

# **KMA Policy Manual 2015-2016**



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## POLICY MANUAL – KMA HOUSE OF DELEGATES

### ALCOHOL

**1) Ban on Promotion in Colleges:** KMA supports a ban on promotion of alcoholic beverages on all Kentucky college and university campuses including sponsorship of athletic events, music concerts, cultural events, and parties, and advertising products or logos in school publications. (*Res 2007-31, 2007, HOD, p 665*)

**2) Enforcement of DUI Laws:** KMA supports the stricter enforcement of penalties provided in current Kentucky laws concerning driving under the influence of alcohol. (*Res K, 1988 HOD, p 728; Reaffirmed 2000, 2010*)

### ANESTHESIA

**1) Administration of Anesthesia:** KMA holds that the administration of anesthesia is the practice of medicine in the state of Kentucky, and it is highly desirable that whenever and wherever possible epidural, spinal, and general anesthesia should be administered by, or directed by, an appropriately trained physician. (*Res 97-110, 1997 HOD, p 558; Reaffirmed 2007*)

### ANIMAL RESEARCH

**Ethical Animal Research:** KMA affirms its support of ethical research on animals to further the goals of providing optimal care to our patients. (*Res 2001-103, 2001 HOD, p 597; Reaffirmed 2011*)

### ANNUAL MEETING

**KMA Annual Meeting Dates:** KMA will not schedule future KMA Annual Meetings on the Jewish High Holy Days. (*Res 98-105, 1998 HOD, p 539; Reaffirmed 2008*)

### ANTI-TRUST

**1) Anti-Trust Relief:** If physicians are to be successful advocates for patients to ensure high quality and affordable insurance, Congress, the Department of Justice, and the Federal Trade Commission must enact federal legislation and appropriate regulations to permit physicians to negotiate with health insurance plans without fear of anti-trust implications. Anti-trust relief should be designed to facilitate physician negotiation with managed care plans and require managed care plans to allow participating physicians to organize for the purpose of commenting on the medical review criteria. That review should include the development of information and networks of consultants necessary to assist physicians in their interaction with managed care plans. (*COSLA Report HOD 1999, p 628; Reaffirmed 2002, 2012*)

**2) Collective Negotiations:** KMA endorses and supports efforts of the AMA to develop the formation of organizations affiliated with organized medicine to assist physicians in collective negotiations. (*Res 98-104, 1998 HOD, p 553; Reaffirmed 2008*)

KMA explores other means that might be legally implemented at the (Kentucky) state level that would allow separate medical practices to act jointly in negotiations along the same lines of quality of care and compensation as new models of physician assessment and payment continue to evolve. (*Res 2011-24, 2011 HOD, p 415*)

### ANY WILLING PROVIDER

**1) Health care benefit plans** should not discriminate against any provider, located within the geographic cov-

erage area of the health benefit plan, willing to meet the terms and conditions for participation established by the health benefit plan. (COSLA HOD 1999; Reaffirmed 2009)

**2) ERISA:** KMA supports a change in the federal ERISA law to allow any willing provider statutes and other patient protections to apply to all self-insured health benefit plans. (Res 2009-19; 2009 HOD, p 533)

**3) Freedom of Choice of Physicians:** Enrollees must have adequate choice among accessible and qualified participating primary care physicians. Patients should be permitted to choose their primary care physician from a list of current physicians and the list must be updated as physicians are added or removed from the plan. Women should be permitted to choose a qualified physician for routine and preventative women's medical services. Access to a consultation with participating physicians for second opinions should be available. (COSLA HOD 1999; Reaffirmed 2009)

KMA supports the patient's freedom of choice of physician; and supports and encourages a pluralistic approach to healthcare delivery that allows patients the option of choosing their own physician. (Res A, 1993 HOD, p 579; Reaffirmed 2003, 2013)

## **ATHLETICS**

**1) Protective eyewear:** KMA supports the use of protective eyewear by all young athletes using guidelines adopted by the American Academy of Pediatrics and American Academy of Ophthalmology, or similar directives, regarding sports injury risk factors, certified eyewear manufacturers and materials, and medical conditions of athletes. (Res 2005-15, 2005 HOD, p 677, Reaffirmed 2015)

**2) Sports Physicals:** All physical examinations for participation in school-sponsored sports should be done under the supervision of a physician. (Report of the Comm on Physical Education and Medical Aspects of Sports, 1995 HOD, p 620; Reaffirmed 2005, 2015)

KMA urges that a preparticipation history and physical examination be completed on every Kentucky student involved in organized sports, and that this evaluation should include a thorough family history to inquire regarding cardiomyopathy and life-threatening arrhythmias. (Res 2012-12, 2012 HOD, p 521)

**3) Use of Creatine (Monohydrate):** KMA opposes the use of performance enhancing drugs. (Res 2000-108, 2000 HOD, p 607; Reaffirmed 2010)

**4) Health and Safety Guidelines:** Kentucky Medical Association communicates to the Kentucky Department of Education its support for extending the Kentucky High School Athletic Association health and safety guidelines to all school-aged athletes. (Res 2012-12, 2012 HOD, p 521)

## **AUDIOLOGY**

KMA strongly opposes any legislation that would expand the scope of practice of audiologists or other non-physician providers to independently diagnose, treat, or manage hearing or balance disorders. (Res 2011-19, 2011 HOD, p 413)

## **AUDITS – RECOVERY AUDIT CONTRACTORS**

**1) Credentials of Auditors:** Health plan claims audits of physicians' medical records must be conducted by certified professional coders trained in abstracting medical records to determine appropriate billing codes and any clinical review must be performed by a board certified specialist within the specialty of the provider

being audited. *(Res 2006-11, 2006 HOD, p 628)*

**2) Oversight:** Federal oversight of private recovery audit contractors should specifically be designed to stop, and prevent further occurrences of, misrepresentation, harassment, and intimidation of physicians by these private contractors. *(Res 2009-07, 2009 HOD, p 532)*

**3) Retroactive Audits:** All insurance companies should have no more than 18 months past the date of filing of a claim to request a refund; claims denied retroactively would not be subject to timely filing requirements; and providers should have a minimum of 12 months from the date of notification of retroactive denial to challenge the refund request or submit a new claim for reimbursement for the service to the responsible party, insurer, medical assistance, or Medicare program responsible for payment at the time the service was rendered. *(Res 2006-15, 2006 HOD, p 634)*

**4) Retrospective Audits:** Insurance companies should be prohibited from performing retroactive audits beyond one year from the date of service and from extrapolating the results to demand larger refunds. *(Res 2006-10, 2006 HOD, p 633)*

## **CANCER SCREENING**

**1) Cancer Screening:** KMA recognizes the necessity for and supports expansion of cancer screening and full development of a screening registry as acknowledged by the KMA Cancer Committee. KMA supports all appropriate efforts by affected agencies to direct actions and to obtain and coordinate necessary resources to develop an effective comprehensive screening registry. *(Res 129, 1999 HOD; Reaffirmed 2009)*

**2) Cervical and Colorectal Cancer Screening:** All entities that serve as payers for medical services should be required to include cervical and colorectal screening, in accordance with nationally accepted standards, as covered services to get reimbursed at a rate that reflects the cost of the procedure and the professional service provided. *(Res 134, 1999 HOD; Reaffirmed 2009)*

KMA actively promotes activities that support colorectal cancer screening, including support for the National Colorectal Cancer Roundtable "80% by 2018" goal. *(Res 2015-2, 2015 HOD)*

**3) Colon Cancer Screening:** KMA supports funding the colon cancer screening program. *(Res 2008-07, 2008 HOD, p 624)*

## **CAPITAL PUNISHMENT**

**Physician Participation in Capital Punishment:** In accordance with the AMA current ethical opinions, which have been adopted by the Kentucky Board of Medical Licensure as conditions of Licensure, physician participation in executions, except to certify cause of death, provided that the condemned has been declared dead by another person, is a serious violation of medical ethics. *(Res 97-131, 1997 HOD, p 564; Reaffirmed 2007)*

## **CERTIFICATE OF NEED**

**Certificate of Need Law:** KMA supports that laws requiring a certificate of need to establish health care facilities be repealed. *(Res 2006-01, 2006 HOD)*

## **CHILD HEALTH**

**1) Childhood Obesity/Competitive School Foods:** KMA supports the proposal that schools sell healthy



foods in vending machines for student use and on the cafeteria a la carte line; KMA discourages the use of unhealthy foods as rewards for good behavior and academic performance in school; and KMA supports schools providing more exercise opportunities for all students. (*Res 2002-112, 2002 HOD, p 591; Reaffirmed 2004, 2014*)

**2) Daily Physical Activity for Children:** KMA encourages its members to work with their local school districts to identify practical ways to incorporate and implement daily physical activity by students. (*Res 2007-18, 2007 HOD, p 650*)

**3) Eye Health of Kentucky Children:** KMA supports the establishment of a state voucher program whereby children who are identified as in need of financial assistance for a state-mandated ophthalmologic examination shall receive care from a Kentucky-licensed ophthalmologist rather than the state contracting such services to out-of-state eye care providers. (*Res 2014-09, 2014 HOD, p 330*)

**4) Health Education and Physical Fitness Testing:** KMA supports uniform health education and physical fitness proficiency testing in all schools. (*Res Q, 1991 HOD, p 682; amended and Reaffirmed, Special Report on Policy Sunset, 2001 HOD, p 578; Reaffirmed 2011*)

**5) Immunizations:** KMA encourages simplification of the immunization certificate and supports the implementation of a Web-based immunization registry for the Commonwealth of Kentucky. (*Res 2003-28, 2003 HOD, p 632; Reaffirmed 2013*)

KMA encourages participation in the Immunization Registry by the medical community. (*Res 2010-03, 2010 HOD, p 422*)

KMA seeks a regulation or legislation by the General Assembly of the Commonwealth of Kentucky to add the HPV vaccination for males and females (according to the recommended age groups in the CDC Committee on Immunization Practices for HPV administration) to the current list of school-based required vaccinations. (*Res 2012-18, 2012 HOD, p 522*)

KMA supports actions to improve child immunization status in the state of Kentucky. (*Res 2014-11, 2014 HOD, p 334*)

**6) Parenting and Family Life Skills:** KMA supports “Parenting and Family Life Skills Education” curriculum in public schools. (*Comm on Maternal and Neonatal Health/ Comm on Child and School Health, 1995 HOD, p 616-18; Reaffirmed 2005, 2015*)

**7) Sex Education:** KMA supports sex education in schools beginning in grades 5-7. (*Report of the Committee on Maternal and Child Health, 1986 HOD, p 769; Reaffirmed 2000, 2010*)

**8) Vaccine for Children (VFC):** KMA supports legislation that would allow states operating a State Children’s Health Insurance Program to provide subsidized immunization as a benefit to children. (*Res 98-112, 1998 HOD, p 565; Reaffirmed 2008*)

**9) Length of School Lunches:** KMA supports legislation requiring a minimum of 30 minutes for lunch for grades K-5 in public schools. (*Res 2015-11, 2015 HOD*)

**10) School Health Care Examinations:** KMA supports preventative health care examinations for initial school entry and sixth grade as outlined in the Kentucky Department of Education’s regulations on school health services.

KMA seeks revisions to the Kentucky Department of Education's regulations on school health services which would require additional preventative health care examinations for students entering the third grade and ninth grade. (*Res 2015-14, 2015 HOD*)

## **COMMUNICATIONS**

KMA encourages members to provide current e-mail addresses in order to effectively and quickly relay critical advisories concerning pandemic and other public health issues. (*Res 2009-01, 2009 HOD, p 533*)

## **CONFIDENTIALITY**

Health insurers must protect patients' rights of privacy regarding medical records and communications between patients and physicians. Clear and definitive action should be taken by the insurer during enrollment to inform the insured that under specific circumstances, especially when seeking approval for a service or billing for reimbursement, transfer of the patient's medical record information will take place between the physician and insurer. No third party to whom disclosure of patient records is made may re-disclose or otherwise reveal the mental health and chemical dependency records of a patient without first obtaining the patient's specific written consent to the re-disclosure. Procedures should be established to safeguard the privacy of individually identifiable patient information and to maintain accurate and timely records for patients. (*COSLA HOD 1999; Reaffirmed 2009*)

## **CONTINUING MEDICAL EDUCATION (CME)**

**1) Mandatory Continuing Medical Education:** KMA reaffirms its support of continuing medical education and also reaffirms its opposition to mandated "disease- and topic-specific" continuing medical education for Kentucky physicians and urges repeal of any and all statutory requirements for continuing medical education of specific diseases. (*Adopted as amended from the floor of the HOD in lieu of Res 103, 120, and 126; 1997 HOD, p 564; Reaffirmed 2007*)

**2) Systematic Participation:** KMA reaffirms its deep commitment to its educational responsibility on behalf of the profession, and encourages all hospitals in Kentucky to expand their implicit educational partnership with physicians by actively supporting and participating in the process of accredited CME activities. (*Res C, 1990 HOD, p 713; Reaffirmed 2000, 2010*)

## **CONTINUITY OF CARE**

Carriers should maintain a plan for providing continuity of care in the event of contract termination with the participating physician or in the event of insolvency or other inability to continue operations. Insurance and managed care plans must provide coverage for enrollees undergoing a course of treatment with a participating physician who has been terminated. That treatment should be covered for the remainder of the course of treatment or for 90 days after termination of the contract. (*COSLA HOD 1999; Reaffirmed 2009*)

## **CONTRACTS – MANAGED CARE**

**1) Contractual Agreements between Physicians and Insurers:** KMA endorses a "Standard Physician Service Agreement" that can be used statewide on a voluntary basis by Kentucky physicians in their contractual arrangements with third-party payers. The agreement should set forth rights and obligations of the physician and payer in a consistent and uniform fashion. The agreement should include standard provisions for licensure and certification; liability insurance coverage; maintenance of and access to records; credentialing and profiling information; provisions for termination and dispute resolution. Fees should not be set. The contract

should refer to a blank fee schedule of CPT codes to be negotiated by each individual physician. (COSLA HOD 1999; Reaffirmed 2009)

**2) Gag Clauses:** KMA supports any and all legislative or regulatory efforts to ban “gag” and “hold harmless” clauses from contracts between managed care entities and physicians. (Res 96-105, 1996 HOD, p 588; Reaffirmed 2006)

**3) Most Favored Nation Clause:** KMA opposes the insertion of “most favored nation” (MFN) clauses in contracts between physicians and health insurance plans, or managed care organizations. MFNs require physicians to afford the insurance or managed care organization the same rates provided to other payers if such rates are more favorable. MFNs require physicians to charge the insurer or managed care organization the lowest rate paid to the physician by other health plans. (COSLA HOD 1999; Reaffirmed 2009)

**4) “Opt Out” Contracts:** KMA objects to any insurance company’s initiative to offer “opt out” contracts, and requests that they end their practice of “opt out” contracting.

