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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-18)

Report of Reference Committee A

Jonathan D. Leffert, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 40 - Medicare Coverage of Services Provided by Proctored Medical Students
2. Council on Medical Service Report 2 - Improving Affordability in the Health Insurance Exchanges
3. Resolution 102 - Effectiveness of Risk Assessment Models in Representing Healthcare Resources Expended for Infants and Children
4. Resolution 115 - Expanding On-Site Physician Home Health Care to Low-Income Families and the Chronically Ill

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

5. Council on Medical Service Report 1 - Council on Medical Service Sunset Review of 2008 AMA House Policies
6. Council on Medical Service Report 3 - Ensuring Marketplace Competition and Health Plan Choice
7. Council on Medical Service Report 7 - Insulin Affordability
8. Joint Report of the Council on Medical Service and the Council on Science and Public Health - Coverage for Colorectal Cancer Screening
9. Resolution 103 - Oppose Medicaid Eligibility Lockout
10. Resolution 104 - Emergency Out of Network Services
11. Resolution 111 - Medicare Coverage for Dental Services
12. Resolution 114 - Inclusion of Bundled Payments Care Improvement (BPCI) Post-Acute only Model 3 in Advanced BPCI
13. Resolution 116 - Ban on Medicare Advantage "No Cause" Network Terminations

RECOMMENDED FOR REFERRAL

14. Resolution 108 - Expanding AMA’s Position on Healthcare Reform Options
15. Resolution 117 - Supporting Reclassification of Complex Rehabilitation Technology

RECOMMENDED FOR NOT ADOPTION

16. Resolution 109 - Medicaid Coverage of Fitness Facility Memberships

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

17. Resolution 105 - Use of High Molecular Weight Hyaluronic Acid
18. Resolution 118 - Payment for Advance Care Planning
19. Resolution 119 - Payment for Palliative Care

Existing policy was reaffirmed in lieu of the following resolutions via the Reaffirmation Consent Calendar:

- Resolution 101 - Medicaid Reform
- Resolution 106 - Prohibit Retrospective ER Coverage Denial
- Resolution 107 - Opposition to Medicaid Work Requirement
- Resolution 110 - Return to Prudent Layperson Standard for Emergency Services
- Resolution 112 - Enabling Attending Physicians to Waive the Three-Midnight Rule for Patients Receiving Care within Downside Risk Sharing Accountable Care Organizations and Advance Bundled Payments Care Improvement Programs
- Resolution 113 - Survivorship Care Plans

(1) BOARD OF TRUSTEES REPORT 40 - MEDICARE COVERAGE OF SERVICES PROVIDED BY PROCTORED MEDICAL STUDENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 40 be adopted and the remainder of the report be filed.

HOD ACTION: The recommendation in Board of Trustees Report 40 adopted and the remainder of the report filed.

Board of Trustees Report 40 recommends that our AMA not adopt Resolution 812-I-17.

Your Reference Committee heard mixed testimony on Board of Trustees Report 40. The Council on Medical Education and the Section on Medical Schools voiced their support for the report. Testimony calling for referral spoke to improving medical student education by ensuring student involvement in procedures. Compelling testimony provided by a contractor medical director in support of Board of Trustees Report 40 stated that teaching physicians can involve students and bill for their services that are personally supervised. The Board of Trustees testified that the Centers for Medicare & Medicaid Services has clarified that teaching physicians can involve students in services they perform, and to the extent that the medical student is involved in procedures under the personal supervision of a teaching physician who is performing the service, there is no prohibition against the teaching physician billing for these services. Any contribution and participation of a student in the performance of a billable service must be performed in the physical presence of a teaching physician or resident in service that meets teaching physician billing requirements. Accordingly, your Reference Committee recommends that the recommendation of Board of Trustees Report 40 be adopted and the remainder of the report be filed.

(2) COUNCIL ON MEDICAL SERVICE REPORT 2 - IMPROVING AFFORDABILITY IN THE HEALTH INSURANCE EXCHANGES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: The recommendations in Council on Medical Service Report 2 adopted and the remainder of the report filed.

Council on Medical Service Report 2 recommends that our AMA support adequate funding for and expansion of outreach efforts to increase public awareness of advance

premium tax credits; support expanding eligibility for premium tax credits up to 500 percent of the federal poverty level; support providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income; encourage state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections; and support the establishment of a permanent federal reinsurance program.

