to the practice.

When negotiating payment schedules, it is important that the practice is aware of its fixed and variable costs for a given service so that the long-term break-even point can be determined. The smaller the practice, the more important it is to negotiate with as much data and defined value proposition as possible, because a smaller practice has less leverage. Given that private insurance payment schedules are negotiated between two parties, they can vary by state, region, payer, specialty, and/or practice. Thus, it is likely that most small practices accept multiple different payment schedules from different payers.

Private insurance payments are variable across physician specialties. The Urban Institute conducted an analysis of FAIR Health professional claims from March 2019 to February 2020, comparing them to the MPPS for the same time period. The analysis included 17 physician specialties and approximately 20 services per specialty, which represented about 40 percent of total professional spending. The Urban Institute found significant variation in relative prices across specialties, with commercial-to-Medicare payment ratio across all selected services for the 17 specialties averaging 1.6 using an expenditure-weighted approach.[11]

Areas where there is greater market concentration among physicians tend to have higher payment amounts from private insurance.[12] The Health Care Cost Institute's Health Care Cost and Utilization Report found that there was substantial variation in private insurance payments across states, with average commercial prices ranging from 98 percent to 188 percent of Medicare rates. Seven states had payments that were, on average, higher than 150 percent of Medicare rates while 11 states had average payments within 10 percent of Medicare. The states with the highest private insurance payments relative to Medicare tended to be in the northwest of the country and along the Great Plains.[13]

MEDICARE VERSUS PRIVATE INSURANCE PAYMENT RATES

A 2020 KFF literature review discovered that private insurance paid 143 percent of Medicare rates for physician services, on average, ranging from 118 percent to 179 percent of Medicare rates across studies.[14] Estimates from a more recent Milliman white paper closely align, finding that 2022 commercial payment for professional medical services to be approximately 141 percent of Medicare fee-for-service rates.[15] A 2022 Congressional Budget Office report identified "rapid increases in the prices that commercial insurers pay for hospitals' and physicians' services,"[16] leading to further divergence between private and public insurance payment rates, a trend that has proven consistent over time. A 2003 Office of the Inspector General review determined that of 217 procedures, 119 were valued lower by Medicare than by private insurers[17] and a 2017 Health Care Cost Institute report found that commercial payments for the average professional service were 122 percent of what would have been paid under Medicare.[18] The 2022 AMA Physician Practice Benchmark Survey found that small practices of 1 to 15 physicians have a higher percentage of private health insurance patients than larger practices (45.9 percent vs 40.9 percent).[19] Since research shows that private insurance payment rates are, on average, higher than Medicare payment rates for the same health services, this may benefit small practices.

While the Council was unable to identify a survey focused on small practice Medicare to private insurance rate ratios, anecdotal reports indicate that some small practices are seeing private insurers offer payment below 100 percent of Medicare, which may be further depressed when insurers utilize a prior year Medicare rate. A Washington, DC two-physician clinic reported receiving private insurance payment rates ranging from 16-43 percent lower than Medicare, despite becoming a Patient-Centered Medical Home and entering into a local accountable care organization (ACO). Similarly, a solo endocrinologist who left a university-affiliated practice

reported being disadvantaged by no longer being able to collect facility fees to generate higher billing, forcing him to opt out of all insurance plans due to inadequate payment.

MEDICAID PAYMENT COMPARISON AND HEALTH EQUITY IMPLICATIONS

In 2019, Medicaid fee-for-service payments for physician services were nearly 30 percent below Medicare payment levels, with an even larger differential for primary care physician services.[20] A 2017 study found that total payments for physician office visits under Medicaid averaged 62.2 percent of payment amounts under private insurance and 73.7 percent of those under Medicare.[21] As the largest public health insurance provider in the United States, Medicaid policy has significant health equity implications. Low payment rates may limit access to quality care and contribute to poor health outcomes for Medicaid beneficiaries. Research has found that increasing Medicaid primary care rates by $45 per service would reduce access-to-care inequities by at least 70 percent.[22]

While Medicaid state flexibility is intended to preserve state operational autonomy and programming, it has fostered wide variability and geographic inequities, particularly between Medicaid expansion states and non-expansion states,[23] further enabling health disparities. Substantial dependence on state revenues has led to low payment rates that effectively limit access, as it disincentivizes providing care to the often minoritized populations the program serves. As small practices must absorb costs required to provide care to the Medicaid population, such as compliance with regulations and addressing Social Determinants of Health toward equitable care, lower payment makes it almost impossible to recover those costs. Small practices experience higher burdens for translation services in regions where Medicaid patients may have limited English proficiency. Small practices also have challenges in assuring adequate patient follow-up due to a lack of reliable communications (e.g., lack of working phone numbers or inability to reach patients during the daytime while they are working, lack of access to a computer/internet) and transportation challenges.

