REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5 - I-96

Subject: Physician Decision-Making in Health Care Systems

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Referred to: Reference Committee G
(Harry M. Carnes, MD, Chair)

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1 BACKGROUND
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3 The increased demand from employers and other large purchasers of health care for cost
4 containment over the past decade has spurred an exponential growth in health plans that
5 aggressively manage care and care costs. Many such plans currently are competing for favorable
6 market position through acquisition strategies such as vertical and horizontal integration,
7 purchase of physicians' practices and widespread selective contracting. One indication of the
8 pace of such acquisitions is a recent report by SMG Marketing Group, a consulting and research
9 firm, that the number of integrated health networks has doubled over a one-year period--from 255
10 at the end of 1994 to 504 in February 1996.
11
12 As a result of this system-wide trend toward mergers and consolidation, more physicians are
13 practicing as employees of or contractors with large health systems that employ a variety of
14 approaches to constrain health care costs. As noted in Council on Medical Service Report 4 (I-
15 95), the proportion of patient care physicians practicing as employees has increased markedly
16 over the past few years. Data from the AMA's Socioeconomic Monitoring System (SMS)
17 indicate that, between 1983 and 1994, the proportion of patient care physicians practicing as
18 employees rose from 24.2% to 42.3%, the proportion self-employed in solo practice fell from
19 40.5% to 29.3%, and the proportion self-employed in group practices fell from 35.3% to 28.4%.
20 A separate Council report on trends in physician practice consolidation is before the House of
21 Delegates at this meeting.
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23 In addition, the percentage of non-employee patient care physicians who independently contract
24 with at least one type of managed care plan--HMOs, PPOs and /or IPAs--has increased steadily,
25 from 61% in 1990 to 83% in 1995. As described in another Council report before the House on
26 financial incentives, a growing number of such contracts place the physician at some financial
27 risk for covered services, through capitation or reimbursement withholds. Such at-risk payment
28 arrangements can act under some circumstances to increase clinical autonomy when they reduce
29 the need for external, non-physician controls on utilization.
30
31 However, there are and likely will remain a significant number of independently contracting
32 physicians who may not wish or be able to assume risk, as well as those physicians salaried by
33 health plans, who will continue to be subject to plan-generated oversight of and sometimes
34 inappropriate interference with their patient care decisions, through such mechanisms as

precertification, concurrent and retrospective review, referral restrictions, drug formularies, length of stay limits and the like. In addition, physicians practicing in large integrated plans may find their influence on overall plan medical policies attenuated or nonexistent, unless a viable medical staff structure or other organized medical advisory mechanism is in place.

GUIDELINES FOR DECISION-MAKING

As this trend toward health systems integration continues, the Council believes it will be increasingly important that physicians contemplating practice in such plans determine to the extent possible the degree to which decisions impacting on patient care will be subject to influence or control by plan administration, so as to make completely informed decisions concerning plan participation. Physicians are ethically bound to recommend any or all services they believe are needed for patients, plan coverage restrictions notwithstanding, and Policy 140.978 (AMA Policy Compendium), among others, emphasizes that obligation. However, physicians practicing in such plans may find themselves in situations where the drug, referral specialist, length of hospital stay or treatment intervention they believe is medically indicated will not be covered by the plan and--for patients in some economic circumstances--is therefore simply not a viable treatment option. It is important for physicians to determine what the specific constraints on physician decision-making might be, and whether this type of professional frustration may be a frequent occurrence in the plan they are considering.

In Appendix I to this report, the Council has listed many of the important decisions that impact directly or indirectly on the quality of care in health plans--decisions concerning both care of individual patients and overall medical policies. The degree of practicing physician involvement in such decisions can vary across a broad continuum between the physician and the plan. Among the possible variations in the physician's role regarding a given decision are the following:

- Physician has sole responsibility for the decision.

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- Physician makes the ultimate decision, but is encouraged to seek and consider recommendations from the plan administration.

- Physician makes the ultimate decision but is required to consider recommendations from the plan administration and justify any non-adoption of such recommendations in writing.

- Both physician and plan must jointly agree on the decision.

- Plan makes the ultimate decision but is required to consider recommendations from the physician and justify any non-adoption of such recommendations in writing.