There was generally supportive testimony on Council on Medical Service Report 2. In introducing the report, a member of the Council on Medical Service underscored that the recommendations of the report aim to continue the coverage gains made since the enactment of the Affordable Care Act, while taking steps to further stabilize premiums in health insurance exchanges. Testimony raised concerns that the report did not address the important issues of high deductibles and other patient cost-sharing requirements. However, the Council on Medical Service responded that individuals with incomes up to 250 percent of the federal poverty level qualify for cost-sharing reductions to lower and limit their cost-sharing responsibilities if they enroll in a silver plan. In addition, the Council noted that premiums for the silver plans upon which premium tax credit amounts are based increased significantly from 2017 to 2018. Not only has this resulted in higher premium tax credit amounts for individuals who are eligible for them, but in some counties, the premium of the lowest-cost gold plan is less than that of the lowest-cost silver plan. Importantly, gold plans have lower out-of-pocket costs than silver and bronze plans.

The Council on Medical Service also shared that it is presenting a report for the 2018 Interim Meeting addressing the first-dollar coverage of services. Your Reference Committee also notes that there exists on the health insurance exchanges a trade-off between selecting plans with lower premiums that have higher out-of-pocket costs, and plans with higher premiums that have lower out-of-pocket costs. In addition, existing policy guides AMA advocacy efforts concerning patient cost-sharing requirements of exchange plans. Policy H-165.846 supports requiring provisions to be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations. In addition, for low-income individuals who qualify for cost-sharing reductions who instead enroll in a bronze plan with higher out-of-pocket costs, Policy H-165.828 encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account partially funded by an amount determined to be equivalent to the cost-sharing subsidy. This change would help affected individuals meet the deductibles and other cost-sharing obligations of their bronze plan. Your Reference Committee believes that Council on Medical Service Report 2 is highly consistent with AMA advocacy efforts in support of ACA marketplace stabilization, taking steps toward coverage and access for all Americans, and ensuring low and moderate income patients are able to secure affordable and adequate coverage. As such, your Reference Committee recommends that the recommendations of Council on Medical Service Report 2 be adopted and the remainder of the report be filed.

(3) RESOLUTION 102 - EFFECTIVENESS OF RISK ASSESSMENT MODELS IN REPRESENTING HEALTHCARE RESOURCES EXPENDED FOR INFANTS AND CHILDREN

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 102 be adopted.

HOD ACTION: Resolution 102 adopted.

Resolution 102 asks that our AMA support risk modeling that appropriately represents care that is specific to all age groups including infants, children, and adolescents as unique risk strata; and advocate that health insurance organizations transparently publish their risk adjustment models so that clinicians can more effectively document care that reflects patient risk and so that clinicians can assess whether the risk adjustment model appropriately defines the risk of their patients.

Testimony on Resolution 102 was unanimously supportive. Your Reference Committee believes that Resolution 102 is consistent with AMA policy addressing risk adjustment and recommends its adoption.

(4) RESOLUTION 115 - EXPANDING ON-SITE PHYSICIAN HOME HEALTH CARE TO LOW-INCOME FAMILIES AND THE CHRONICALLY ILL

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 115 be adopted.

HOD ACTION: Resolution 115 adopted.

Resolution 115 asks that our AMA amend Policy H-210.981, "On-site Physician Home Health Care," by addition and deletion as follows: (1) recognizes that timely access to physician care for the frail, chronically ill, disabled or low-income patient is a goal that can ~~only~~ be met by an increase in physician house calls to this vulnerable, underserved population; (5) believes that physician on-site care through house calls is important when there is a change in condition that cannot be diagnosed over the telephone with the assistance of allied health personnel in the home and assisted transportation to the physician's office is costly, difficult to arrange, or ~~excessively tiring and painful for~~ detrimental to the patient's health; (7) recognizes the importance of removing economic, institutional and regulatory barriers to physician house calls, including the development of programs for low-income families and older adults; and (11) urges CMS to clarify and make more accessible to physicians information on standards for utilization of home health services, such as functional status, ~~and~~ severity of illness, and socioeconomic status.

Testimony on Resolution 115 was unanimously supportive. Your Reference Committee believes that Resolution 115 is consistent with AMA policy addressing home health care and recommends its adoption.