PAYMENT BENCHMARKS

An ideal payment benchmark will reflect the cost of providing care both in the short term and long term while acknowledging risk, variable expenses, an appropriate allocation of fixed costs, and physician work. It is essential that the benchmark reflect the full cost of practice and the value of the care provided, as well as include inflation-based updates. The benchmark should disclose payment amounts and the methodology used to calculate them, as these are fundamental to establishing trust between physicians and insurers and promoting sound decision making by all participants in the health care system. As the Medicare RBRVS values and methodology are fully transparent, a payment benchmark uncoupled from the RBRVS must be accompanied by commensurate transparency in payment methodology.

A general measurement of a payment schedule is its relative payment rate compared to the MPPS or “benchmarking” to Medicare. Payment schedules that are less than the MPPS are considered beneficial for the payer, whereas payment schedules that match or are greater than the MPPS are considered beneficial for the practice. The percentage of MPPS rates is one of the most widely accepted payment benchmarks when evaluating physician payment level and comparing contracts in the health care industry. It can reflect the mix of services across physicians and plans while removing impacts from billed charges that can vary widely across providers and regions. Additionally, Medicare RBRVS values remain the foundation for many Alternative Payment Models (APMs) as they can produce more or less value by influencing how physicians spend their time and the mix of services provided to patients.

However, there are challenges presented by tying payment to a Medicare benchmark. Some payers may adopt only a portion of the Medicare RBRVS (e.g., use RVU) but utilize a lower conversion factor) or use an outdated RBRVS where the RVUs are no longer reflective of current resource costs. Other payers may implement time-limited or temporary arrangements or apply the RBRVS to only certain specialties, leading to disruption in care or difficulties with patient referrals. Most importantly, continuing to tether payment to a Medicare payment rate that has been reduced by almost 10 percent in four years presents an untenable situation for small practices. After adjusting for inflation, Medicare physician payment has effectively declined 29 percent from 2001 to 2024.

Some have suggested the development of a "minimum government rate" as a payment benchmark. However, it is challenging to identify a rate and methodology defensible across the six major government health care programs:

1) Medicare
2) Medicaid
3) The Children's Insurance Program (CHIP)
4) The Department of Defense TRICARE and TRICARE for Life Programs
5) The Veterans Health Administration program
6) The Indian Health Service

While these programs collectively provide health care services to one-third of Americans, they differ extensively in terms of size, scope, financing, and program design, making it unfeasible to establish an equitable minimum payment rate appropriate for all. Furthermore, it would be impracticable to establish a minimum payment rate in the private physician market, which is currently riding a consolidation wave, transforming health insurers into much larger and more powerful conglomerates. Helping small practices escape the vice grip of unfair market rates from consolidated insurers begs the need for strong antitrust reform. While reference prices and price floors have been used in various sectors of the economy, they appear to have a low likelihood of being adopted in health care, as demonstrated by the Economic Stabilization Program of the early 1970s.[24] Programs that provide for low income and rural patient populations already struggle to obtain adequate funding. As demonstrated in the oil and agricultural sectors, policymakers are not likely to set a payment floor unless they are granted influence over the distribution of health care prices in return.

SUSTAINABLE PAYMENT FOR SMALL COMMUNITY PRACTICES

Small practices are disproportionately affected by payment rates that fall below an ideal benchmark. One of the most notable changes has been the redistribution of physicians from small to large practices. The share of physicians who worked in practices that had 10 or fewer physicians decreased from 61.4 percent in 2012 to 51.8 percent in 2022, with the need to better negotiate favorable (higher) payment rates with payers as one of the most important motivations for private practices selling to hospitals or health systems.[25]

The term "sustainable" denotes that something is bearable and capable of being continued at a certain level over a period of time. For small community practices, sustainable payment reflects the full cost of practice and the value of the care provided. Additionally, it includes annual inflation-based payment updates, which are essential to measure practice cost inflation and account for changes in physicians' operating costs. Annual updates enable small practices to better absorb other payment redistributions triggered by budget neutrality rules and performance adjustments, as well as periods of high inflation and rising staffing costs; they also help physicians invest in their practices and implement new strategies to provide high-value care.