- Plan makes the ultimate decision but is encouraged to seek and consider recommendations from the physician.

- Plan has sole responsibility for the decision.

1 Given the increased shift toward medical practice in larger, market-driven health systems, the
2 Council on Medical Service believes there is a need for guidelines as to the extent of physician
3 involvement in such decisions that is most conducive to good patient care. Such guidelines can
4 be helpful as a "checklist" for physicians who are considering practice in plans with
5 administrative oversight or controls on the utilization of health services and who are concerned
6 about the opportunity for input to plan medical policies and procedures. However, the desirable
7 extent of individual practicing plan physician involvement in many of the decisions listed in
8 Appendix I may vary depending on such factors as:
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10 • Whether the plan is owned by a lay entity, physician group, hospital, or other provider.
11
12 • The practicing physician's relationship with the plan (employee, independent contractor,
13 owner/partner).
14
15 • The extent (if any) of an organized medical staff structure in the plan, or the size and
16 negotiating ability of the physician group contracting with the plan.
17
18 • Applicable state legislation or regulation affecting health plans.
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20 For example, in plans with a viable medical staff structure or committee representing the
21 interests of practicing plan physicians, the opportunity for participation by all plan physicians in
22 selection of the drug formulary may be less critical. In a state with strong patient protection
23 legislation in effect, the opportunity for participation by all physicians in developing physician or
24 patient appeal or grievance procedures will be less critical in plans subject to such legislation
25 than it will be in plans that are exempted by the Employee Retirement Income Security Act of
26 1974. The selection of practice guidelines to be used for plan quality and utilization review may
27 be more safely entrusted to the ownership in a physician-sponsored plan than to that in a lay-
28 owned entity. In contrast to individual physicians or a small group, a large physician group
29 contracting with a lay-owned plan may already have in place and be able to retain appropriate
30 medical policies and practices.
31
32 For this reason, the Council believes that for many decisions, meaningful guidelines as to the
33 extent of physician involvement can best be developed by physicians or their medical staff
34 structure in the individual plan or, at most, at a level no higher than that of the state, consistent
35 with applicable state legislation and the predominant characteristics of the health care market and
36 the health plans in that jurisdiction. An example of such state-level guidelines, titled "Decision-
37 Making Authority for Integrated Entities Criteria," were developed by the California Medical
38 Association in 1994, to assist California physicians contemplating practice in integrated plans
39 that consolidate practicing physicians and lay business(es) to evaluate the potential impact on
40 their professional autonomy, and to assess the extent to which a given plan's operating policies
41 conformed with state legislation prohibiting the corporate practice of medicine. For the
42 information of the House, these guidelines are included in Appendix II to this report.
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44 At the same time, the Council believes that certain professional decisions are so integral and
45 critical to quality patient care that they should always be the ultimate responsibility of the

physicians practicing in health plans, either alone or with consultation from the plan, irrespective of plan characteristics or the market in which it operates. These decisions are as follows:

- What diagnostic tests are appropriate.
- When and to whom in-plan physician referral is indicated.
- When and to whom out-of-plan physician referral is indicated.
- When and with whom consultation is indicated.
- When non-emergency hospitalization is indicated.
- When hospitalization from the emergency department is indicated.
- Choice of in-plan service sites for specific services (office, outpatient department, home care, etc.).
- Hospital length of stay.
- Frequency/length of office/outpatient visits or care.
- Use of out-of formulary medications.
- When and what surgery is indicated.
- When termination of extraordinary/heroic care is indicated.
- Recommendations to patients for other treatment options, including non-covered care.
- Scheduling on-call coverage.
- Terminating a patient-physician relationship.
- Whether to work with, and what responsibilities should be delegated to, a mid-level practitioner.

Depending on the sponsorship and structure of specific plans, there may be additional patient care decisions that should always be the ultimate responsibility of the practicing plan physician. However, the Council believes that the foregoing decisions should be the prerogative of the physician across all plans.