KMA pursues legislation to end insurance company “opt out” contracting in Kentucky. (Res 2013-11, 2013 HOD, p 384)

**5) Parity in Compensation:** KMA maintains as a principle that whenever possible in the negotiation of contracts for health care services, physicians in all regions of Kentucky be compensated equally for equal services. (Res 96-107, 1996 HOD, p 589; Reaffirmed 2006)

**6) Termination of Contracts:** Physicians should have the option of terminating contracts with third-party payers immediately if such payers unilaterally amend their contracts in a manner unacceptable to the contracting physicians. In such a case, to ensure continuity of care for the patient, the third-party payer should continue to fulfill its obligations under the original terms of the agreement until the patient has sufficient time to engage the services of a new physician. (Report of the Committee on Managed Care, Recommendation 3, as amended by Ref Com C, 2001 HOD, p 612; Reaffirmed 2011)

Should the contracting physician find the proposed contract changes unacceptable he/she will have the option of terminating the contract before the changes take effect. (Res 2001-128, 2001 HOD, p 614; Reaffirmed 2011)

**7) Third-Party Payers:** KMA will seek to require all third-party payers to make their fee schedules available to physicians at the time a contract is presented to a physician for consideration or when changes are proposed to the fee schedules. (Report of the Committee on Managed Care, Recommendation 1, 2001 HOD, p 612; Reaffirmed 2011)

Third-party payers must notify contracting physicians prior to any contract changes. (Res 2001-128, 2001 HOD, p 614; Reaffirmed 2011)

## **CREDENTIALING**

**1) Claims Processing:** Health insurance plans should accept and process claims for medical services submitted by physicians undergoing the credentialing and new participating applicant process, and such plans should reimburse for such claims once credentialing is completed. (Res 2004-08, 2004 HOD, p 621; Reaffirmed 2014)

**2) Credentialing of Nuclear Medicine Technologists:** KMA endorses the state credentialing of nuclear med-

icine technologists by the Cabinet for Health Services. (*Res 98-106, 1998 HOD, p 544; Reaffirmed 2008*)

**3) Economic Credentialing:** KMA maintains that prospective quality improvement shall remain the primary purpose of any credentialing process involving physicians; that economic credentialing in the form of hospital-physician exclusive contract shall not be used to disenfranchise any member(s) of the hospital staff; that physician credentialing in a hospital shall be used to guarantee the quality of care and not be subverted by economic considerations in the form of hospital-physician exclusive contracts that place cost above quality of care; and that KMA will establish a repository for instances of economic credentialing and this information will be provided to the Hospital Medical Staff Section. (*Res B as amended, 1994 HOD, p 544; Reaffirmed 2004, 2014*)

KMA opposes health plans' ranking of physicians based on claims-based cost per diagnosis criteria, particularly when such rankings are used to exclude from their networks those physicians falling outside an arbitrarily-selected percentile. KMA supports legislation that would ban economically-based tiering programs in order to dispel the confusion of employers and patients resulting from health plans' implications that economic profiling of physicians is in any way related to the physicians' quality of patient care. Legislation supported by KMA would prohibit health plans from notifying affected physicians' patients of their impending exclusion or making any such public announcement until all due process rights of appeal are exhausted and a final determination is reached. (*Res 2009-06, 2009 HOD, p 532*)

**4) Physician Credentialing:** KMA strongly opposes political interference in the physician credentialing process. (*Res AA, 1989 HOD, p 727; Reaffirmed 2000, 2010*)

Insurance and managed care plans must establish minimum professional requirements for participating physicians. Plans must have a process for the selection of physicians, with written policies, procedures, and approvals used by the plan. The selection process should include verification of each health care physician's license, history of license suspension or revocation, and liability claims history. (*COSLA HOD 1999; Reaffirmed 2009*)

## **DEATH**

**1) Brain Death:** A physician in the exercise of his professional judgment may declare an individual dead in accordance with accepted medical standards. Such declaration may be based solely on an irreversible cessation of brain function including the function of the brain stem. (*Res I, 1979 HOD, p 723; Reaffirmed 2000, 2010*)

**2) Definition of Death:** Legislative and judicial intrusion into circumstances surrounding the possible death of critically or terminally ill patients should be kept at an absolute minimum, and decisions concerning the care of such patients should be left to the patient and his doctor and the patient's relatives in accordance with time-honored customs. The patient's wishes in these matters should be of utmost importance and should be respected whenever possible. This policy of the KMA concerning death and dying is totally opposed to any form of "active euthanasia." KMA endorses the use of criteria of the AMA's position on death to assist physicians in their determination of death. Death shall be determined by the clinical judgment of the physician using the necessary available and currently accepted criteria. (*Res G, 1976 HOD; Reaffirmed 2000, 2010*)

**3) Electronic Death Registration System:** KMA supports the implementation of the Kentucky Electronic Death Registration System and encourages participation by the medical community. (*Res 2010-02, 2010 HOD, p 422*)

**4) Physician Certification of Cause of Natural Death:** When the coroner determines that death was due to natural causes, the cause should be determined by a physician after appropriate investigation. This physician

should be the pathologist if an autopsy was performed. Otherwise, the physician should be one familiar with the patient's condition. If no such physician is available, the coroner's office should utilize the services of one employed to evaluate those cases not under the care of any physician. KMA should work for changes in Kentucky law to require physician certification on the cause of natural deaths. (*Res P, 1998 HOD, p 729; Reaffirmed 2000, 2010*)

**5) Timely Signing of Death Certificates:** KMA encourages physicians to establish procedures to assure death certificates are signed and returned within five business days of receipt. (*Res 2001-101, 2001 HOD, p 591; Reaffirmed 2011*)

## **DISASTER PREPAREDNESS**

**1) Liability Protection During Disasters:** KMA supports a constitutional amendment that would provide liability protection for physicians and other medical practitioners who provide services during the event of a declared national or state disaster. (*Res 2008-21, 2008 HOD, p 625*)

**2) Local Planning:** KMA encourages its members to become more involved in local disaster response planning by contacting their local health department or responsible agency. (*Res 2003-01, 2003 HOD, p 631; Reaffirmed 2013*)

## **DISPARITIES IN HEALTH CARE**

**Equality and Fairness in Delivery of Medical Care:** Disparities in the delivery and rendering of medical care, whether based upon race, gender, income, education, social, cultural or geographic factors, are unjustifiable and must be eliminated. Physicians should examine their practices to ensure that prejudices and biases do not inadvertently affect clinical judgment in medical care. KMA supports the position that resources for medical research should be distributed in a manner, which promotes the health of all individuals without regard to race, sex, or gender to the greatest extent possible. (*COSLA HOD 1999; Reaffirmed 2009*)

## **DO NOT RESUSCITATE (DNR)**

**Standard Pre-Hospital DNR Form:** KMA reaffirms existing policy to inform its members of the Kentucky Emergency Medical Services Do Not Resuscitate (DNR) Order form, and how it is intended to be used to minimize potential misunderstandings among physicians, EMS personnel, and affected family members; to encourage members to include the DNR form when they discuss advance directives with their patients; and to convey to associations representing hospitals, nursing homes, and emergency medical services the desire of Kentucky physicians that use of the DNR form be widely encouraged and honored. (*Res K, 1995 HOD, p 599; Reaffirmed 2005, 2015*)

## **DRUG ABUSE**

**1) KASPER:** KMA strongly supports the intent and efforts of the Kentucky All Schedule Prescription Electronic Program (KASPER) and supports expansion of KASPER with the necessary financial and human resources to accomplish mandatory and timely reporting by all dispensing agents, and the capability by physicians to retrieve data quickly based on a unique identifier such as the medical license number. (*Res 2001-115, 2001 HOD, p 608; Reaffirmed 2011*)

**2) Enhancement of KASPER:** KMA encourages state government to enhance the KASPER system so that information can be obtained in "real time" and that additional state and federal funding be supported for treatment programs for those addicted to prescription drugs. (*Res 2009-03, 2009 HOD, p 530*)

KMA continues to strongly advocate for improvements in the Kentucky All Schedule Prescription Electronic Reporting system (KASPER) including the incorporation of real-time and multi-state prescription data. *(Res 2012-03, 2012 HOD, p 523)*

**3) Use of KASPER:** KMA encourages its members to continue using the state's KASPER system. *(Res 2009-03, 2009 HOD, p 530)*

**4) NASPER:** KMA supports establishment of a National All Schedule Prescription Electronic Reporting System. *(Res 2005-03, 2005 HOD, p 665, Reaffirmed 2015)*

**5) Prescription Monitoring System:** KMA supports the adoption of a regional and/or nationwide shared prescription monitoring system that provides for state-level control. *(Res 2010-04, 2010 HOD, p 419)*

**6) Treatment and Education of Patients:** KMA encourages its members to participate in the treatment of patients addicted to illegal drugs and in the education of their patients as to the harmful nature of these drugs. *(Res S, 1989 HOD, p 690; Reaffirmed 2000, 2010)*

KMA will expand and intensify efforts to educate both health care providers and the lay population about the risks of opioid dependence or opioid addiction as well as their resultant adverse medical and socioeconomic effects.

Kentucky health care practitioners are encouraged to inform patients that in starting opioids for many chronic, non-malignant forms of pain that a physician will work with the patient toward an endpoint, where feasible, based on the treating physician's clinical opinion. *(Res 2013-05, 2013 HOD, p 382)*

KMA reaffirms its support and actively seek adequate reimbursement for psychiatric therapies for narcotic and polysubstance addiction, including office-based opioid treatment. *(Res 2012-23, 2012 HOD, p 523)*

KMA will work with the appropriate state agencies to expand coverage and secure Medicaid funding for the treatment of substance abuse and addiction in the Commonwealth. *(Res 2013-02, 2013 HOD, p 381)*

KMA advocates for additional resources for prevention and treatment of addiction for individuals in all socio-economic groups. *(Res 2014-17, 2014 HOD, p 335)*

KMA supports increasing access to multi-modality treatment for opioid addiction by qualified physicians and affiliated providers. *(Res 2014-06, 2014 HOD, p 335)*

KMA uses its influence to expand mental health and addiction treatment in all forms of drug abuse including evidence-based medical and non-medical addiction treatment modalities. *(Res 2015-4, 2015 HOD)*

**7) Prescription Drug Abuse Law (House Bill 1):** KMA seeks amendment of HB 1 so that the law will reflect appropriate consideration of the exigencies of various practice settings, medical procedures, and patients and achieve the proper balance between patient needs and the interest of the state to address the prescription drug abuse issue. *(Res 2012-01, 2012 HOD, p 523)*

KMA reaffirms its understanding that there is a significant prescription drug abuse problem in Kentucky and reaffirm its commitment to work with any other interested party to combat prescription drug abuse, also understanding that the undertreatment of pain is a serious public health problem that may be attributed to a myriad of social, economic, political, legal, and educational factors, including inconsistencies and restrictions

in state pain policies.

KMA acknowledges that by borrowing flexible language from The Federation of State Medical Boards' The Model Policy for the Use of Controlled Substances for the Treatment of Pain, designed to allow for physicians' clinical judgment, and then rewriting this language as unequivocal regulations bearing the weight of law, and further by necessitating the Kentucky Board of Medical Licensure's promulgation of numerous emergency regulations with inflexible standards, HB 1 is inconsistent with The Model Policy.

KMA acknowledges that HB 1 burdens patients, physicians and physician-owned facilities; inconsistently exempts optometrists and dentists; and most importantly, sets inflexible legal standards that are impossible to always meet.

KMA will offer support and encouragement to the state medical societies of Kentucky's border states in drafting consistent and collaborative policies in order to effectively combat drug abuse while maintaining and promoting the quality of, and access to, appropriate pain management, psychiatric care, and substance abuse treatment. (*Res 2012-04, 2012 HOD, p 523*)

**8) Physician Efforts:** KMA endorses the continued efforts of Kentucky physicians to reduce prescription drug abuse. (*Res 2012-13, 2012 HOD, p 524*)

## **DRUGS**

**1) Drug Formulary:** KMA opposes the provision of drugs under (Title XIX) by generic prescription. KMA will inform the Governor and the State Department of Health that usual and customary fees should be the foundation upon which payments to physicians should be made. (*Technical Advisory Comm on Indigent Medical Care, 1967 HOD; Reaffirmed 2000, 2010*)

**2) Generic Drugs:** Third-party payers should provide accurate information regarding the effectiveness, costs, and benefits, if any, of using generic brand drugs. (*Res 2002-121, 2002 HOD, p 620; Reaffirmed 2012*)

**3) Pharmaceutical Manufacturers:** KMA supports AMA policies that retain appropriate drug prescribing as determined by physicians. (*Res 96-120, 1996 HOD, Reaffirmed 2006*)

**4) Physician Prescribed and Administered Drugs:** KMA supports an amendment to regulations or statutes stating that drugs directly administered by physicians or their staffs to patients should be exempted from the sales tax in the exact manner as "pharmacist dispensed" medications. (*Res 121, Ref Comm A, 1999; COSLA HOD 1999; Reaffirmed 2009*)

**5) Prescribing Data:** KMA condemns the practice of pharmaceutical manufacturers' representatives obtaining individual physician prescribing data. (*Res 2004-15, 2004 HOD, p 622; Reaffirmed 2014*)

**6) Prescription Drugs:** When a drug is approved by the FDA, as well as other federal and state regulatory bodies, and the drug is properly prescribed by a licensed physician for treatment for a medical condition, additional restrictions on physicians' ability to properly prescribe such medication should not be imposed by judicial decisions. (*Res 2002-119, 2002 HOD, p 598, Reaffirmed 2012*)

**7) Promotion of Alternate Medications:** KMA opposes pharmaceutical industry financed communication by pharmacists recommending to patients alternate medications to health care provider prescribed medications. (*Res 2002-111, 2002 HOD, p 597; Reaffirmed 2012*)

**8) Pseudoephedrine by Prescription:** KMA supports legislative efforts that would require pseudoephedrine by prescription in the Commonwealth. (*Res 2010-17, 2010 HOD, p 420*)

**9) Prescription Opioid Anti-Tampering Legislation:** KMA work with Congressman Hal Rogers (KY-5) and other national and state legislative leaders to consider national and state legislation that prohibits dispensing non-tamper-resistant sustained release opioid preparations in Kentucky, and potentially other scheduled drugs when cost-effective, tamper-resistant formulations are available. (*Res 2012-05, 2012 HOD, p 524*)

## **e-HEALTH**

**1) Electronic Medical Records:** Third party payers, including Medicare and Medicaid, should be encouraged to provide financial incentives from additional funding to physicians, hospitals, and other medical providers who implement and use an electronic medical record system. (*Res 2005-06, 2005 HOD, p 671, Reaffirmed 2015*)

**2) E-Health Network:** KMA should work with government agencies, insurers, the health care industry, and others to overcome barriers to e-health adoption and assist in the formation of e-health networks throughout the state. State and other entities working to establish an e-health network in Kentucky inform the public of efforts to make medical information more readily accessible through electronic means and the benefits of doing so. Efforts to establish an e-health network in Kentucky address not only medical information, but administrative information as well, in order to reduce hassles for patients and physicians. Efforts to establish an e-health network in Kentucky address the issue of systems being unable to transfer data easily to other systems, which is the promise around e-health adoption. (*Res 2008-06, 2008 HOD, p 619*)

KMA advocates for interested parties to collaborate with Kentucky physicians on testing data transfer protocols of health information exchange. (*Res 2014-14, 2014 HOD, p 334*)

**3) Formation of e-Health Center of Excellence:** KMA supports the Kentucky e-Health Network Action Plan recommendation that the state form an “e-Health Center of Excellence” that would provide information, education, and assistance to practices interested in adopting e-health, whether in the form of electronic medical records, access to high speed Internet, or administrative systems. (*Res 2008-06, 2008 HOD, p 619*)

**4) Opposition to Mandated Participation:** KMA opposes any attempts to mandate the implementation of costly systems or impose costs on physicians for using or accessing such systems. (*Res 2008-06, 2008 HOD, p 619*)

**5) Privacy of Data:** KMA supports the highest level of privacy, security, and control available regarding any e-health data. (*Res 2008-06, 2008 HOD, p 619*)

## **EMPLOYED PHYSICIANS**

**1) Employed Physician’s Ability to Refer Patients:** KMA supports the concept that hospital employed physicians be able to freely refer patients to facilities and consultants of their choice. (*Res 2005-17, 2005 HOD; Reaffirmed 2015*)

KMA reaffirms that all physicians should be free to refer patients to physicians and facilities they believe will best serve their patients without enticement or penalty from any employing or contracting hospital system or other corporation.