The single most influential factor in ensuring a sustainable level of payment for small practices is leverage. Strong network adequacy requirements that expect all health plans to contract with sufficient numbers and types of physicians bestow bargaining power by making it difficult for insurers to dismiss negotiation on an in-network payment schedule. Alternatively, when small practices are able to drop onerous insurance contracts and achieve out-of-network status, their leverage is amplified, most markedly when underwritten by fair out-of-network rules that require out-of-network physicians be eligible to be paid at rates higher than in-network physicians would otherwise receive for those services.

Physicians have been moving to larger group practices in order to gain leverage as well as access to more resources to effectively implement value-based care and risk-based payment models.[26] In this era of consolidation, there is an expectation of progression from solo or small physician practices to groups and multispecialty practices and, finally, to fully integrated delivery systems that employ the physicians, own the hospitals, and use a single information system. In this limited view, the earlier forms of practice organization are assumed to be incapable of implementing the supporting systems needed for population health (e.g., registries, electronic medical records, care management, team-based care) and are therefore unable to compete in value-based payment systems. A 2011 report of the Massachusetts Attorney General concluded that while bearing financial risk through value-based payments encourages coordinated care, it also requires significant investment to develop the capacity to effectively manage risk, which is more difficult for most physicians who practice in small groups and have historically been paid less than larger practices.[27] The report also found that physicians who transitioned to larger groups received professional payment that was approximately 30 percent higher, which accelerated the number of physicians leaving small practices and joining larger groups.

However, small practices are able to compete if they join forces to create profitable economies of scale without forfeiting the advantages of being small.[28] When small practices collaborate, they form a network of peers to learn from and to glean deeper insights from population health models. Alliances can provide the scale needed to negotiate value-based contracts and to spread the risk across multiple practices, so that a handful of unavoidable hospitalizations does not destroy a single practice. Collaboration allows each practice access to the necessary technologies to draw actionable insights from data and regulatory and coding expertise to maximize revenue, while laying the groundwork for future savings.

Independent practice associations (IPAs), if structured in compliance with antitrust laws, allow contracting between independent physicians and payers and can succeed in value-based purchasing arrangements if they are able to achieve results equal to more highly capitalized and tightly structured large medical groups and hospital-owned practices. Traditionally, most IPAs have been networks of small practices organized for the purpose of negotiating fee-for-service contracts with health insurers. While small practices considering participating in an IPA should be aware of the potential risks, such as underfunded capitation revenue, IPAs can act as a platform for sharing resources and negotiating risk-bearing medical services agreements on behalf of participating practices. Many IPAs, especially those that are clinically integrated, have already converted to an ACO, or provide the infrastructure for their members to organize as one. Because many of these organizations have already operated as risk-bearing provider networks, IPAs are well positioned to take leading roles in developing ACOs or acting as sustaining member organizations. Even if the physician organization has operated in a fee-for-service environment, an IPA can bring expertise regarding contracting, analytics, and management. For example, the Greater Rochester IPA (GRIPA) has over 1,500 physician members who benefit from data analytics services to stratify and manage patients, as well as care management support, pharmacists, visiting home nurses, and diabetes educators. GRIPA has its own ACO, which distributed 83 percent of its 2020 shared

savings to participants. ACOs can also benefit from participation by small practices. A 2022 study found that small practices in ACOs reduced their beneficiaries' spending more than large practices in ACOs, thereby generating higher savings for the ACOs consisting of small practices.[29]