RECOMMENDATIONS

Based on its study of this subject, the Council on Medical Service recommends adoption of the following, and that the remainder of this report be filed:

1. That it be the policy of the AMA that the following professional decisions critical to high quality patient care should always be the ultimate responsibility of the physician practicing in a health plan, whether in primary care or another specialty, either unilaterally or with consultation from the plan:

    a) What diagnostic tests are appropriate.
    b) When and to whom in-plan physician referral is indicated.
    c) When and to whom out-of-plan physician referral is indicated.
    d) When and with whom consultation is indicated.
    e) When non-emergency hospitalization is indicated.
    f) When hospitalization from the emergency department is indicated.
    g) Choice of in-plan service sites for specific services (office, outpatient department, home care, etc.).
    h) Hospital length of stay.

   i) Frequency/length of office/outpatient visits or care.
   j) Use of out-of formulary medications.
   k) When and what surgery is indicated.
   l) When termination of extraordinary/heroic care is indicated.
   m) Recommendations to patients for other treatment options, including non-covered care.
   n) Scheduling on-call coverage.
   o) Terminating a patient-physician relationship.
   p) Whether to work with, and what responsibilities should be delegated to, a mid-level practitioner.

2. That the AMA widely disseminate this policy to the medical profession through all appropriate channels.

3. That the AMA attempt to obtain information on the extent to which authority for these “core” decisions is being retained by physicians practicing in such health plans.

4. That the AMA encourage state medical associations to consider development and wide dissemination of guidelines for the extent of practicing physician involvement in plan medical decisions and policies. Such guidelines should be relevant to their jurisdiction, allow for variation in plan sponsorship and structure, and optimize patient care.

5. That the AMA publicize any activities of state medical associations in developing such guidelines.

6. That the AMA encourage organizations and entities that accredit or develop and apply performance measures for health plans to consider inclusion of plan compliance with any applicable state medical association or medical staff-developed decision-making guidelines in their evaluation criteria.

Appendix I

Decisions Impacting on Patient Care in Health Plans

	Decisions Re Patient Care
1.	What diagnostic tests are appropriate
2.	When and to whom in-plan physician referral is indicated
3.	When and to whom out-of-plan physician referral is indicated
4.	When and with whom consultation is indicated
5.	When non-emergency hosptalization is indicated
6.	When hospitalization from ER is indicated
7.	Use of out-of-plan hospital
8.	Use of other out-of-plan service sites
9.	Choice of in-plan service sites for specific services (office, OP department, home care, etc.)
10.	Hospital length of stay
11.	Frequency/length of office/outpatient visits or care
12.	Use of out-of formulary medications
13.	When and what surgery is indicated
14.	When deviation from plan practice guidelines is indicated
15.	Use of investigative procedures
16.	When termination of extraordinary/heroic care is indicated
17.	Recommendations to patients for other treatment options, including non-covered care
18.	Choice of in-plan hospital
19.	Generic vs. brand-name drug
20.	Billing codes used
21.	Scheduling on-call coverage
22.	Terminating a patient-physician relationship
23.	Whether to work with and what responsibilities to be delegated to a mid-level practitioner
24.	Provision of uncompensated care to non-member patient
	Decisions Re Plan Policies
25.	Procedures/services/care sites requiring prior authorization
26.	Need for and content of plan formulary
27.	Practice guidelines/protocols used in medical necessity determinations
28.	Physician credentialing standards for plan membership/employment
29.	Physician credentialing standards for performing specific procedures/treatments
30.	Individual credentialing decisions re 28 and 29 above
31.	Mid-Level Practitioner patient care functions/responsibilities
32.	Decisions re credentialing/employment of MLPs
33.	Use and responsibilities of triage personnel
34.	Physician CME requirements
35.	Development and conduct of QA and UR plans
36.	Termination of physicians for clinical concerns
37.	Physician termination appeal/grievance procedures
38.	Patient benefits appeal/grievance procedures
39.	Standards re medical records format/documentation
40.	Standards re physician productivity
41.	Form/magnitude of physician bonuses and withholds
42.	Selection of plan participating hospitals
43.	Use and selection of “carve-out” vendors
44.	Level and scope of plan malpractice coverage
45.	Composition of plan medical policy committees
46.	High cost technology to be purchased
47.	Selection of physician office staff
48.	Plan benefits and exclusions
49.	Plan payment policies re emergency services

50.	Policies re confidentiality
51.	“No cause” termination policies
52.	Physician compensation
53.	Contractual relations with payors