KMA opposes efforts to close medical staffs in ways that restrict open referral at the discretion of the requesting physician. (*Res 2012-07, 2012 HOD, p 521*)



**2) Hospitalist Programs:** KMA opposes all mandatory hospitalist programs as an infringement on the physician/patient relationship and supports legislation that prohibits mandatory hospitalist programs. (*Res 104, Ref Comm B, 1999; COSLA HOD 1999; Reaffirmed 2009*)

**3) Hospital Employed Physicians Insurance Requirement:** Physicians employed by hospitals should have comparable insurance coverage or be protected through a hospital insurance mechanism (*Ref Comm B, 2003 HOD, p 612; Reaffirmed 2013*)

## **FRAUD AND ABUSE**

**1) Fraud and Abuse:** KMA opposes all bounty systems in the investigation and prosecution of fraud and abuse. (*Res 98-118, 1998 HOD, p 554; Reaffirmed 2008*)

KMA supports all efforts by the American Medical Association to encourage Congress to implement appropriate amendments to federal laws, which would prevent inappropriate investigations and prosecution of unintentional errors, which could be easily resolved through an educational process. (*Res 97-132, 1997 HOD, p 565; Reaffirmed 2007*)

**2) Legal Process for Alleged Fraud:** It is the policy of KMA that no duly authorized law enforcement or legal agency conduct any unannounced search of physicians' offices or seizure of records without observance of legal due process procedures. Should unannounced search and seizure procedures be warranted in emergency situations based on clear and immediate threats to lives or physical well-being of patients or the general public, such searches/seizures be conducted within the following parameters:

- The search and/or seizure shall be conducted in a non-threatening and thoroughly professional manner
- The search and/or seizure shall not disrupt patient care
- The search and/or seizure shall be conducted in a manner to avoid publicity injurious to a physician's practice and professional reputation until all facts are known and culpability, if any, can be proven. (*Res 2001-130, 2001 HOD, p 615; Reaffirmed 2011*)

## **HEALTH CARE FUNDING**

**Funding of Health Care in Kentucky:** KMA will work strenuously in concert with other interested parties to achieve a funding plan for health care that is broad-based among Kentucky citizens and involves contribution from multiple segments of society according to their ability to pay; and KMA opposes any kind of funding plan that singles out physicians as a discrete element within society and places upon physicians a unique and disproportionate responsibility for the funding of health care for the citizens of Kentucky. (*Res A, 1992 HOD, p 641; Reaffirmed, Special Report on Policy Sunset, 2002 HOD, p 576; Reaffirmed 2012*)

## **HEALTH DEPARTMENTS/BOARDS OF HEALTH**

**Physician Representation on Boards of Health:** KMA urges that the current membership of local boards of health with regard to physician membership not be changed. (*Res O, 1977 HOD; Reaffirmed 2000, 2010*)

## **HEALTH INSURANCE**

**1) AMA-CPT Coding:** KMA endorses AMA-CPT as the standard accepted coding system in Kentucky and (notes that) proper use of CPT by insurance carriers requires adherence to all of its rules and guidelines. (*Res 96-117, 1996 HOD; Reaffirmed 2006*)

**2) Availability:** Every insurer should be required to offer a “basic” plan, on a guaranteed-issue basis, as a condition of doing business in Kentucky. (*COSLA HOD 1999; Reaffirmed 2009*)

**3) Bundling:** KMA opposes the inappropriate bundling practices of insurance carriers doing business in Kentucky. (*Res 127, 2001 HOD, p 613; Reaffirmed 2011*)

**4) Claim Filings/Standard Claim Form/Electronic Claim Submission:** KMA supports a standard, mandatory, and common claim form for all insurers. Insurance companies should be required to adopt a standardized or open electronic claims submission protocol. Physicians should be provided incentives to switch to a uniform electronic billing in a uniform format within a designated period of time. Physicians should not be penalized for failure to adopt electronic billing systems. (*COSLA HOD 1999; Reaffirmed 2009*)

**5) Claims Review:** Insurance companies should be required to use board certified specialists within the specialty of the provider to review clinical information prior to issuing any form of denial or payment reduction, and that the name, title, and contact information for each such reviewer be made available to the physician. (*Res 2006-12, 2006 HOD, p 628*)

**6) Consumption of Benefits:** Rising medical costs require patients and physicians to use appropriate restraint in utilizing health insurance. Healthy lifestyles, preventive health measures, and proper restraint in the use of drugs, alcohol, and tobacco can dramatically restrain health costs. Patients have an individual responsibility to be aware of the benefits and limitations of their health care coverage. Patients should exercise autonomy by participation in the formulation of benefit packages and by prudent selection of health care coverage that best suits their needs. The U.S. Congress and the Kentucky General Assembly should actively promote health and medical education in schools and to the public. In addition, KMA supports Medical Savings Accounts, various deductible type insurance plans, and other insurance incentive plans as alternatives to contemporary health insurance and managed care policies. KMA opposes any financial incentives that directly compensate physicians for ordering or providing less medically necessary or appropriate medical care. (*COSLA HOD 1999; Reaffirmed 2009*)

**7) Coverage for Dependents:** KMA support initiatives that would allow health insurance policy holders the option to include as beneficiaries dependent children 25 years or younger. (*Res 2007-33, 2007 HOD, p 657*)

**8) Data Collection:** Insurers, including ERISA-exempt plan contractors, should be required to provide health insurance data as identified by the Commissioner of Insurance. Data may include total premiums, enrollment statistics, costs, claims paid and policies cancelled. Physician data is submitted routinely to carriers on a claim-by-claim basis and reports related to patients can be easily obtained from claims submitted. (*COSLA HOD 1999; Reaffirmed 2009*)

KMA encourages all health insurers offering insurance in the state of Kentucky to submit de-identified quality data to aggregators such as the Kentuckiana Health Collaborative.

KMA encourages all self-funded employers in Kentucky to require their third party administrators to submit quality data to aggregators such as the Kentuckiana Health Collaborative. (*Res 2013-04, 2013 HOD, p 381*)

**9) Deductibles for Colorectal Screening:** KMA advocates for insurance companies and other commercial payers to eliminate co-insurance and deductibles for all colorectal screening, regardless of findings of the exam. (*Res 2009-11, 2009 HOD, p 532*)

**10) Government Rate Setting:** KMA opposes governmental rate setting of physicians’ fees, and restriction

of freedom of choice by the citizens in selection of health insurance. (*Res M, 1993 HOD, p 581; Reaffirmed 2003, 2013*)

**11) Health Insurance Exchange:** KMA House of Delegates confirms the policy on health insurance exchanges established by the KMA Executive Committee that:

- The Commonwealth should operate a state-based exchange.
- The exchange should function as an easily understood portal of information for consumers, health care providers, employers, insurers, and others.
- It should be transparent and provide a comparison tool for consumers to determine their insurance options.
- The exchange's oversight body should include physicians.
- Kentucky's patient protection and provider fairness laws should apply to plans in the exchange.
- Insurance plans operating in the exchange should be subject to fair premium rate standards.
- The long-term economic sustainability should be carefully considered and operational expenses should be kept to a minimum.
- Considering the current financial strain on physicians' offices to continue providing care to patients, physicians should not be asked to help fund a state-based exchange.
- The exchange should consider regional differences in the provision of health care. (*Res 2011-02, 2011 HOD, p 412*)

KMA advocates that Kentucky's Health Benefits Exchange offer all interested persons in the Commonwealth the opportunity to enroll in a health care savings account. (*Res 2012-17, 2012 HOD, p 522*)

**12) Health Insurer Code of Conduct:** KMA urges Kentucky health insurers to commit to abide by the Principles contained in the AMA Health Insurer Code of Conduct. (*Res 2010-12, 2010 HOD, p 421*)

**13) Insurance Coverage for Obstetrical Care:** KMA supports legislation that would prevent third-party payors from interfering, by refusing to pay for care, with physicians' clinical judgment regarding patient care, including timing of discharge. (*Res D, 1995 HOD, p 13; Reaffirmed 2005, 2015*)

**14) Mandatory Provisions in Health Insurance Policies:** KMA supports payment for medically necessary services by insurers/payers based on the appropriate care of the patient; and that decisions regarding insurance coverage of medical services be considered separately for each service in question in the context of patient need and the physician's medical judgment. (*Res 97-134, 1997 HOD, p 572; Reaffirmed 2007*)

**15) National Health Insurance:** KMA opposes any form of compulsory national health insurance. (*Final Reports of BOT & AMA Delegates, 1969 HOD; Reaffirmed 2000, 2010*)

**16) On Call Emergency Room Coverage:** KMA supports the policy that it is appropriate for physicians to receive fair and suitable compensation and consideration for emergency room coverage. (*Res 2007-28, 2007 HOD, p 651*)

**17) Out-of-Network Benefits:** KMA supports appropriate reimbursement for procedures ordered by non-participating physicians when medically appropriate. (*Res 132, Ref Comm C, 1999; COSLA HOD 1999; Reaffirmed 2009*)

KMA advocates for the passage of laws, including provisions for enforcement and penalties, designed to alleviate managed care hassles that apply to out-of-network physicians in order to provide patients who seek out-of-network physicians the same protections from managed care abuses that are available under the law.

*(Res 2007-22, 2007 HOD, p 660)*

**18) Out-of-Network Care:** When coverage from the insurer or managed care plan is not possible, the primary care physician and insurer must refer the patient to an appropriate out-of-network physician within a reasonable time and proximity to the enrollee's home. The out-of-network physician should be reimbursed either the UCR fee or the agreed upon fee between the insurer and the out-of-network physician. *(COSLA HOD 1999; Reaffirmed 2009)*

**19) Payment for Screening:** Third-party payers should reimburse physicians for tests and office visits for ruling out disease processes. *(Res 2002-109, 2002 HOD, p 597; Reaffirmed 2012)*

**20) Point-of-Service:** A point-of-service option should be required in all non-ERISA managed health care plans. Insurers should offer a benefit plan with a point-of-service option to obtain out-of-network benefits without having to obtain a referral. Plans may require enrollees to pre-certify selected services, pay a higher deductible, co-payment, or higher premium. Insurers should provide each enrollee the opportunity to enroll in an out-of-network option, and provide written notice of out-of-network benefits and financial costs. *(COSLA HOD 1999; Reaffirmed 2009)*

**21) Portability:** Once an individual obtains health insurance, they may use evidence of that insurance to reduce or eliminate any preexisting medical condition exclusion period imposed upon them by joining another group plan or transferring to an individual policy. Portability is defined simply as maintaining coverage and given credit for having been insured when changing health plans. *(COSLA HOD 1999; Reaffirmed 2009)*

**22) Pre-Existing Conditions:** When an individual applies during open enrollment in a health plan, health insurance policies or contracts relating to pre-existing conditions on diseases or health conditions should not extend beyond 9 months for maternity benefits and 12 months for all other conditions. *(COSLA HOD 1999; Reaffirmed 2009)*

**23) Provider-Sponsored Networks:** KMA supports Provider-Sponsored Network (PSN) provisions, and the lesser requirements of PSNs to maintain reserve levels. Provider-sponsored integrated health delivery network means an organization wholly owned, governed, and managed by health care providers, and which provides through arrangements with others, a health benefit plan to consumers voluntarily enrolled in the organization on a per capita or a predetermine, fixed prepayment basis. PSNs' authority allows providers to assume risk for coverage but does not require them to fund and maintain the reserve levels required of insurers. *(COSLA HOD 1999; Reaffirmed 2009)*

**24) Reimbursement for Smoking Cessation Treatment:** KMA supports reimbursement from third-party payers to physicians for smoking cessation treatment. *(Res 2009-10, 2009 HOD, p 533)*

**25) Reimbursement:** KMA supports a requirement that reimbursement to participating hospitals, laboratories, and ancillary service providers should be the same whether or not the ordering physician participates in the patient's plan. *(Res 118, 2000 HOD, p 603; Reaffirmed 2010)*

KMA advocates for physician reimbursement for time spent obtaining pre-certification and pre-authorization for designated services and prescriptions. *(Res 2015-19, 2015 HOD)*

**26) Renewability:** Health plans should be required to renew contracts except for nonpayment of premium, fraud, misrepresentation, noncompliance with plan provisions, or if the insurer ceases doing business in Kentucky. *(COSLA HOD 1999; Reaffirmed 2009)*

**27) Screening:** Screening should be defined in managed care and insurance contracts as health care services or products provided to an individual without apparent signs or symptoms of an illness, injury or disease for the purpose of identifying or excluding an undiagnosed illness, disease, or condition. (COSLA HOD 1999; Reaffirmed 2009)

**28) Tax Subsidization of Insurance Spending:** KMA recognizes federal and state tax inequities governing health insurance, and supports tax policies that are equally fair to employer, employee, self-insured, and non-group private purchasers. (COSLA HOD 1999; Reaffirmed 2009)

**29) Third-party Payer Payments and *kyhealthnow* Initiatives:** KMA advocates for changes to the third-party reimbursement system that encourage achieving the health priorities established by Kentucky's *kyhealthnow* initiatives and similar future initiatives. (Res 2015-10, 2015 HOD)

## **HEALTH KENTUCKY**

**1) Health Kentucky:** KMA continues its endorsement of the Health Kentucky goal of increasing access to care for Kentucky's less fortunate citizens. KMA continue to encourage all Kentucky physicians to continue to voluntarily participate in Kentucky Physicians Care to the extent possible.