CMS structures several of its initiatives in an effort to support small practices in value-based participation, such as the Small, Underserved, and Rural Support initiative, which provides free, customized technical assistance to practices with 15 or fewer physicians. Small practices can contact selected organizations in their state to receive help with choosing quality measures, strategic planning, education and outreach, and health information technology optimization. CMS also includes several reporting flexibilities and rewards, specifically targeting solo and small practices under the Quality Payment Program's Merit-Based Incentive Payment System, most notably by varying submission methods and allowing special scoring consideration. The CMS ACO Investment Model built on the experience with the Alternative Payment Model (APM) to test the use of pre-paid shared savings to encourage new ACOs to form in rural and underserved areas and to encourage current Medicare Shared Savings Program ACOs to transition to arrangements with greater financial risk. It resulted in more physicians in rural and underserved communities signing on to participate in ACOs. These new ACOs invested in better care coordination, and savings have been attributed to fewer unnecessary acute hospitalizations, fewer emergency department visits, and fewer days in skilled nursing facilities among beneficiaries. The ACO Investment Model generated $381.5 million in net Medicare savings between 2016 and 2018.[30] In June 2024, CMS will launch the Making Care Primary program to allow practices to build a value-based infrastructure by "improving care management and care coordination, equipping primary care clinicians with tools to form partnerships with health care specialists, and leveraging community-based connections to address patients' health needs as well as their health-related social needs such as housing and nutrition." The program will offer three progressive tracks to recognize participants' varying experience in value-based care, including one reserved for practices with no prior value-based care experience.

RESOURCES FOR SMALL PRACTICES

There has been a recent emergence of payer-sponsored arrangements, such as the one sponsored by Acuitas Health. It is a partnership between a nonprofit health plan and a large multispecialty group that offers a range of services to small practices, including billing and coding assistance, practice transformation consulting, and patient aggregation, thereby allowing practices to achieve the scale needed for value-based contracts. Through its work with Acuitas, the NYC Population Health Improvement Program was able to "answer important questions about what skills small practices need in order to succeed in the new environment and how small practices might work together to share the services necessary to develop those skills…(as well as) break new ground by presenting a financial model for the cost of shared services and probing the legal and regulatory issues raised by such arrangements."[31] Other private companies have created shared service infrastructures to allow small, independent practices to participate in APMs, offering low-cost shared resources in return for a portion of downstream savings.

Regardless of the payment rates, small practices can increase profit margins if they are able to keep their costs down. Group purchasing organizations (GPOs) and physician buying groups (PBGs) can offer independent practices a chance to access lower costs by using the power of many practices to benefit all. Some GPOs do not require purchases from a given supplier yet still offer leverage with other suppliers to grant small practices reduced rates. As most community-based practices offer vaccines, PBGs can play an important role in keeping costs down. Vaccines are one of the most costly and important investments a practice makes, and PBGs can offer practices lower contract pricing and rebates from the vaccine manufacturer. Practices can save five to 25 percent on the cost

of supplies by joining a GPO or PBG, most of which have no fee and often allow practices to join several organizations.[32]

Small practices typically sign "evergreen" contracts with payers, which continuously renew automatically until one party terminates the agreement. A payment schedule is part of the contract and will not be updated unless one party opens the contract for negotiation. In most cases, this must be the practice since it is not usually in the payer's best financial interest to negotiate a new contract. As such, practices need to be prepared to contact the payer multiple times in order to actually get a contract negotiated – and then come to the table with as much data and population health metrics (e.g., A1C numbers for patients with diabetes) as possible. A practice able to successfully manage complex patients will have costs within a relatively narrow range without many outliers, thereby increasing negotiating leverage. Small practices can also gain a negotiating advantage if they have extended office hours, are considered the "only show in town," provide specialized care for an underserved patient population, have obtained quality accreditation recognition (e.g., National Committee for Quality Assurance), or can share positive patient testimonials.

The AMA has several resources dedicated to support physicians in private practice, such as the AMA Private Practice Simple Solutions series, which are "free, open access rapid learning cycles designed to provide opportunities to implement actionable changes that can immediately increase efficiency in private practices." Session topics range from marketing to recruitment to reducing administrative burden. The AMA Practice Management Center developed the Evaluating and Negotiating Emerging Payment Options manual to assist members who are considering transitioning to risk-based payment, while the AMA Value Based Care Toolkit is being updated for 2023 to provide a step-by-step guide to designing, adopting, and optimizing the value-based care model. The 2016 adoption of AMA Policy D-160.926, which calls for the development of a guide to provide information to physicians in or considering solo and small practice on how they can align through Independent Practice Associations, Accountable Care Organizations, Physician Hospital Organizations, and other models to help them with the imminent movement to risk-based contracting and value-based care, resulted in the development of the Joining or Aligning with a Physician-Led Integrated Health System guide, which was updated in June 2020. The AMA also offers a Private Practice Group Membership Program to drive sustainability and accelerate innovation for members in private practice, as well as a Voluntary Best Practices to Advance Data Sharing Playbook to address the future of sustainable value-based payment.