KMA continues its endorsement of Health Kentucky contingent on:

- a. Program funding being continued, as appropriate, by Health Kentucky.
- b. A continuing commitment from the Cabinet for Human Resources to evaluate the program applicants for eligibility as is currently done.
- c. The other participating provider groups maintaining the same or increased level of participation in the foundation program.
- d. Health Kentucky making documented efforts to vigorously encourage the participation of all other health care delivery and/or financing organizations in the foundation's program, as may be appropriate.
- e. Health Kentucky making documented efforts to make Kentucky legislators and the general public aware of the plight of those ineligible for Medicaid assistance, solely because they do not meet the confusing and arbitrary requirements of the Medicaid program, while working to broaden the societal financial obligation necessary to provide care to those in need of such assistance. (1997 HOD, p 550; Reaffirmed 2000, 2002, 2003, 2004, 2014)

**2) Kentucky Physicians Care Program:** Overall responsibility for the continued operation and coordination of the Kentucky Physicians Care Program is transferred to the Kentucky Health Care Access Foundation January 1, 1995. KMA will continue to appoint three physician KMA members to the Kentucky Health Care Access Foundation Board of Directors. KMA continues to endorse the Kentucky Health Care Access Foundation's goal of increasing access to care for Kentucky's less fortunate citizens. KMA encourages all Kentucky physicians to continue to voluntarily participate in Kentucky Physicians Care to the extent possible. (1994 HOD, p 536; Reaffirmed 2004, 2014)

## **HEALTHY LIFESTYLES**

**1) Healthy Lifestyle Events:** KMA encourages and actively promotes communities to have free events promoting healthful lifestyles. (Res 2015-6, 2015 HOD)

KMA encourages Community Connectors and other physicians to establish programs in their local communities based on local needs and resources and designate a specific month, days of the week, or other times of the year to focus efforts on improving the health and fitness of the local population.

KMA encourages its members to promote efforts to improve the health of Kentucky by speaking at educational opportunities free to the public such as town hall meetings, social media campaigns, and presentations at local schools. *(Res 2015-12, 2015 HOD)*

**2) Healthy Living Among Physicians:** KMA calls upon its members as well as physicians and other health professionals across the Commonwealth to engage in positive health practices based on well-established public health data. *(Res 2015-13, 2015 HOD)*

## **HOSPITALS**

**“Whole Hospital” Exemption to Stark Laws:** KMA supports appropriate physician investment and competitive participation in the business of medicine and that which preserves the “whole hospital” exemption to the Stark Laws. *(Res 2007-25, 2007 HOD, p 656)*

**Adoption of Universal Transfer Form:** KMA actively encourages the adoption and use of the universal transfer form developed by the Greater Louisville Medical Society and Bluegrass Health Collaborative in Lexington by all long-term care facilities and hospitals throughout Kentucky. *(Res 2013-03, 2013 HOD, p 381)*

## **HPV VACCINE**

**HPV Vaccine:** KMA supports the coverage of the HPV vaccine as a standard policy benefit for medically eligible patients. *(Res 2006-19, 2006 HOD, p 616)*

## **HUMAN IMMUNODEFICIENCY VIRUS (HIV)**

**HIV Testing of Pregnant Women:** KMA supports universal HIV testing of all prenatal patients. *(Res. 96-113, 1996 HOD, p 597; Reaffirmed 2000, 2010)*

## **IMAGING SERVICES**

KMA opposes efforts to require patients to receive imaging services at imaging centers that are mandated to require specific medical specialty supervision, supports patients receiving services at facilities where appropriately trained medical specialists can perform and interpret images regardless of medical specialty, supports the reimbursement of imaging procedures being performed and interpreted by physicians based on the proper indications for the procedure, regardless of medical specialty, and opposes any third party payor’s attempts to limit access to medical imaging procedures based upon specialty of the provider. *(Res 2006-29, 2006 HOD, p 628)*

## **KENTUCKY MEDICAL GROUP MANAGEMENT ASSOCIATION (KMGMA)**

**KMGMA Observer Status:** KMA grants official observer status in the House of Delegates. *(Res 2004-16, 2004 HOD p 628; Reaffirmed 2014)*

## **LABORATORY SERVICES**

**1) Availability of Laboratory Services:** KMA adopts the position that local laboratory services should be available to physicians for use by their patients so that results may be promptly available if needed. *(Res 96-127, 1996 HOD, p 589; Reaffirmed 2006)*

**2) Laboratory Accreditation:** KMA endorses the accreditation program for laboratories of the Commission on Office Laboratory Accreditation. KMA to provide information about the Commission on Office Laboratory Accreditation and encourage physicians to seek laboratory accreditation through COLA. (*Res 96-101 as amended, 1996 HOD; Reaffirmed 2006*)

## **LEGAL TRUST FUND**

**Guidelines:** KMA establishes a "Legal Trust Fund" with the following purposes and mechanisms:

The purpose of the Fund will be to support the legal efforts of any active KMA member to effect change of or gain redress from legislation, government regulations, or "third party" policies which, subject to the stipulations below, adversely affect the practice of medicine, patient protection, or physicians' rights either as individuals or professionals, and the further purpose of this Fund will be to support participation by physicians or physician-oriented organizations in other legal efforts concerning matters of broad interest to or effect on the medical profession.

Such support will be granted by the Trustee of the Fund only to those issues which have widespread or potentially widespread effects on medical practice, physicians' or patients' rights. The Trustee of the Fund will be the KMA Board of Trustees.

The decision to support a cause may be made only after advice of KMA counsel and will require affirmative vote of  $\frac{3}{4}$  of the KMA Trustees present and voting at a properly scheduled meeting of the Board of Trustees. All such decisions will be final and unappealable unless, by unanimous consent, the Board votes to reconsider the matter at a later date.

Having underwritten a cause, the Trustee will continue support from the Trust of all or part of the legal costs during the course of the litigation, if in the opinion of the Trustee the cause continues to promote or protect the broad interest of the medical profession, the legal costs are reasonable and are commensurate with the degree of importance of the cause supported, and the legal costs are within the financial ability of the Fund, taking into consideration the other current or prospective demands upon the Fund.

The support given should ordinarily cover all legal and physician expenses (*vide infra*) but may be less at the discretion of the Trustee.

The Fund will be provided by an annual assessment of the entire active KMA membership to be determined by the Fund Trustee but not to exceed \$100.00, changed by 2004 House, per year. Should the expenses exceed the limits of the Fund in a given year, the Fund Trustee, with the consent of the House of Delegates, may assess the KMA active membership for sufficient funds to carry litigation forward without interruption. This will be done as a special assessment, but will carry the same obligation as KMA dues.

The House of Delegates will strongly urge all active members of the KMA to voluntarily contribute to the KMA Legal Trust Fund. (*Res 2004-29, 2004 HOD; Reaffirmed 2006, 2014*)

Any physician or organization requesting support by the Trust Fund must do so in writing at least six weeks before the next scheduled meeting of the KMA Board of Trustees. Such requests will immediately be forwarded to all KMA Trustees and to KMA Counsel for formulation of legal opinion.

All requests must clearly relate the cause of grievance and the principle(s) upon which the complaint is based – in language comprehensible to a (legalistic) layman.

Although not strictly necessary, it is advisable that any physician or organization applying for support from the Trust Fund consult his or its personal attorney for competent opinion of merits and practicality of legal action, and the preparation of the request prior to submission of that request.

If, in the opinion of the Trustee, the Trust contains sufficient funds for the projected need in the ensuing year, the per annum assessment shall be held in abeyance until such time a replenishment of the Fund shall be deemed necessary by the Trustee.

Funds from the Trust may be invested for capital growth as seems prudent to the Trustee, but monies must always be available to support the stated purpose of the Fund.

Trust funds will be used only to pay for legal costs and expenses of the physician(s) or organizations involved in the case. The physician expenses will be restricted to travel, lodging, and food costs incurred as a result of the litigation, and commensurate with business expenses ordinarily provided for KMA employees. In no case will involved physicians be reimbursed for time lost from practice.

If the outcome of litigation results in a monetary award to the plaintiff/defendant physician or organization, he or it must agree in advance that all funds provided by the Trust in the conduct of the case will be repaid (interest free) up to the limits of the judgment – any surplus monies will belong to the plaintiff/defendant.

If the outcome of the litigation is adverse or results in no monetary award, the plaintiff/defendant physician or organization will have no financial obligation to the Trust Fund.

The Trustee is empowered to impose other administrative procedures and regulation as necessary to the administration of the Trust as long as such procedures and regulations in no way compromise nor contravene the principles embodied in this Resolution.

The specific activities of the Trust will be reported to the KMA membership annually as part of the report of the Chairman of the Board of Trustees. *(Established by Resolution Q, 1973; Amended by Resolution C, 1978; Amended by Resolution A, 1986; Amended by Resolution D, 1994; Amended by Resolution 2004-29; Reaffirmed 2004, 2014)*

## **LIABILITY INSURANCE**

KMA encourages professional liability insurers to make more widely available extended premium payment options, including level monthly premium payments for all Kentucky physicians' professional liability insurance. *(Res 2010-11, 2010 HOD, p 421)*

## **LIABILITY REFORM POLICY**

**1) Tort Reform:** *(Elements of United States and Kentucky civil law are based on tort law precedence that presumes guilt and assigns fault for given acts. Section 54 of the Kentucky Constitution prohibits limiting court awards for injuries or death.)*

KMA supports statutory and constitutional reform to allow such legal changes as: monetary caps on non-economic damages in medical liability awards, restrictions on plaintiff attorney fees, periodic payment of future damages, shortened time limitations for discovery of alleged injuries and collateral source payments. *(Report of the Ad Hoc Committee on Professional Liability Insurance, 2002, p 609; Reaffirmed 2012, 2013)*

KMA supports an amendment to the Kentucky Constitution or the adoption of federal legislation that limits non-economic damages. KMA supports an amendment to the federal ERISA law that immunized employer-sponsored health plans from state-based liability claims by injured patients. Patients covered by ERISA



plans should have the same right of redress as those who are covered by non-ERISA plans. Permitting plans to escape liability for negligence due to legal loopholes places patients in serious jeopardy. Health insurance and managed care employees and physicians who make decisions that result in patient injury or death should be held legally responsible for their decisions. Other supported measures include establishment of arbitration boards to resolve problems without going to court, and limiting the percentage lawyers can take of an award. (COSLA HOD 1999; Reaffirmed 2009, 2012, 2013)

**2) Professional Liability Process Reforms:** KMA supports the establishment of regulatory and administrative processes that would equitably streamline the resolution of liability questions, to include: alternatives dispute resolution processes, peer review confidentiality, ethical sheltering of assets. Mechanisms to exclude elements of claims not associated with hands-on care such as drawing blood as an action for battery. (Report of the Ad Hoc Committee on Professional Liability Insurance, 2002, p 608; Reaffirmed 2012)

**3) Medical Professional Liability Insurance:** Resolution of the problems of availability and cost of liability insurance is a necessary element of medical liability reform. KMA supports insurance market operation considerations such as requiring the public reporting of underwriting loss ratio statements, required publication of carrier underwriting guidelines, requiring Department of Insurance approval for rate increases more than 10%. (Report of the Ad Hoc Committee on Professional Liability Insurance, 2002, p 608; Reaffirmed 2012)

**4) Electoral Reform:** As part of regular judicial gubernatorial legislative and congressional activity evaluations, KMA shall consider candidate positions on tort reform. (Report of the Ad Hoc Committee on Professional Liability Insurance, 2002, p 608; Reaffirmed 2012)

**5) Certificate of Merit:** KMA supports a requirement that a physician with similar expertise and current clinical competence as the defendant sign a certificate of merit before the filing of a liability suit and that the attesting physician's identity be made public record. (Res 2003-19, 2003 HOD, p 618; Reaffirmed 2013)

**6) Expert Witness:** KMA supports a requirement that physician expert witnesses, as pertains to standards of care in medical liability lawsuits, have similar expertise and current clinical competence as the physician defendant. (Res 2003-17, 2003 HOD, p 617; Reaffirmed 2013)

KMA supports requirements for physician expert witnesses, such as:

- Training and experience in the same discipline as the defendant, or specialty expertise in the disease process or procedure of subject in the case; and
- Recognition by the American Board of Medical Specialties or an equivalent board in the same discipline as the defendant or in the specialty generally considered to include the subject of liability; and
- A majority of professional time in the active practice of clinical medicine or substantial time teaching at an accredited medical school about the medical care at issue within two years of the alleged negligence. (Res 2013-10, 2013 HOD, p 384; Reaffirmed 2014)

KMA collaborate with the state's leading business and health care organizations to examine the political and legal feasibility of expert witness reform legislation. (Res 2014-05, 2014 HOD, p 334)

**7) Liability Protection for Volunteer Physicians:** KMA supports legislation providing liability protection for physicians who provide uncompensated voluntary health care. (Res 2010-15, 2010 HOD, p 421)

**8) Limited License and Liability Protection:** KMA supports legislation in the Kentucky General Assembly that provides for limited licensure and civil immunity for retired physician providing uncompensated care for low-income or indigent individuals through public or nonprofit institutions. (Res 2010-11, 2010 HOD, p 421)

**9) Clear and Convincing Evidence:** KMA supports the application of a clear and convincing evidence standard to medical liability cases to help stabilize medical liability insurance premiums. (*Res 2011-07, 2011 HOD, p 414*)

## **LONG-TERM CARE INSURANCE**

KMA supports the purchase of long-term care (LTC) insurance with the ability to deduct the LTC premiums from taxes. (*COSLA HOD 1999; Reaffirmed 2009*)

## **MANAGED CARE REGULATIONS**

**1) Consumer Assistance Program:** Insurance and managed care plans should establish a Consumer Assistance Office to respond to consumer questions and concerns, assist patients in exercising their rights, and protect their interests. The establishment of a Consumer Advisory Board is appropriate to advise the insurer. The Commissioner of Insurance should establish and staff a managed care Ombudsman Office to assist patients and protect their interest. Appropriate complaint procedures should be established and enforced. (*COSLA HOD 1999; Reaffirmed 2009*)

**2) Emergency Care:** Health plans should educate their insured about the use of emergency services, and availability of other more appropriate medical services. Plans must cover emergency department screening and stabilization without prior authorization for use consistent with the “prudent layperson” standard. (*COSLA HOD 1999; Reaffirmed 2009*)

**3) Experimental Treatment:** Clinical research is important to the development of more effective and often more cost-effective treatments. Patients should have access to, when appropriate, and be encouraged to participate in clinical trials. Physicians, not insurers, should determine whether various treatments are consistent with the standard of care or considered experimental. Insurers should provide coverage for patient care in the context of clinical trials, which do not increase significantly the cost of care. Plans that limit coverage of experimental treatment must define the limitation and disclose the limits. Plans should note and disclose who is authorized to make determination and the criteria the plan uses to determine whether a treatment, procedure, drug or device is experimental. Once a health plan receives a request for prior authorization of an experimental procedure, and required information is received, the plan should issue a coverage decision within five working days. If the insured is diagnosed as terminal, the plan must provide a letter of denial setting forth the specific medical and scientific reasons for denying coverage and notice of the insured’s right to appeal and a description of the appeal process. (*COSLA HOD 1999; Reaffirmed 2009*)

**4) External Appeals:** Independent external appeals programs should be established to provide an independent medical necessity or appropriateness of service review of final decisions by insurers to deny, reduce, or terminate benefits. Appeals should be determined by physicians practicing in the same state as the insured who is appealing. Physicians involved in the review process should be independent of the carrier. Physicians, who act without malice or fraud, and within the scope and function of the review process, should be immune from liability for decisions rendered. The cost of external appeals should be borne by the carriers. (*COSLA HOD 1999; Reaffirmed 2009*)

**5) Genetic Testing:** An insurer should be prohibited from denying, canceling, refusing to renew, or varying terms and premiums based upon results of genetic testing. (*COSLA HOD 1999; Reaffirmed 2009*)