AMA POLICY

The AMA's longstanding goal to promote the sustainability of solo, small, and primary care practices is reflected in numerous AMA policies, including those that:

- Call for the development of a guide to provide information to physicians in or considering solo and small practice on how they can align through IPAs, ACOs, Physician Hospital Organizations, and other models to help them with the imminent movement to risk-based contracting and value-based care (Policy D-160.926);
- Advocate in Congress to ensure adequate payment for services rendered by private practicing physicians, create and maintain a reference document establishing principles for entering into and sustaining a private practice, and issue a report in collaboration with the Private Practice Physicians Section at least every two years communicating efforts to support independent medical practices (Policy D-405.988);
- Support development of administrative mechanisms to assist primary care physicians in the logistics of their practices to help ensure professional satisfaction and practice

sustainability, support increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, and advocate for public and private payers to develop physician payment systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes (Policy H-200.949);
- Reinforce the freedom of physicians to choose their method of earning a living and the right of physicians to charge their patients their usual fee that is fair, irrespective of insurance/coverage arrangements between the patient and the insurers (Policy H-385.926);
- Support insurance payment rates that are established through meaningful negotiations and contracts (Policy H-165.838);
- Call for a formal, legal review of ongoing grievous behaviors of the health insurance industry (Policy D-385.949);
- Advocate for payment rates that are sufficient to cover the full cost of sustainable medical practice, continue to monitor health care delivery and physician payment reform activities, and provide resources to help physicians understand and participate in payment reform initiatives (Policy H-390.849);
- Seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs to ensure payment rates cover the full cost of sustainable medical practice (D-390.946); and
- Support fair out-of-network payment rules coupled with strong network adequacy requirements for all physicians (H-285.904).

The AMA has policy that addresses the challenges presented by the evolving value-based health care system, such as those that:

- Provide guidance and support infrastructure that allows independent physicians to join with other physicians in clinically integrated networks independent of any hospital system, identify financially viable prospective payment models, and develop educational opportunities for physicians to learn and collaborate on best practices for such payment models for physician practice, including but not limited to independent private practice (Policy H-385.904);
- Support a pluralistic approach to third-party payment methodology, promoting flexibility in payment arrangements (Policy H-385.989);
- Reaffirm the AMA's support for a neutral public policy and fair market competition among alternative health care delivery and financing systems (Policy H-385.990); and
- Emphasize the AMA's dedication to seeking payment reform, supporting independent physicians in joining clinically integrated networks, and refining relative values for services based on valid and reliable data (Policy H-400.972).

AMA policy does not endorse a specific payment mechanism such as Medicare RBRVS, but instead, states that use of RBRVS relative values is one option that could provide the basis for both public and private physician payment systems. Among the most relevant policies are those that:

- Oppose any type of national mandatory fee schedule (Policy H-385.986);
- Support uncoupling of commercial fee schedules from Medicare conversion factors and seek legislation and/or regulation to prevent insurance companies from utilizing a physician payment schedule below the updated Medicare professional fee schedule (Policy D-400.990); and

- Support a pluralistic approach to third-party payment methodology under fee-for-service, and do not support a preference for usual and customary or reasonable or any other specific payment methodology (Policy H-385.989).

Finally, AMA policies establish a minimum physician payment of 100 percent of the RBRVS Medicare allowable for CHIP and Medicaid (Policy H-290.976) as well as for TRICARE and any other publicly funded insurance plan (Policy H-385.921).

DISCUSSION

Research has found that small community practices are able to deliver more personalized patient care and have lower rates of preventable hospital admissions. They are able to detect potential conditions before they result in hospital admissions and accordingly play a vital role in keeping patients healthier. However, small community practices may be challenged in implementing the support systems needed for participation in population health management and value-based purchasing arrangements. As such, the Council believes that bonuses for population-based programs must be accessible to small community practices, taking into consideration the size of the populations they manage and with a specific focus on improving care and payment for children, pregnant people, and people with mental health conditions, as these groups are often disproportionately covered by Medicaid.