**6) Grievance and Appeal Procedures:** Any insured denied a covered service or whose claim for services is denied, may pursue an established review process. Each insurer must include with the insured’s policy, evidence of coverage and a separate information packet regarding their appeal process. Several review mech-

anisms should be included in an appropriate grievance and appeal process. An Expedited Review process should be available when an insured has been denied a covered service. When this occurs, the treating physician must certify in writing and provide supporting documentation to the utilization review agent that the time period for a lengthy reconsideration could cause significant negative change in the insured's medical condition. Under the Expedited Review process, the review agent must respond in one working day by mail to the insured and the treating physician. A final Independent External Review process should be available for patients denied a medical service or for cases involving an issue of coverage. The External Independent Review Committee should be composed of physicians practicing in the same specialty and preferably in the same state as the treating physician and the insured. Procedural guidelines should be established for cases involving medical necessity and issue of coverage, and information relating to these guidelines should be made available to both the patient and physician. The physician reviewers should be independent of the carrier, the treating physician, and the patient. Internal appeal processes and informal reconsideration for denial of claims or services for elective, non-emergency, or routine conditions should also be made available to the insured and the treating physician. (COSLA HOD 1999; Reaffirmed 2009)

**7) Managed Care Protection:** Protections should be enacted to monitor managed care and assure patient safety and decreased costs, along with quality care. Protections should include patient rights, physician fairness standards, and physician advocacy for patients to enhance patient safety and quality of care. (COSLA HOD 1999; Reaffirmed 2009)

**8) Managed Care Liability:** Patients who suffer injury or death resulting from a decision to delay or deny care by a managed care plan employee or plan medical director, should be permitted to bring action against the plan to recover damages. (COSLA HOD 1999; Reaffirmed 2009)

**9) Pap Smear as "Clinical" Laboratory Test:** KMA supports reclassification of Pap smear screening as a medical consultation; removal of Pap smear screening from categorization as a clinical laboratory test, and exclusion of Pap smear screening from clinical lab bids proposed by managed care groups. (Res 96-125, 1995 HOD; Reaffirmed 2005, 2015)

**10) Patient Protection and Physician Fairness in Managed Care:** KMA advocates state laws that provide for patient protection and physician fairness in managed care organizations, to include:

- Permit physicians to negotiate with managed care organizations, as appropriate.
- Provide for formal practicing physician input in the development and refinement of medical policies, including credentialing, utilization review, quality assurance, and benefit package.
- Require disclosure of all participation requirements and selective contracting decisions, and disclosure of reasons for denial or de-selection.
- Provide enrollees and participating physicians with the opportunity to complete a "report card" at regular intervals regarding the quality of service rendered. (Res H, 1995 HOD, p 614; Reaffirmed 2005, 2015)

**11) Plan Certification:** The Commissioner of Insurance should promulgate rules to certify managed care plans and utilization reviews programs, and identify procedures for periodic review and re-certification. (COSLA HOD 1999; Reaffirmed 2009)

**12) Prompt Payment:** Managed care plans or licensed insurers must pay a written claim submitted by physicians within 30 days of receipt of fully documented clean claim. Payers should be required to notify physicians within 30 days if a claim is inadequately prepared. Otherwise the claim is presumed valid. Payments for electronically filed claims should be paid within 15 days. If plans fail to remit payment as required, interest may accrue at 12% per annum added to the amount owed on the fully documented clean claim. KMA recommends that the Department of Insurance (DOI) adopt regulations that define a "clean claim." The law should apply to all third-party payers, including those under the federal ERISA law and the statues should be rigidly

enforced. KMA opposes any attempts by the legislature or executive branch of state government to repeal or weaken statutes pertaining to prompt payment. (*COSLA HOD 1999; Reaffirmed Res 2004-24, 2004 HOD, p 623; Reaffirmed 2014*)

**13) Rights of Patients in Managed Care:** KMA supports the priority of patient welfare in all managed care programs and the rights of patients to be advised of:

- Services covered or excluded under a health plan printed in easily understood language.
- Requirements for preauthorization of physician services or post treatment review, which may lead to denial of coverage.
- Financial arrangements which would limit services, restrict referrals, or establish incentives not to deliver services.
- Information in an understandable format that states the percentage of premium dollars spent on direct patient care.
- Patients' ability to continue treatment with their provider of choice during the period of enrollment.
- Patients' ability to receive necessary emergency services and assurances that the plan will provide reimbursement for such services regardless of the provider's participating status in such plan with no post treatment denial.
- A grievance and appeal procedure to resolve disputes over medical necessity, appropriateness of care decisions and coverage issues. (*Res H, 1995 HOD, p 614; Reaffirmed 2005, 2015*)

**14) State Patient Protections vs. Federal Patient Rights Bills:** Federal patient protection enactments should become a floor and not a ceiling for state managed care fairness reforms. (*COSLA HOD 1999; Reaffirmed 2009*)

**15) Utilization Review:** Utilization Review (UR) programs should be based on open and consistent review criteria that are acceptable to, and have been developed in conjunction with, the medical profession. Physicians participating in the UR process should be actively practicing physicians in direct patient care, in the same specialty as that of the physician or service under review. Physicians reviewing medical necessity, appropriateness of services, or site of services should be licensed in Kentucky. (*COSLA HOD 1999; Reaffirmed 2009*)

## **MEDICAID**

**1) Reimbursement and Funding:** KMA actively promotes a reasonable reimbursement rate for Medicaid providers, and stands for adequate and broad-based state general funding for the Medicaid Program. (*Res S, 1995 HOD, p 621; Reaffirmed 2005, 2015*)

Reimbursement methods should not discriminate against any class or specialty of physicians. KMA urges the Cabinet for Health Services to examine the Medicaid reimbursement policy, and this policy should reflect reimbursement levels proportionate to charges and level of skill and training, regardless of physician location or specialty. (*Res V, 1990 HOD, p 742; Reaffirmed 2000, 2010*)

KMA will pursue all reasonable channels to promote adequate financing of the Medicaid Program for the provision of vital primary medical services. KMA will pursue all reasonable channels to preserve and promote full funding for primary medical services prior to expansion through new or nonmedical services. (*Res L, 1983 HOD, p 992; Reaffirmed 2000, 2010*)

**2) Medicare Crossover:** KMA advocates for the reinstatement of Kentucky Medicaid payment of Medicare Part B crossover claims. (*Res 2004-21, 2004 HOD, p 629; Reaffirmed 2014*)

**3) SCHIP:** KMA supports funding of the State Children's Health Insurance Program (SCHIP). (*Res 07-04, 2004 HOD, p. 664; Reaffirmed 2014*)

**4) Managed Care:** KMA advocate for Kentucky's Department of Medicaid Services to adopt the long-term goal that Medicaid managed care plans use the model of provider-sponsored, community-based, not-for-profit managed care to more effectively deliver Medicaid services in Region 3 of Kentucky and to assist in avoiding the significant administrative and implementation failures which occurred in 2012 as Medicaid managed care was initiated outside of Region 3. *(Res 2012-06, 2012 HOD, p 521)*

**5) Prescriber Only Participating Status:** KMA urges the Kentucky Cabinet for Health and Family Services to establish the "Prescriber Only" status for physicians and other providers throughout the Kentucky Medicaid program. *(Res 2015-7, 2015 HOD)*

## **MEDICAL CANNABIS**

KMA advocates for further clinical research of cannabis in the treatment of medical conditions. *(Res 2015-16, 2015 HOD)*

## **MEDICAL NECESSITY**

KMA supports the position that only physicians may determine medical necessity. Medical necessity is clearly defined as health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, disease or its symptoms:

1. In accordance with generally accepted standards of medical practice
2. Clinically appropriate in terms of type, frequency, extent, site and duration
3. Not primarily for the convenience of the patient, physician, or other health care provider

*(Res 99-109, 1999 HOD; Reaffirmed 2009)*

KMA supports the American Medical Association's (AMA) efforts to pursue legislation or regulations requiring direct-to-consumer advertising from Durable Medical Equipment (DME) advertisers to include a disclaimer stating that eligibility for and coverage of DME is subject to specific criteria and when feasible list the actual criteria. *(Res 2013-16, 2013 HOD, p 382)*

## **MEDICAL PRACTICE REGULATIONS**

**1) Maintenance of Licensure/Maintenance of Certification:** KMA joins the American Medical Association in advocating for an impact study that addresses the effect of maintenance of certification, osteopathic continuous certification, and maintenance of licensure principles on workforce, costs, access to care, and quality improvement in patient care.

KMA urges the Kentucky Board of Medical Licensure to reject any action that would implement any requirement of maintenance of certification, osteopathic continuous certification, or the Federation of State Medical Boards maintenance of licensure program as a condition of licensure until results of an impact study are known.

KMA works with the American Medical Association and other organizations, hospitals/employers, and payers to make them aware of the onerous impact on Kentucky's physician workforce that could result from mandating maintenance of certification and osteopathic continuous certification as a condition of employment or of inclusion in health plans' provider panels.

KMA continues to encourage physicians to strive to constantly improve their care of patients by the means they find most effective, within the standards of accepted and prevailing medical practices. *(Res 2014-03,*

## **2) Physician Fairness:**

- Plans should provide enrollees and participating physicians with the opportunity to complete a “report card” at regular intervals regarding quality of service.
- There should be no payment differentials to physicians based on geographic location. Reimbursement methodologies should not discriminate against any class or specialty of physicians. In the process of instituting single, equitable statewide reimbursement schedules, insurance companies should not diminish existing reimbursement schedules.
- In accordance with the principles of medical ethics, except in emergencies, physicians are free to choose whom to serve, with whom to associate, and the environment in which to provide medical service. (*COSLA HOD 1999; Reaffirmed 2009*)

**3) Quality of Patient Care:** AMA defines quality of care as “the degree to which care services influence the probability of optimal patient outcomes.” Physicians are uniquely qualified and positioned to provide quality measurement. The present managed care and health insurance market is driven by cost and there is the potential for price competition that may negatively affect quality care in very significant ways. Physicians must reclaim their role in determining the clinical configuration of the emerging managed care and health insurance system. Through various organizations, including IPAs, large practices, physician management enterprises, medical societies, and other ventures with hospitals and providers, physicians now have the ability and opportunity to evaluate the content of care. The KMA believes that physicians and patients must be aggressive in retaining their rightful place in the emerging delivery system. The medical association, legislative bodies, and patient consumer groups must position physicians to serve the legislative purpose of our medical care system – assuring appropriate access to quality care. (*COSLA HOD 1999; Reaffirmed 2009*)

**4) Reduction of Regulations:** The burden of government and third party regulation on medical practice and health insurance should be reduced. Its intrusion and “hassle factor” into the physician-patient relationship and doctor-patient time is costly and delays treatment of patients. The Association vigorously opposes uncompensated regulatory requirements for physicians and supports economic impact statement requirements for all legislation and regulation affecting the delivery of medical care and increased cost. (*COSLA HOD 1999; Reaffirmed 2009*)

**5) Unnecessary Clerical and Documentation Requirements:** KMA opposes clerical and related requirements imposed by insurance or managed care entities that are disruptive to the physician-patient relationship, jeopardize quality of care, and result in cost shifting, rather than long-term cost savings. Physicians spend an inordinate amount of patient care time documenting records to comply with reimbursement, fraud and abuse, and professional liability requirements. Government, health insurers, and other entities should be required to provide economic impact statement requirements for all legislation, regulation, and imposition of clerical and documentation requirements upon providers of medical care. Further, insurers requiring pre-authorizations, pre-certifications, referrals, or other tools for directing or managing a patient’s care, must provide these services through a centralized mechanism which is easily accessible by network providers (i.e., no lengthy telephone delays, additional paperwork outside the original medical record, etc.) (*COSLA HOD 1999; Reaffirmed 2009*)

## **MEDICAL STAFF**

**1) Hospital Patient Care Activities:** Recommend to hospital medical staffs that a mechanism be developed whereby the hospital provides timely notice to the medical staff when business ventures, contracts, letters of intent, and all other legal tying arrangements that affect patient care are considered, including additional new services or elimination of existing services; and further recommend that all ventures and legal tying arrangements that affect patient care and the medical staff’s inherent responsibility for the adequacy and quality of

medical care be reviewed through these mechanisms for comment and recommendation before rejection or implementation by the hospital. (*Res B, 1986 HOD; Reaffirmed 2000, 2010*)

**2) Medical Staff Self Governance:** KMA adopted the following statement regarding medical staff governance:

1. The medical staff bylaws, rules and regulations shall be initiated and adopted by the medical staff and shall establish a framework of self-government
2. The medical staff shall govern itself by these bylaws, rules and regulations which shall:
  - a. Be approved by the governing body whose approval shall not be unreasonably withheld
  - b. Be reviewed and revised as necessary to reflect current medical staff practices
  - c. Define the Executive Committee of the medical staff whose members are selected in accordance with criteria and standards established by the medical staff
3. The medical staff shall have authority to approve or disapprove all amendments to medical staff by-laws, rules and regulations.

KMA endorses the position of the AMA with respect to the responsibilities and functions of the hospital, its governing board, and the medical staff, that:

1. The hospital has corporate responsibility for maintaining the necessary facilities, a safe environment, and a mechanism for the prudent selection of those who treat patients within the institution
2. The governing board is responsible for the operation and management of the hospital and fulfilling its corporate responsibilities
3. The organized medical staff and its members have a contractual obligation entered into with the hospital, to carry out their professional medical responsibilities through:
  - a. The efficient operation of medical staff committees
  - b. The objective selection of professionally qualified members of the organized medical staff and disciplinary functions relative to their competent performance
  - c. Functioning as a self-governing body in promoting quality patient care within the hospital
4. Members of the organized medical staff may likewise deal collectively, as an entity, with the hospital and its governing board with respect to professional matters involving their own interests, as distinguished from the functions the organized medical staff performs on behalf of the hospital. (*Res O, 1984 HOD, p 710; Reaffirmed 2000, 2010*)

**3) Medical Staff Representation on the Hospital Governing Board:** KMA supports the JCAHO standards requiring the hospital governing body to accept medical staff representation on all governing bodies. (*Res X, 1983 HOD, p 958; Reaffirmed 2000, 2010*)

**4) Legal Representation:** KMA encourages organized self-governing medical staffs to make arrangements for separate legal representation. (*Res Z, 1983 HOD, p 959; Reaffirmed 2000, 2010*)

**5) Medical Staff Liability Insurance Requirement:** KMA supports the province of the hospital medical staff to determine if it will require liability insurance coverage and the level of policy limits as a condition for medical staff membership. (*Ref Comm B, 2003 HOD, p 612; Reaffirmed 2013*)

## **MEDICAL STUDENTS**

**Medical Student Engagement in Organized Medicine:** KMA works with the University of Louisville Medical School, the University of Kentucky College of Medicine, and the University of Pikeville Kentucky College of Osteopathic Medicine to develop more on-campus KMA Medical Student Section (MSS) activities, including regularly scheduled organizational meetings, and the mentoring of medical students by KMA members of the Commission on Young Physicians and Physicians in Training and the Resident & Fellow Section.

KMA provides funding for one medical student from each of the University of Louisville Medical School, the University of Kentucky College of Medicine, and the College of Osteopathic Medicine in Pikeville to attend the Annual and Interim meetings of the American Medical Association Medical School Section, if said funding is matched one-to-one by the Medical Schools. *(Res 2014-07, 2014 HOD, p 330)*

## **MEDICAL WASTE**

**Disposal of Medical Waste:** KMA condemns the disposal of hazardous medical waste in any fashion which might be harmful or dangerous to humans, animals, or the environment. *(Res V, 1988 HOD, p 753; Reaffirmed 2000, 2010)*

## **MEDICARE**

**Reimbursement:** KMA continue to work to stop cuts in Medicare physician reimbursement. *(Res 07-04, 2004 HOD, p. 664; Reaffirmed 2014)*

## **MEMBERSHIP**

**1) Elective Office:** KMA encourages any interested member to run for KMA elective office. *(Res 2003-8, 2003 HOD, p 604; Reaffirmed 2013)*

**2) Physician Representation by Organized Medicine:** KMA urges doctors in all medical groups, managed care organizations, and academic institutions to join and participate in organized medicine to preserve a unified and broad-based voice that focuses on patient advocacy and physician priorities in health care. KMA encourages corporate health care entities and their directors to financially support and underwrite membership in all levels of organized medicine. *(Res 96-124, 1996 HOD; Reaffirmed 2006)*

## **MENTAL ILLNESS**

**1) Parity for Mental Illness in Medical Benefits Programs:** KMA supports the provision of benefits for emotional and mental illness under all governmental and private insurance programs which are equivalent in scope and duration to those benefits provided for other illnesses. *(Res 97-123, 1997 HOD, p 572; Reaffirmed 2007)*

**2) Physician Reimbursement:** KMA opposes the reimbursement policy of Blue Cross/Blue Shield or any other insurer not paying primary care physicians for the outpatient treatment of depression and other mental health diagnoses. *(Res 96-126, 1996 HOD, p 599; Reaffirmed 2006)*

KMA adopted the policy that physicians treating depression and depression-related symptoms should be compensated by health insurance plans without regard to the physician's specialty. *(Res 120, 2000 HOD, p 603; Reaffirmed 2010)*

KMA advocates for payment mechanisms that allow adequate funding of mental health care in order to assure its continued availability in the primary care physician office. *(Res 2015-3, 2015 HOD)*

## **MENU LABELING**

KMA supports the requirement that restaurants provide nutritional information, including calorie count, carbohydrate count, salt content, and fat grams, for their menu selections. *(Res 2009-09, 2009 HOD, p 533)*



## **MILITARY MEDICAL CARE**

**1) Funding:** KMA supports adequate federal funding of the Tricare program. (*Res 2003-15, 2003 HOD, p 617; Reaffirmed 2013*)

**2) Support for Tricare:** KMA encourages support for families of those on active military duty by accepting Tricare insurance. (*Sub Res 2003-14, 2003 HOD, p 611; Reaffirmed 2004, p 629; Reaffirmed 2014*)

**3) Location of Louisville Regional VA Medical Center:** KMA opposes the selected Midlands location for construction of a new Louisville Region VA Medical Center.

KMA supports a location in close proximity to the University of Louisville Medical Center for the proposed VA Hospital. (*Res 2013-08, 2013 HOD, p 382*)

## **NURSING**

**1) Nurse Workforce:** KMA reemphasizes its support for the necessary improved conditions to attract and maintain an adequate supply of nurses to assure the continued availability of quality medical care. KMA continues to emphasize the importance of good professional relationships between physicians and nurses. (*Res W, 1988 HOD, p 742; Reaffirmed 2000, 2010*)

**2) Advanced Registered Nurse Practitioners (ARNP)** The Ad Hoc Work Group on Prescriptive Authority for Advanced Registered Nurse Practitioners recommends that the Legislative Quick Action Committee shall formulate a position (which may include opposition) that protects the general public from increased risks of drug diversion, strengthens collaborative agreements between physicians and nurse practitioners, and limits the timeframe, schedules, or narcotics for which ARNPs may write. (*Report of the Ad Hoc Work Group on Prescriptive Authority for Advanced Registered Nurse Practitioners-2005 HOD; Reaffirmed 2015*)

KMA encourages physicians who are contemplating or who have entered into a written collaborative agreement with an ARNP familiarize themselves with the content of the Kentucky Board of Medical Licensure's advisory opinion regarding Acceptable and Prevailing Medical Practice for Physicians Involved in Collaborative Agreements with ARNPs. (*Res 2010-20, 2010 HOD, p 420*)

KMA supports the maintenance of the collaborative agreement requirement between nurse practitioners and supervising physicians. (*Res 2011-20, 2011 HOD, p 413*)

**3) Scope of Practice:** Advanced Registered Nurse Practitioners, Physician Assistants, and Pharmacists should be able to provide professional services under their scope of practice so long as the services provided are pursuant to protocols by a medical doctor with whom the patient has established a physician-patient relationship. Plans should not be required to reimburse nonphysician practitioners directly. (*COSLA HOD 1999; Reaffirmed 2009*)

KMA continues to study the role of physicians in their relationship to mid-level practitioners, with particular regard to oncoming changes of payment systems that may shift the organization of health care delivery in the future. (*Res 2010-20, 2010 HOD, p 420*)

KMA, in the public interest, opposes enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the state's requirements for licensure to engage in the practice of medicine and surgery in all of its branches, consistent with AMA policy H-35.988.

KMA endorses existing AMA policies H-160.947 and H-160.950 that present guidelines for the integrated practice of physicians with nurse practitioners and physician assistants and support legislation consistent with these guidelines. (*Res 2011-20, 2011 HOD, p 413*)

## **OPHTHALMOLOGY**

**Ophthalmologists as Primary Care Providers:** Ophthalmologists shall be regarded as comprehensive (primary, secondary, and tertiary) eyecare providers. (*Res R as amended, 1994 HOD, p 560; Reaffirmed 2004, 2014*)

## **OPTOMETRY**

**Optometrists as Primary Care Providers:** KMA opposes legislation allowing optometrists to act or serve as primary care providers in performance of the practice of medicine, surgery, or laser surgery in the Commonwealth of Kentucky. (*Res 97-129, 1997 HOD, p 572; Reaffirmed 2007*)

**Optometric Surgery Law:** KMA will pursue all necessary legal and legislative options to repeal Kentucky's optometric surgery law. (*Res 2011-01, 2011 HOD, p 412*)

## **PATIENT ADVOCACY**

### **Physician Responsibility for Patient Advocacy:**

- The duty of patient advocacy is a fundamental element of the physician/patient relationship that should not be altered by the system of health care delivery in which physicians practice. Physicians must continue to place the interest of their patients first.
- Physicians must advocate for appropriate care they believe will materially benefit their patients.
- Physicians should be given an active role in contributing their expertise to any allocation process and should advocate guidelines that are sensitive to differences among patients.
- Strong appellate mechanisms, including independent external appeals processes, for both patients and physicians, should be in place to address disputes regarding medically necessary care.
- Health insurance and managed care plans must adhere to the requirement of informed consent that patients be given full disclosure of material information, including limitations or restrictions on benefits before entering a plan.
- Physicians should not participate in any plan that encourages or requires care at or below minimum professional standards.
- Financial incentives are permissible only if they promote cost-effective delivery of health care and not withholding of necessary medical care. (*COSLA HOD 1999; Reaffirmed 2009*)
- Health/medical care facility processes or procedures or payment system rules should not interfere with the counsel of patients by physicians and should not subject physicians to any reprisals that would restrain, suppress, or prevent them from providing information to patients and their families regarding cost and quality issues. (*Res 2008-18, 2008 HOD, p 625*)

## **PATIENT/PHYSICIAN RELATIONSHIP**

**Patient/Physician Relationship:** KMA endorses the position that the physician should be in the focal position of directing medical care to produce an outcome in the best interest of the patient, appropriate to the patient's situation, in the most timely and cost-effective manner possible, adhering to established principles of ethics, and for fair and reasonable compensation. (*Res 98-108, 1998 HOD, p 559; Reaffirmed 2008*)

## **PAY FOR PERFORMANCE**

**1) Pay for Performance Guidelines:** KMA supports provision of high quality care to patients and opposes any pay-for-performance programs based solely on cost. KMA also supports the principles of the AMA regarding pay-for-performance programs. (*Report of the Committee to Investigate Changing Trends in Medicine 2005 HOD, p 671, Reaffirmed 2015*)

KMA supports these principles:

- a. KMA opposes physician profiling, tiering, or pay-for-performance programs based solely on economic criteria.
- b. Physicians who meet quality standards should be identified separately from their economic standards.
- c. Such programs should be designed to improve quality of care using nationally accepted standards.
- d. Measurements and guidelines used in such programs should be evidence-based and not based solely upon economic criteria.
- e. Physician rankings must provide complete transparency and a mechanism for physicians to appeal their classification.
- f. Any such programs instituted by third-party payers should be reviewed by a nationally recognized, independent health care quality standard-setting organization, retained at their own expense.
- g. KMA should support legislation based on these principles regarding pay-for-performance, physician profiling, and tiering programs established by third-party payers:

(*Report of the Comm on Medical Business Advocacy, 2009 HOD, p 531*)

**2) Information Systems to Judge Quality and Cost-Effectiveness:** Quality is defined by the AMA Council on Medical Service as the degree to which care services influence the probability of optimal patient outcomes. Adequate levels of government and private funding should be budgeted to finance outcomes research, practice parameters development, and similar approaches, provided they have appropriate physician input. The results of such mechanisms should be educational and not punitive. Third party payers should be prohibited from releasing information except to the individual physician or within a formal peer review process. (*COSLA HOD 1999; Reaffirmed 2009*)

## **PEER REVIEW**

**Medical Review Committee:** A Medical Review Committee is composed of physicians under the auspices or requirements of medical associations or societies, hospitals, clinics, nursing homes, private insurers, government, or other entities which require or generate review of medical care. A Medical Review Committee evaluates the quality, cost, and necessity of medical services, including credentialing. Members who act without malice or fraud should not be subject to liability for damages on account of any act, statement, or proceeding performed within the scope and functions of the committee. Proceedings of the medical review committee, records and the materials it produces, and materials it reviews should be confidential and not considered public records. (*COSLA HOD 1999; Reaffirmed 2009*)

**Confidentiality:** KMA seeks relief from the lack of confidentiality of peer review. (*Res 2012-21, 2012 HOD, p 522*)

## **PHYSICIAN ASSISTANTS**

**1A) Guidelines:** KMA reconfirms its support for the concept of Physicians Assistants with the following guidelines:

1. That a Physician Assistant must be a recognized graduate of a PA program of an accredited institution of higher learning;
2. That Physician Assistants must be certified or eligible for certification through the National Board of

Certification for PAs;

3. That there be no more than four PAs working under the supervision of any one licensed physician, except those in training in an accredited institution, and that the practice of a PA shall be limited to the same area of practice as that in which the supervising physician is qualified; (*Res 2014-10, 2014 HOD, p 334*)
4. Jurisdiction over PAs should be maintained by the Board of Medical Licensure;
5. That the physician's supervision be required in a reasonable manner at the time of service provided and in a manner acceptable to the Board of Medical Licensure;
6. The PAs must document their services in acute care and/or long-term care facilities, and any orders written must be countersigned by the responsible physician.

(*Res P, 1979 HOD, p 695; Reaffirmed 2000, 2010*)

**1B) Guidelines:** KMA supports legislative action to:

1. Increase the physician to physician assistant ratio so that physicians may supervise up to four physician assistants at any one time. (*Res 2014-10, 2014 HOD, p 334*)
2. Reestablish the requirement that medical services or procedures delegated to a physician assistant (PA) be within the scope of practice of the supervising physician;
3. Forbid independent practice by physician assistants; and
4. Require the Kentucky Board of Medical Licensure to promulgate administrative regulations which:
  - A. Establish an application procedure whereby a physician seeking supervisory privileges regarding a PA must submit to the Board, for its approval, a utilization plan outlining the range and scope of services to be provided by the PA and demonstrating that these services or procedures are among those for which the PA received training in an accredited educational program or for which the physician assistant has acquired satisfactory knowledge and experience under physician supervision; and
  - B. Require, prior to the PA performing any service or procedure beyond those authorized under the utilization plan, that the supervising physician gain the Board's approval of a supplemental plan which delineates the additional service or procedure, stipulates the level of supervision involved, describes the education, training and experience of the PA, and identifies the location where the service or procedure will be provided (ie, hospital, physician office, ambulatory surgery center, etc). The credentialing approval by an accredited hospital medical staff (eg, JCAHO) may be adequate documentation information for the supplemental utilization plan.

In addition, the ad hoc committee recommends the following principles concerning PA scope of practice become KMA policy and that the Association encourage the Kentucky Board of Medical Licensure to promulgate regulations for approving PA utilization and supplemental utilization plans using these principles as guidelines.

### **Principles and Policy for Physician Assistant Scope of Practice**

1. Supervising physicians may delegate to a physician assistant medical services or procedures that are:
  - A. Within the scope of training received in an accredited educational program for physician assistants, or within the scope of such additional training and experience as gained in practice under a supervising physician, and
  - B. Within the supervising physician's scope of practice, and
  - C. Part of a utilization plan approved by the Board of Medical Licensure.
2. Supervising physicians may delegate additional medical services or procedures to physician assistants that are outside their initial scope of training if:
  - A. The additional medical services or procedures delegated are within the supervising physician's scope,

and

- B. The physician assistant's capability to perform the additional medical service or procedure is competently gained through extensive training and experience in practice, and
  - C. The additional medical service or procedure is part of a supplemental utilization plan approved by the Kentucky Board of Medical Licensure. The KBML may consider training received from a supervising physician and experience acquired during supervised practice as equivalent to formal education and instructional courses, or may require the supervising physician to certify that the physician assistant has completed a formal course or courses of education and instruction that pertain to the additional medical service or procedure.
3. Medical services or procedures may require varying levels of supervision. The different levels of supervision are defined as follows:
- A. Direct Supervision – The highest level of supervision is “direct supervision.” This means the supervising physician is actually in sight of the physician assistant when the physician assistant is performing the function requiring direct supervision. Although the physician may be performing some other task at the time, the supervising physician is physically present in the same room, so that the supervising physician may immediately provide direction or assume the performance of the task if difficulties arise. This does not require that the physician is watching “over the shoulder” of the physician assistant as would be required during the training period to ensure that the physician assistant is competent to perform the task. The term “immediate presence” means that direct supervision is being provided.
  - B. On-site Supervision – The next level of supervision is “on-site supervision.” On-site supervision requires the physical presence of the supervising physician in the same location (ie, the physician's office suite) as the physician assistant, but does not require the physical presence in the same room.
  - C. Off-site Supervision – The remaining level of supervision is “off-site supervision.” When providing off-site supervision, the supervising physician must be continuously available for direct communication with the physician assistant and must be in a location that, under normal conditions, is not more than sixty minutes travel time from the physician assistant's location.
4. The physician is responsible for the supervision of the physician assistant in all settings.
5. The physician is responsible for managing the health care of patients in all settings.
6. The relationship of the supervising physician and physician assistant must involve frequent consultations and frequent review of practice patterns. The relationships must always be complementary to the supervising physician's overall care of the patient and must never be independent or in place of the supervising physician.
7. The supervising physician must be available for consultation with physician assistant at all times, either in person or through electronic communications, and must be in a location that, under normal conditions, is not more than sixty minutes travel time from the physician assistant's location.
8. The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and activity of the patient's condition and the training, experience, and preparation of the physician assistant, as determined by the supervising physician.
9. Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
10. A physician assistant scope of practice should not be of a type that cannot be performed safely and effectively.