Small practices are typically not eligible to collect facility fees or utilize various addresses or facility types to generate higher billing for similar procedures depending on contracts and incentives, thereby creating a revenue differential with larger practices. Most importantly, small practices lack the leverage retained by larger practices, putting them at a significant disadvantage when negotiating payment schedules. The single most influential factor in ensuring a sustainable level of payment for small practices is leverage. Strong network adequacy requirements that expect all health plans to contract with sufficient numbers and types of physicians bestow bargaining power by making it difficult for insurers to dismiss negotiation on an in-network payment schedule. Alternatively, when small practices are able to drop onerous insurance contracts and achieve out-of-network status, their leverage is amplified, most markedly when underwritten by fair out-of-network rules that require out-of-network physicians be eligible to be paid at rates higher than in-network physicians would otherwise receive for those services. There are resources available to help small practices succeed, most notably in underserved markets where average private professional service payments tend to be higher than those in more competitive physician markets.[33]

Resolution 108-A-23 presumes that small practices experience private insurance payment rates well below Medicare payment rates. However, research shows that private insurance payment rates are, on average, higher than Medicare payment rates for the same health care services.[34] While there are limitations in the available data due to inclusion of larger practices and hospital-employed physicians, variability in private insurance payment schedules means that most small practices accept multiple different payment schedules from different payers, making it difficult for them to respond to questions about payment rates with accuracy. Accordingly, the Council believes a physician survey is not likely to illuminate payment variations in small practices between private insurance and Medicare payment rates. Small practices have a higher percentage of private health insurance patients than larger practices, which should benefit them. However, not all private insurance payments are reflective of the full cost of practice, the value of the care provided, or include inflation-based updates.

Research also indicates that Medicaid payment rates are substantially below Medicare payment rates. As the largest public health insurance provider in the United States, Medicaid policy has significant health equity implications. Low payment rates may limit access to quality care and contribute to poor health outcomes for Medicaid beneficiaries. While Medicaid state flexibility is intended to preserve state operational autonomy and programming, it has fostered wide variability and geographic inequities, particularly between Medicaid expansion states and non-expansion states, further enabling health disparities. Substantial dependence on state revenues has led to low payment rates that effectively limit access, as it disincentivizes providing care to the often minoritized populations the program serves. As small practices must absorb costs required to provide care to the Medicaid population, such as compliance with regulations and addressing Social Determinants of Health toward equitable care, lower payment makes it almost impossible to recover those costs.

Although AMA policy does not endorse a specific payment mechanism such as the Medicare RBRVS and opposes any type of mandatory payment schedule, it does support payment at no less than 100 percent of RBRVS Medicare allowable as one option that could provide the basis for both public and private physician payment systems. However, consideration must be given to the challenges presented by tying payment to a Medicare benchmark, which can be manipulated by payers to provide them with a financial advantage. Some payers may adopt only a portion of the Medicare RBRVS or use an outdated RBRVS where the RVUs are no longer reflective of current resource costs. Other payers may implement time-limited or temporary arrangements or apply the RBRVS to only certain specialties, leading to disruption in care or difficulties with patient referrals. Most importantly, continuing to tether payment to a Medicare payment rate that has been reduced by almost 10 percent in four years presents an untenable situation for small practices. As such, uncoupling payment schedules from a Medicare benchmark may allow for a level of payment that reflects the full cost of practice, the value of the care provided, and includes inflation-based updates, thereby sustaining small practices.

It is unfeasible to establish an equitable minimum government payment rate defensible across the six major government health care programs. Furthermore, it would be impracticable to establish a minimum payment rate in the private physician market, which is currently riding a consolidation wave, transforming health insurers into much larger and more powerful conglomerates. The Council believes that an ideal payment benchmark will reflect the cost of providing care both in the short term and long term while acknowledging risk, variable expenses, an appropriate allocation of fixed costs, and physician work. It is essential that the benchmark reflect the full cost of practice and the value of the care provided, as well as include inflation-based updates. The benchmark should disclose payment amounts and the methodology used to calculate them, as these are fundamental to establishing trust between physicians and insurers and promoting sound decision making by all participants in the health care system.