11. KMA endorses legislation, regulations, and agency and institutional policies that authorize that health care services provided by physician assistants be reimbursed to the physician who supervises the physician assistant.

*(Report of the Ad Hoc Committee on Physician Assistant Scope of Practice, 2001 HOD, p 605 607; Reaffirmed 2011)*

**2) Physician Assistants Certification:** KMA reaffirms support for certification of Physician Assistants by the Kentucky Board of Medical Licensure. The KMA believes that medical institution policies for purposes of staff privileges for practitioners be established by the local institution in conjunction with medical staff. The KMA believes that institutional staff privileges be determined commensurate with an applicant's education, training, experience, and demonstrated current competence; JCAHO standards; and federal, state, and other government laws and regulations. *(Res 98-124, 1998 HOD, p 545; Reaffirmed 2008)*

**3) Physician Assistants Reimbursement:** KMA endorses legislation, regulations, and agency and institutional policies that authorize that health care services provided by Physician Assistants be reimbursed to the physician who supervises the Physician Assistant. *(Res 98-109, 1998 HOD, p 545; Reaffirmed 2008)*

**4) Physician Assistants Scope of Practice:** KMA vigorously oppose legislative attempts to expand PA scope of practice. *(Res 2004-35, 2004 HOD, p 636; Reaffirmed 2014)*

**5) Modification of Co-Signature Policy:** KMA supports working with the Kentucky Academy of Physician Assistants to provide for physician discretion on the need for co-signature. *(Res 2013-18, 2013 HOD, p 384)*

## **PHYSICIAN NETWORKS**

**1) Access to Specialty Care and Referral:** Insurance and managed care plans should be required to demonstrate that there are adequate physicians for enrollees to have an appropriate choice of physicians and access to services. Each insurance or managed care plan should develop appropriate plans to ensure proper access to specialty care including: referral to a nonparticipating specialist in instances where the network does not have a specialist in the appropriate area; the provision of standing referrals to a particular specialist in necessary instances; the coordination of care by a specialist for enrollees with life-threatening or degenerative/disabling conditions and/or referral to a specialty care center if care would be most appropriately provided. *(COSLA HOD 1999; Reaffirmed 2009)*

**2) Network Adequacy:** Managed care plans must have sufficient number and type of primary care physicians, specialists and subspecialists throughout the plan area. The network should be available to enrollees within 30 miles or 30 minutes, and access to urgent and emergency care should be well defined. Telephone access to the plan during business hours should be available, and reasonable standards for waiting times to obtain appointments should be present. *(COSLA HOD 1999; Reaffirmed 2009)*

## **PHYSICIAN, TITLE OF**

KMA seeks legislation that limits the use of the title "Physician" to individuals who have completed the requirements for an MD or DO degree. *(Res 2011-17, 2011 HOD, p 417)*

## **PREGNANCY**

**1) Primary Care During Perinatal Period:** KMA maintains that obstetricians be regarded as primary care physicians to their obstetrical patients during the perinatal period. *(Res N, 1994 HOD, p 560; Reaffirmed 2004,*

**2) Quality Care Standards:** The 1994 House of Delegates adopted the report of the Wisconsin Association for Perinatal Care that recommends certain quality of care standards be met prior to hospital discharge of mother and newborn. The following steps are utilized to decrease morbidity in mothers and children and as a method of negotiating with third-party payors:

- A. All patients should have a case manager, be it the patient herself, the primary care provider, public health nurse, tertiary care provider, or some other advocate or support person.
- B. Hospital staff should be expected to accomplish the following goals during the time they have with the patient during the intrapartum and postpartum periods:
  - The physiological stability of the mother and infant.
  - An intact feeding interaction.
  - Patient education on how to care for herself and her baby, and when and how to contact her care provider.
- C. A physician-directed referral source of continuing medical care for both mother and baby should be identified and arrangements made for the baby to be examined with 48 hours of discharge:
- D. The following assessments should be performed on all infants/families prior to discharge:
  - Parents' concerns, priorities, and resources
  - Developmental/sensory risk assessment
  - Maternal/infant interaction
  - Psychosocial
    - Parenting readiness
    - Home environment
    - Financial Needs
- E. A formal discharge plan should be developed for each infant/family. Care conferences should be convened for infants/families that have a variety of needs/concerns.
- F. Standard interagency referral and communication forms should be considered as a way to communicate the same information to multiple providers, patient support personnel, and the family.
- G. Health care providers and payors should work together and have a common understanding about which patients fall within their managed care guidelines for each discharge and which patients are outliers. (*Report of the Committee on Maternal and Child Health, 1994 HOD, pp 563-4; Reaffirmed 2004, 2014*)

**3) Folic Acid:** KMA recommends women of childbearing age to take folic acid. (*Report of the Committee on Maternal and Neonatal Health, 1999; COSLA HOD 1999; Reaffirmed 2009*)

**4) Smoking:** KMA recognizes the importance of perinatal smoking cessation. (*Report of the Committee on Maternal and Neonatal Health, 1999; COSLA HOD 1999; Reaffirmed 2009*)

**5) High-Risk Newborns:** KMA recommends that all high-risk newborns be followed by their physicians and their designates to insure PKU testing, infant immunizations, preventive care, and repeat pregnancy education. The importance of preventive health measures, including immunization, is recognized for all infants and children in the Commonwealth. (*Comm on Maternal and Child Health, 1992 HOD, p 671; Reaffirmed, Special Report on Policy Sunset, 2002 HOD, p 576; Reaffirmed 2012*)

**6) Breast-feeding:** KMA fully supports breast-feeding and its promotion in the state of Kentucky. (*Res Z, 1990 HOD, p 741; Reaffirmed 2000, 2010*)

## **PREGNANCY, TERMINATION OF**

**1) After the stage of viability, termination of pregnancy must be limited to those situations in which the life of**

the mother is jeopardized or a proven fatal anomaly exists;

Abortion on demand be discouraged at any time;

Any live infant must be accorded the same rights and the same care that would be given to an infant delivered by more traditional means;

The practice of using fetuses as experimental material is condemned;

No hospital, clinic, institution, or any other facility in this state should be required to admit any patient for the purpose of performing an abortion, nor required to allow the performance of an abortion;

No person should be required to perform or participate directly or indirectly in an abortion procedure. No hospital, governing board, or any other person, firm, association, or group should terminate the employment or alter the position of, prevent or impair the practice or occupation of, or impose any other sanction or otherwise discriminate against any person who refuses to participate in an abortion procedure; and

We recommend that the Bureau of Vital Statistics, Department of Health, establish an abortion reporting form, which shall be used for the reporting of every abortion performed or prescribed in this state. Such forms shall include the following items in addition to such other information as may be necessary to complete the form:

1. The age of the pregnant woman;
2. The marital status of the pregnant woman;
3. The location of the facility where the abortion was performed or prescribed;
4. The type of procedure performed or prescribed;
5. Complication, if any;
6. The pregnant woman's obstetrical history regarding previous pregnancies, abortion, and live births;
7. The stated reason or reasons for which the abortion was requested;
8. The state and county of the pregnant woman's legal residence.

*(Ref Comm Sub Res, 1973 HOD, p 882; Reaffirmed 2000, 2010)*

**2) KMA Recommendations on Guidelines for Facilities:** Criteria laid down by the Board of Certificate of Need and Licensure, or any other agency determining where abortions may be performed on an out-patient basis, must meet the following standards:

1. A permanent record must be kept for each patient.
2. It should include a preoperative history and physical examination which is particularly directed to the identification of preexisting or concurrent illnesses or drug sensitivities that may have a bearing on operative procedures or anesthesia.
3. A hematocrit and/or hemoglobin and Rh typing should be done on all patients and any other further laboratory work that would be indicated by the patient's medical history.
4. In the case of an unmarried pregnant minor seeking an abortion, the same rules should be applied in requiring the consent to the abortion of the person legally responsible for the minor as are followed in obtaining such consent for any medical operation.
5. Analgesia and anesthesia should accompany the procedure in accordance with generally established good medical practice.
6. There should be means to resuscitate and treat the unconscious patient and the patient with cardiovascular collapse.
7. It shall be the responsibility of the licensed physician performing an abortion to provide pre- and post-operative care in a traditional and continuing manner. This physician should operate under a transfer agreement insuring that any patient in whom complications develop will be accepted by a licensed hospital on an around-the-clock basis for emergency care.



8. Abortions should be done by standard and approved methods and recorded in the patient's record. Histologic examination of the tissues is necessary.
9. The presence of pregnancy should be confirmed by an appropriate and recognized test for gonadotropin by either immuno-assay methods. The pregnancy must also be confirmed by examination by a licensed physician.
10. Pre- and post-abortion counseling should be a part of the services offered. Counseling should include alternatives to abortion, possible psychological evaluation, and contraceptive and sterilization information.
11. Each facility must offer (but not require) tests for cervical carcinoma and venereal disease to each patient.
12. All Rh-negative patients should be given Rh immune globulin following the surgical procedure in order to prevent Rh sensitization.
13. No hospital, physician, or employee should be compelled to participate in abortion.
14. For the sake of clarity, the following definitions were agreed upon by the committee:
  - a. Abortion – Termination of pregnancy prior to the 20<sup>th</sup> week, or before viability
  - b. Viability is the ability of the fetus to sustain life outside the uterus with usual measures after the 20<sup>th</sup> week of pregnancy.
  - c. First trimester begins with the first day of the last menstrual period and ends 12 weeks later.
  - d. Second trimester begins at the 13<sup>th</sup> week after the onset of the last menstrual period and goes through the 24<sup>th</sup> week.
  - e. Third trimester is from the 25<sup>th</sup> week until delivery.

*(Report of the Ad Hoc Comm on Abortion Guidelines, Addendum to the Report of the Chairman, Board of Trustees, 1973 HOD, p 879; Reaffirmed 2000, 2010)*

## **PUBLIC HEALTH**

**1) Awareness of Public Health Issues:** In an effort to prevent disease and promote improved health for all citizens of the Commonwealth, the Kentucky Medical Association (KMA), in conjunction with other organizations when appropriate and feasible, will raise the awareness of a specific public health issue, as chosen by the KMA Board of Trustees, to be introduced each year as a part of the annual *KMA Physicians Day at the Capitol*.

KMA will work with other health care organizations and non-governmental organizations, including private business and local communities, that express an interest in the specific public health issues annually chosen by the KMA. *(Res 2013-22, 2013 HOD, p 385)*

**2) Health Promotion/Disease and Violence Prevention:** Physicians and patients should become more active participants in health promotion and disease and violence prevention. Physicians should play an active part in emphasizing healthy lifestyles. Such activities can improve the extent and quality of life and reduce health spending. Physicians, health insurance companies, and private and government agencies should promote health promotion and disease prevention measures. Programs include: smoking cessation, treatment/prevention of alcohol and drug abuse, appropriate and healthy diet, adolescent health measures, enforcement of traffic and boating safety laws, regular exercise programs; recognizing and reporting family violence; cancer screening; and other appropriate measures. Health insurance companies should encourage health promotion and disease prevention by reducing premiums for enrollees who exhibit healthy lifestyles. *(COSLA HOD 1999; Reaffirmed 2009)*

**3) Obesity:** KMA encourages its members to recognize that the body mass index is an important tool in the evaluation and treatment of obesity. *(Res 2003-29, 2003 HOD, p 612; Reaffirmed 2013)*

KMA works with all relevant organizations to address the issue of obesity. *(Res 2014-19, 2014 HOD, p 331)*

**4) Mission Critical Public Health Activities:** KMA advocates that the Cabinet for Health and Family Services develop plans to maintain fundamental public health services. *(Res 2014-13, 2014 HOD, p 334)*

**4) Diabetes and Prediabetes:** KMA support efforts by state and federal legislators to enact legislation supporting prevention and treatment of diabetes. *(Res 2015-9, 2015 HOD)*

## **RESIDENTS**

**1) Family Practice Residency Program:** KMA encourages and supports the strengthening of existing family practice residency programs in the state of Kentucky with regard to funding, faculty, and clinical experience. *(Res T, 1992 HOD, p 650; Reaffirmed, Special Report on Policy Sunset, 2002 HOD, p 576; Reaffirmed 2012)*

**2) Service Requirement for Kentucky-Trained Physicians:** KMA opposes any legislative proposals that institute an involuntary service requirement for physicians trained in Kentucky. *(Res L, 1992 HOD, p 656; Reaffirmed, Special Report on Policy Sunset, 2002 HOD, p 576; Reaffirmed 2012)*

**3) Resident and Fellow Engagement in Organized Medicine:** KMA and the Resident-Fellow Section (RFS) Governing Council work with the Graduate Medical Education Offices of each accredited post-graduate medical training program in the Commonwealth of Kentucky to develop more on-campus KMA Resident-Fellow Section activities, including regularly scheduled organizational meetings, and mentoring of residents and fellows by members of the KMA Commission on Young Physicians and Physicians in Training *(Res 2014-08, 2014 HOD, p 332)*

## **RETAIL CLINICS**

KMA adopts the policy that retail clinic operations should limit their scope of clinical services consistent with state laws, be required to use standardized evidence-based medical protocols, establish arrangements for direct access to and supervision by physicians and establish referral arrangements with the physician practices and other medical facilities. KMA further adopts as policies that these operations should support the medical home model, through prompt communication with physicians of record, and observe accepted contagious disease treatment standards. *(Res 2007-02, 2007 HOD, p 659)*

KMA advocates requiring corporate entities known as “retail clinics” to properly identify their employed health care providers’ credentials *(Res 2012-09, 2012 HOD, p 519)*

## **SAFETY ISSUES**

**1) ATVs:** KMA supports state legislation to prohibit persons under 16 years of age from operating ATV’s on public roadways. *(Res 2006-18, 2006 HOD, p 622)*

**2) Ban on Fireworks:** KMA opposes the private use of all fireworks with the exception of approved professional displays. *(Report of the Committee on State Legislative Activities, 1991 HOD, p 659; amended and Reaffirmed, Special Report on Policy Sunset, 2001 HOD, p 578; Reaffirmed 2011)*

**3) Bicycle Helmets:** KMA reaffirm its support for enactment of legislation requiring individuals to wear helmets while riding bicycles. *(Res 2000-114, 2000 HOD, p 599; Reaffirmed 2010)*

**4) Helmets:** KMA supports the use of approved helmets, at all times, while riding motorcycles, motor scoot-

ers, bicycles, skateboards, ATVs, or in-line skates. (*Res 2002-101, 2002 HOD, p 613; Reaffirmed 2012*)

**5) Motorcycle Helmet Legislation:** KMA supports the passage of legislation requiring all motorcyclists, regardless of age, to be helmeted. (*Res 2007-12, 2007 HOD, p 650*)

**6) Tanning Salon Use by Minors:** KMA supports the enactment of state legislation to protect minors from the hazards of indoor tanning by prohibiting the sale of tanning salon ultraviolet rays to those under 18 years of age. (*Res 2010-16, 2010 HOD, p 422*)

## **SEXUAL ASSAULT VICTIMS**

KMA is committed to continuing education for its members and the community on the resources available to victims of sexual assault and supports legislative efforts that provide additional protection and resources for these victims. (*Res 2009-15, 2009 HOD, p 534*)

## **STATE BOARD OF MEDICAL LICENSURE**

**Appointments:** KMA seeks amendment of KRS 311.050 in order to once again require the Governor's use of names recommended by the KMA for appointment to the State Board of Medical Licensure in order to restore the professional vetting process for such nominations. (*Res 2012-02, 2012 HOD, p 523; Reaffirmed 2013*)

## **SUNSET PROVISION**

**Sunset Provision:** KMA adopts the following regarding a sunset provision:

- A sunset mechanism with a ten-year time horizon shall exist for all KMA policy positions established by the House of Delegates
- Under this sunset mechanism, a policy will cease to be KMA policy after ten years and the House will be informed annually of those policies being "sunsetting," unless action is taken by the House of Delegates to reestablish them
- Any action of the House of Delegates that reaffirms or modifies an existing policy position shall reset the sunset "clock," making the Reaffirmed policy viable for ten years from the date of its reaffirmation unless subsequent House of Delegates action amends, deletes or alters existing policy (*Res 120, Ref Comm A, 1999; COSLA HOD 1999; Reaffirmed 2009*)

## **SUPPLIES OVER SEAS**

KMA commends Supplies Over Seas for 20 years of recovering surplus medical supplies and equipment from Kentucky hospitals, and delivering it to save lives in impoverished communities worldwide.