For small community practices, sustainable payment reflects the full cost of practice and the value of the care provided. Additionally, it includes annual inflation-based payment updates, which are essential to measure practice cost inflation and account for changes in physicians' operating costs. Annual updates enable small practices to better absorb other payment redistributions triggered by budget neutrality rules and performance adjustments, as well as periods of high inflation and rising staffing costs; they also help physicians invest in their practices and implement new strategies to provide high-value care.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 108-A-23, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support making bonuses for population-based programs accessible to small community practices, taking into consideration the size of the populations they manage and with a specific focus on improving care and payment for children, pregnant people, and people with mental health conditions, as these groups are often disproportionately covered by Medicaid. (New HOD Policy)

2. That our AMA amend Policy D-400.990 by addition and deletion, and modify the title by addition and deletion, as follows:

   Uncoupling Commercial Fee Schedules from the Medicare Physician Payment Schedule ~~Conversion Factors~~ D-400.990
   Our AMA: (1) shall use every means available to convince health insurance companies and managed care organizations to immediately uncouple fee schedules from the Medicare Physician Payment Schedule ~~conversion factors~~ and to maintain a ~~fair and appropriate~~ level of payment ~~reimbursement~~ that is sustainable, reflects the full cost of practice, the value of the care provided, and includes an inflation-based update; and (2) will seek legislation and/or regulation to prevent managed care companies from utilizing a physician payment schedule below the updated Medicare Physician Payment ~~professional fee~~ ~~s~~Schedule. (Modify Current HOD Policy)

3. That our AMA amend Policy H-290.976 by addition and deletion, and modify the title by addition and deletion, as follows:

   Enhanced ~~S~~CHIP Enrollment, Outreach, and Payment ~~Reimbursement~~ H-290.976
   1. It is the policy of our AMA that prior to or concomitant with states' expansion of ~~State~~ Children's Health Insurance Programs (~~S~~CHIP) to adult coverage, our AMA urge all states to maximize their efforts at outreach and enrollment of ~~S~~CHIP eligible children, using all available state and federal funds.
   2. Our AMA affirms its commitment to advocating for ~~reasonable~~ ~~S~~CHIP and Medicaid payment that is sustainable, reflects the full cost of practice, the value of the care provided, and includes inflation-based updates, ~~reimbursement for its medical providers, defined as at minimum~~ and is no less than 100 percent of RBRVS Medicare allowable. (Modify Current HOD Policy)

4. That our AMA amend Policy H-385.921 by addition and deletion as follows:

   Health Care Access for Medicaid Patients H-385.921
   It is AMA policy that to increase and maintain access to health care for all, payment for physician providers for Medicaid, TRICARE, and any other publicly funded insurance plan must be sustainable, reflect the full cost of practice, the value of the care provided, and include inflation-based updates, and is no less than ~~at minimum~~ 100 percent of ~~the~~ RBRVS Medicare allowable. (Modify Current HOD Policy)

5. That our AMA reaffirm Policy D-405.988, which calls for advocacy in Congress to ensure adequate payment for services rendered by private practicing physicians, creating and maintaining a reference document establishing principles for entering into and sustaining a

1 private practice, and issuing a report in collaboration with the Private Practice Physicians
2 Section at least every two years to communicate efforts to support independent medical
3 practices. (Reaffirm HOD Policy)
4
5 6. That our AMA reaffirm Policy H-200.949, which supports development of administrative
6 mechanisms to assist primary care physicians in the logistics of their practices to help
7 ensure professional satisfaction and practice sustainability, support increased financial
8 incentives for physicians practicing primary care, especially those in rural and urban
9 underserved areas, and advocate for public and private payers to develop physician
10 payment systems to promote primary care and specialty practices in progressive,
11 community-based models of integrated care focused on quality and outcomes. (Reaffirm
12 HOD Policy)
13
14 7. That our AMA reaffirm Policy H-285.904, which supports fair out-of-network payment
15 rules coupled with strong network adequacy requirements for all physicians. (Reaffirm
16 HOD Policy)
17
18 8. That our AMA reaffirm Policy H-385.986, which opposes any type of national mandatory
19 fee schedule. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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Council on Medical Service Report 8-A-24
Sustainable Payment for Community Practices
Policy Appendix

Uncoupling Commercial Fee Schedules from Medicare Conversion Factors D-400.990
Our AMA: (1) shall use every means available to convince health insurance companies and managed care organizations to immediately uncouple fee schedules from Medicare conversion factors and to maintain a fair and appropriate level of reimbursement; and (2) will seek legislation and/or regulation to prevent managed care companies from utilizing a physician payment schedule below the updated Medicare professional fee schedule.
Res. 137, A-02 Reaffirmed: CCB/CLRPD Rep. 4, A-12 Appended: Res. 103, A-13 Reaffirmation: A-19