KMA informs its members and their hospitals of the great benefits of the Supplies Over Seas (SOS) program, and KMA works with the Kentucky Hospital Association to encourage additional hospital participation, greater support for SOS from hospital and community sponsors, and increased use of SOS resources by physicians and health care workers on medical missions. (*Res 2014-02, 2014 HOD, p 330*)

## **SURGERY**

**1) Definition of Surgery:** KMA adopts policy that only licensed physicians and surgeons be allowed to perform surgery and that any procedures that can damage the eye (cornea to retina), including the use of lasers, are ablative and should only be performed by appropriately trained and licensed physicians. (*Res 2007-27,*

2007 HOD, p 656)

**2) Use of Laser Therapy:** KMA recognizes that the use of lasers is a surgical procedure and only those practitioners licensed to perform surgery should be authorized to utilize laser therapy. (*Res S, 1994 HOD, p 561; Reaffirmed 2004, 2014*)

## **TEAM-BASED MEDICAL CARE**

KMA work with the AMA and other state medical associations, as appropriate, to develop a proposal for physician-led, patient-centered, team-based medical care in Kentucky.

KMA, in the interest of patient health and safety, seeks and actively supports legislation to require that all medical care teams are led by physicians in Kentucky. (*Res 2012-10, 2012 HOD, p 519*)

KMA supports the Kentucky Academy of Physician Assistants (KAPA) in their efforts to provide high quality, team-based, physician-led access to care for Kentuckians. (*Res 2013-18, 2013 HOD, p 384*)

## **TOBACCO**

**1) Access to Tobacco by Children:** KMA is to use every means at its disposal to support legislation that would contain the following elements:

- A. Opposition to the use of billboards or other mediums which advertise tobacco products visible from school property (K-12);
- B. Tobacco vending machine usage be restricted to persons over 18 years of age;
- C. In those areas where free smoking cessation clinics are unavailable, local health departments make available free smoking cessation clinics to children under the age of 18; and
- D. No person, except adult employees of the school system who smoke in a designated room for that purpose, shall smoke on school property during school hours; outside sporting events are excluded. (*Res E as amended, 1991 HOD, p 652; Reaffirmed, Special Report on Policy Sunset, 2001 HOD, p 578; Reaffirmed 2011*)
- E. KMA supports increased fines for those who sell tobacco to minors. (*Res 2009-10, 2009 HOD, p 533*)
- F. KMA supports penalties on the unlawful sale of tobacco products on the Internet to minors. (*Res 2003-12, 2003 HOD, p 617; Reaffirmed 2013*)
- G. KMA supports the 100% Tobacco-Free School Campaign calling for all school districts to prohibit tobacco use by staff, students, and visitors 24 hours a day, seven days a week, inside school board-owned buildings or vehicles, on school-owned property, and during school-sponsored student trips and activities. (*Res 2010-06, 2010 HOD, p 422*)

**2) Deleterious Effects of Tobacco Use:** KMA encourages physicians to continue educational efforts directed to patients on the deleterious effects of tobacco use and encourages the Kentucky General Assembly to increase its attention to the serious health problem of tobacco product use and the trend of teenage smoking. (*Res D, 1992 HOD, p 648; Amended and Reaffirmed, Special Report on Policy Sunset, 2002 HOD, p 576; Reaffirmed 2012*)

### **3) Excise Tax:**

- A. New revenues raised by increasing tobacco excise taxes should be applied to Kentucky Medicaid. (*Res 2002-116, p 597; Reaffirmed 2012*)
- B. KMA supports a substantial increase in the cigarette tax with additional revenues generated to be

used to fund health-related initiatives including, but not limited to, tobacco cessation, expansion of insurance coverage for children, nutritional supplements for dialysis patients, and the colon cancer screening and treatment program. (*Res 2008-14, 2008 HOD, p 625*)

- C. KMA seeks introduction and passage of legislation to increase the Kentucky state tax on all forms of smokeless tobacco to at least the national average. (*Res 2013-09, 2013 HOD, p 384*)

**4) FDA Regulations:** KMA does not support the use of tax dollars to finance efforts, including lawsuits, aimed at overturning or postponing FDA regulations regarding tobacco. (*Res 96-122, 1996 HOD, p 599; Reaffirmed 2006*)

**5) Legal Minimum Age:** KMA supports legislation that increases the legal minimum sale age for tobacco in Kentucky to 21. (*Report of Community & Rural Health Committee, 2004 HOD, p 627; Reaffirmed 2014*)

**6) Sale of Tobacco:** KMA reaffirms support for local municipalities and counties to adopt more stringent laws and regulations governing the sale and use of tobacco in local facilities; that smoking restrictions in state facilities used by the public in local communities be governed by the same local laws or regulations affecting other local businesses and privately owned facilities. KMA continues to support both additional state taxation on tobacco products to discourage use of tobacco products by minors and public funding of the development of agricultural alternatives to growing and processing of tobacco and tobacco products. (*Res 97-135, 1997 HOD, p 578; Reaffirmed 2007, 2009*)

**7) Secondhand Smoke:** KMA supports prohibition of smoking in public places including restaurants, bars, hospital campuses and in motor vehicles with children and encourages physicians to counsel patients about the health risks attributed to exposure to secondhand smoke. (*Res 2007-06, 2007 HOD, p 664*)

KMA works with others to increase awareness of the dangers of radon and secondhand smoke as a health risk to Kentuckians. (*Res 2010-05, 2010 HOD, p 422*)

**8) Statewide Ban on Smoking:** Any statewide ban on smoking that KMA supports would not preempt local initiatives. (*Res 2009-10, 2009 HOD, p 533*)

**9) Tobacco Use Prevention and Cessation Program:** KMA endorses the efforts of the Kentucky Department for Public Health to prevent and reduce the use of tobacco products in Kentucky. (*Res 2001-121, 2001 HOD, p 622; Reaffirmed 2009*)

**10) Workplace Wellness Smoking Cessation Incentives:** KMA supports legislation to create an exemption to state law allowing employers to offer workplace wellness smoking cessation incentive programs. (*Res 2009-05, 2009 HOD, p 533*)

## **TRAUMA SYSTEM**

KMA supports the collection of trauma system data and the development of a trauma system in Kentucky. (*Report of the EMS Committee, 2002 HOD, p 619; Reaffirmed 2012*)

## **UNINSURED**

**1) High-Risk Individuals:** KMA supports state operated plans that provide health insurance to high-risk individuals under private or group policies. Insurance companies which market in this state should either participate in the insuring of high-risk individuals or assist in the funding of such plans. The Insurance Commissioner should define those conditions classified as "high-risk" in consultation with appropriate medical and

insurance professionals. (*COSLA HOD 1999; Reaffirmed 2009*)

**2) Principles for Reducing the Number of Uninsured Individuals:** KMA will consider the following principles when developing or determining policy on initiatives that purport to reduce the number of uninsured:

- Universal access to care and coverage for that care must be made available to citizens through a pluralistic approach
- Efforts to reform healthcare to achieve universal access and coverage should include a physician-centered oversight authority insulated from both political and commercial interests
- Health insurers, health-related manufacturers, and pharmaceutical companies should either make concessions to reduce burdens or receive additional oversight that reduces overhead, maximizes efficiency, and increases the proportion of premium and product dollars that are applied to the delivery of healthcare. Such oversight would mandate that health insurers make public the percentage of premiums used to pay administrative costs and stockholder profit
- Cost effective and medically appropriate resource initiatives for patients, insurers, physicians, non-physicians, and other healthcare-related organizations are imperative
- Regionalizing healthcare to meet a population's health needs is important to eliminate risks specific to the area as well as to provide regions with the ability to determine how health dollars are spent
- Patient choice and preservation of the patient-physician relationship are essential; and
- A progressive financing system should be based on personal responsibility and, in part an individual's ability to pay. (*Res 2008-22, 2008 HOD, p. 620*)

**3) Provision of Insurance for Uninsured:** KMA recommends risk pools and voluntary programs to provide insurance for the uninsured indigent. Specific incentives to employers who provide group health insurance should be advocated, and enactment of tax and employment practices that encourage employers to include dependents is supported. KMA supports the Child Health Insurance Program (K-CHIP), and Medicaid expansion, provided it is appropriately funded to provide health insurance for Kentucky children. (*COSLA HOD 1999; Reaffirmed 2009*)

**4) Treatment of Uninsured/Indigent:** In accordance with ethical principles, each physician has an obligation to share in providing care to the indigent. KMA supports the establishment of free medical clinics and programs to treat the poor. Several county medical societies are operating free clinics and other indigent care programs. KMA has been recognized nationally for founding the Kentucky Physicians Care program, which was established in 1985. (*COSLA HOD 1999; Reaffirmed 2009*)

**5) Universal Health Insurance Coverage:** KMA affirms its support for a pluralistic approach to health care delivery systems and financing mechanisms in achieving universal health insurance coverage. We recommend a plan that provides a standard set of benefits and includes a fee-for-service option. There are a variety of approaches to Universal Coverage, including employer mandate, individual mandate, or Medical Savings Accounts. KMA strongly supports the patient's freedom and responsibility to choose his/her physician, insurance carrier, and health insurance. Nationalized or socialized health care plans, or single payer systems are not in the best interest of the patient, physician, or the nation and should be opposed. (*COSLA HOD 1999; Reaffirmed 2009*)

## **VISION SCREENING**

**1) Instrument-Based Vision Screening:** KMA advocates that Medicaid and all private insurers doing business in Kentucky compensate pediatricians and other primary care physicians appropriately for vision screening, CPT code 99174 (2013 edition of CPT), when performed on children 6 months to 5 years of age and for those patients who are unable to cooperate for visual acuity screening by standard vision charts.

KMA works with the American Medical Association (AMA) to petition the FDA to approve equipment required to conduct instrument-based screening on patients unable to participate in visual acuity screening by standard vision charts.

KMA promotes the use of instrument-based vision screening by pediatricians and primary care physicians for patients 6 months to 5 years of age. (*Res 2013-06, 2013 HOD, p 382*)

**2) Vision Retesting:** KMA supports periodic retesting of vision, preferably at the time of each quadrennial driver's license renewal, and will carefully consider any legislation regarding the requirement for such retesting and take action as appropriate. (*Res B, 1983 HOD, p 964; Reaffirmed 2000, 2010*)

**3) Vision Testing at Driver's License Renewal:** KMA works toward passage of legislation requiring the testing of vision at the time of driver's license renewal in Kentucky. (*Res 2015-8, 2015 HOD*)

## **WARDS OF STATE**

**1) Advance Directive re: Wards of the State:** KMA believes that decisions should be allowed to be made regarding advance directives and termination of inappropriate medical intervention in patients who are wards of the state, on a case-by-case basis. (*Res J, 1995 HOD, p 606; Reaffirmed 2005, 2015*)

**2) Medical Decisions:** KMA supports changes in the state guardianship medical care approval procedures in order to ensure that urgent medical decisions can be made on a timely basis for wards of the state. (*Res 2010-19, 2010 HOD, p 422*)

**3) Do Not Resuscitate (DNR) Designation for Patients Under State Guardianship:** KMA seeks changes in the current regulations that would allow for ethics committees in hospitals at the local level to make reasonable recommendations on the end-of-life care of patients under state guardianship and that these recommendations be considered in the final decision by the Cabinet for Health and Family Services on a request for DNR status. (*Res 2014-18, 2014 HOD, p 330*)

## **WOMEN'S HEALTH**

**1) Mammography:** KMA supports HCFA's efforts on a statewide basis to ensure that all eligible women receive mammography at a certified unit. (*1995 HOD, p 596; Reaffirmed 2005, 2015*)

**2) Pap Smears:** KMA endorses the official College of American Pathologists "Guidelines for Review of Pap Smears in the context of Litigation or potential Litigation." (*Res 98-107, 1998 HOD, p 544; Reaffirmed 2008*)

## **WORKFORCE, PHYSICIAN**

**1) Contributions of International Medical Graduates:** KMA supports and applauds the contributions and efforts of the AMA-IMG Section to enhance immigration of qualified IMG physicians to the US to help reduce physician shortages, especially in rural areas. (*Res 2004-34, 2004 HOD, p 617; Reaffirmed 2014*)

**2) Encouraging a Career in Medicine:** KMA supports the development of new programs and/or the use of existing programs to encourage young people, especially those from underserved areas, to consider medicine as an attainable career option. (*Res 2010-01, 2010 HOD, p 419*)

**3) Funding for Medical Education and Trauma Care:** KMA opposes funding cuts to medical school physician residency education programs and trauma centers and works to ensure adequate ongoing state funding

for medical school education programs and trauma centers in order to meet future medical care needs. (*Res 2010-08, 2010 HOD, p 419*)

**4) Increase Primary Care Physicians:** KMA supports continued funding of the Public Health Service Act, Title VII, Section 747, to increase the number of primary care physicians working with medically underserved populations; works to maintain current or higher numbers of residency positions at our Kentucky medical schools, and advocates for adequate reimbursement of primary care and specialty physicians and for improved recruitment of physicians into shortage specialties. (*Res 2004-02, 2004 HOD, p 615; Reaffirmed 2014*)

**5) Medical Education Debt Repayment:** KMA supports the principle of medical education debt loan repayment as useful in physician recruitment to medically underserved areas. (*Res 2011-10, 2011 HOD, p 414*)

KMA advocates for the use of economic development funds to be used to provide debt relief in order to attract physicians to rural and underserved areas in Kentucky. (*Res 2012-14, 2012 HOD, p 522; Reaffirmed 2014*)

KMA works with the Kentucky General Assembly to develop debt relief for physicians willing to practice in rural and underserved areas. (*Res 2014-12, 2014 HOD, p 334*)

**6) Residency Program Funding:** KMA supports increased state and federal funding for all rural residency programs in Kentucky. (*Res 2004-23, 2004 HOD, p 617; Reaffirmed 2014*)



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