The Preservation of the Private Practice of Medicine D-405.988
Our AMA: (1) supports preserving the value of the private practice of medicine and its benefit to patients; (2) will utilize its resources to protect and support the continued existence of solo and small group medical practice, and to protect and support the ability of these practices to provide quality care; (3) will advocate in Congress to ensure adequate payment for services rendered by private practicing physicians; (4) will work through the appropriate channels to preserve choices and opportunities, including the private practice of medicine, for new physicians whose choices and opportunities may be limited due to their significant medical education debt; (5) will work through the appropriate channels to ensure that medical students and residents during their training are educated in all of medicine's career choices, including the private practice of medicine; (6) will create, maintain, and make accessible to medical students, residents and fellows, and physicians, resources to enhance satisfaction and practice sustainability for physicians in private practice; (7) will create and maintain a reference document establishing principles for entering into and sustaining a private practice, and encourage medical schools and residency programs to present physicians in training with information regarding private practice as a viable option; and (8) will issue a report in collaboration with the Private Practice Physicians Section at least every two years communicating their efforts to support independent medical practices.
Res. 224, I-10 Appended: Res. 604, A-12 Reaffirmation I-13 Appended: Res. 735, A-14 Reaffirmed in lieu of Res. 223, I-14 Modified: Speakers Rep. 01, A-17 Reaffirmed: Res. 724, A-22 Reaffirmation: A-22 Appended: Res. 602, A-22

Principles of and Actions to Address Primary Care Workforce H-200.949
1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to

ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.

15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.
CME Rep. 04, I-18

Out-of-Network Care H-285.904

1. Our AMA adopts the following principles related to unanticipated out-of-network care:
A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
B. 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.
C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
E. 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.
F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
G. 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.
H. Independent Dispute Resolution (IDR) should be allowed in all circumstances as an option or alternative to come to payment resolution between insurers and physicians.
2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.
3. Our AMA will advocate that any legislation addressing surprise out-of-network medical bills use an independent, non-conflicted database of commercial charges.
Res. 108, A-17 Reaffirmation: A-18 Appended: Res. 104, A-18 Reaffirmed in lieu of: Res. 225, I-18 Reaffirmation: A-19 Reaffirmed: Res. 210, A-19 Appended: Res. 211, A-19 Reaffirmed: CMS Rep. 5, A-21 Modified: Res. 236, A-22

Enhanced SCHIP Enrollment, Outreach, and Reimbursement H-290.976

1. It is the policy of our AMA that prior to or concomitant with states' expansion of State Children's Health Insurance Programs (SCHIP) to adult coverage, our AMA urge all states to maximize their efforts at outreach and enrollment of SCHIP eligible children, using all available state and federal funds.
2. Our AMA affirms its commitment to advocating for reasonable SCHIP and Medicaid reimbursement for its medical providers, defined as at minimum 100 percent of RBRVS Medicare allowable.
Res. 103, I-01 Reaffirmation A-07 Reaffirmation A-11 Reaffirmed: CMS Rep. 7, I-14 Reaffirmation
A-15 Reaffirmed: CMS Rep. 3, A-15 Reaffirmation: A-17 Reaffirmed: CMS Rep. 02, A-19 Reaffirmed: CMS Rep. 5, I-20 Reaffirmed: CMS Rep. 9, A-21 Reaffirmed: CMS Rep. 3, I-21 Reaffirmed: CMS Rep. 1, I-22

Health Care Access for Medicaid Patients H-385.921
It is AMA policy that to increase and maintain access to health care for all, payment for physician providers for Medicaid, TRICARE, and any other publicly funded insurance plan must be at minimum 100 percent of the RBRVS Medicare allowable.
Res. 103, A-07 Reaffirmed: CMS Rep. 2, I-08 Reaffirmation A-12 Reaffirmed: Res 132, A-14 Reaffirmed in lieu of Res. 808, I-14 Reaffirmation A-15 Reaffirmed in lieu of: Res. 807, I-18

National Mandatory Fee Schedule H-385.986
The AMA opposes any type of national mandatory fee schedule.
Res. 27, A-85 Reaffirmed: BOT Rep. UU, A-93 Reaffirmed CLRPD Rep. 2, I-95 Reaffirmed: CMS Rep. 7, A-05 Reaffirmed in lieu of Res. 127, A-10 Reaffirmation A-15