(5) COUNCIL ON MEDICAL SERVICE REPORT 1 - COUNCIL ON MEDICAL SERVICE SUNSET REVIEW OF 2008 AMA HOUSE POLICIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendation of Council on Medical Service Report 1 be amended by addition to read as follows:

That our American Medical Association (AMA) policies listed in the appendix to this report be acted upon in the manner indicated, with the exception of Policies D-335-984 and H-185.948, which should be retained. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendation of Council on Medical Service Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: The recommendation of Council on Medical Service Report 1 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 1 contains recommendations to retain or rescind 2008 AMA socioeconomic policies.

Your Reference Committee heard generally supportive testimony on Council on Medical Service Report 1. However, there were two suggested amendments to the report. First, an amendment was offered to retain Policy D-335-984 regarding Medicare Part B contractor changes. Another speaker testified that Policy H-185.948, regarding health insurance for children, should be retained as still relevant. Your Reference Committee agrees, and therefore recommends adoption of Council on Medical Service Report 1 as amended.

(6) COUNCIL ON MEDICAL SERVICE REPORT 3 - ENSURING MARKETPLACE COMPETITION AND HEALTH PLAN CHOICE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 2 in Council on Medical Service Report 3 be amended by addition and deletion to read as follows:

2. That our AMA oppose the sale of health insurance plans in the individual and small group markets that do not ~~comply with Affordable Care Act requirements, including those related to~~ guarantee: a) pre-existing condition protections and b) coverage of essential health benefits and their associated protections against annual and lifetime limits, and out-of-pocket expenses, except in the limited circumstance of short-term limited duration insurance offered for no more than three months.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

HOD ACTION: The recommendations in Council on Medical Service Report 3 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 3 recommends that our AMA support health plans offering coverage options for individuals and small groups competing on a level playing field, including providing coverage for pre-existing conditions and essential health benefits; oppose the sale of health insurance plans in the individual and small group markets that do not comply with Affordable Care Act requirements, including those related to pre-existing condition protections and essential health benefits, except in the limited circumstance of short-term limited duration insurance offered for no more than three months; support requiring the largest two Federal Employees Health Benefits Program (FEHBP) insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation; reaffirm Policies H-165.838 and D-180.986; and rescind Policies H-165.882 and D-165.934.

Your Reference Committee heard mixed but predominantly supportive testimony on Council on Medical Service Report 3. In introducing the report, a member of the Council on Medical Service outlined an amendment to the second recommendation of the report to remove specific reference to the Affordable Care Act. Your Reference Committee accepts the amendment, noting that the amended wording of the recommendation still would achieve the intent of opposing the sale of health insurance plans in the individual

and small group markets that do not guarantee critical patient protections and meet strong coverage standards. Importantly, the recommendation provides an exception for short-term limited duration insurance (STLDI) offered for no more than three months. Your Reference Committee underscores that the purpose of STLDI coverage is to serve as a bridge between coverage in plans offering meaningful coverage. As such, limiting the duration of its offering to three months is appropriate, especially as STLDI plans do not have to comply with the market reforms and consumer protections of the ACA. As such, STLDI plans can deny coverage or charge higher premiums based on health status; exclude coverage for pre-existing conditions; impose annual or lifetime limits; have higher out-of-pocket limits than the ACA maximums; not cover categories of essential health benefits; rescind coverage; and not comply with medical loss ratio requirements.

A speaker opposed the rescission of Policy H-165.882, stating that it was not aptly superseded by the policy cited in the report. However, your Reference Committee notes that Policy H-165.882 is in direct conflict with the first and second recommendations of Council on Medical Service Report 2. Policy H-165.882 supports certain plans being allowed to be exempt from selected state regulations regarding mandated benefits and small group rating laws to achieve lower premiums. In addition, the policy encourages certain entities including farm bureaus to be included as entities that would be exempt from such laws. Your Reference Committee notes that the Council report explicitly details the adverse impacts of laws that enable such farm bureau plans in states including Iowa and Tennessee. The remainder of the policy is superseded by AMA policy in support of value-based insurance design (Policies H-185.939 and H-155.960) and the multitude of AMA policies in support of covering the uninsured. In addition, your Reference Committee notes that the reference in Policy H-165.882 to Consumer Operated and Oriented Plans (CO-OPs) established by the ACA is outdated, as most CO-OPs failed in the early years of operation. There was also testimony raising concerns with narrow networks, high deductibles and underinsurance, all of which are addressed in this report, CMS Report 2-A-18, and/or existing policy on health plan affordability and network adequacy. Your Reference Committee also notes that some issues raised in testimony were not germane to the topic of Council on Medical Service Report 3.

Your Reference Committee believes that this report is incredibly timely, as some regulations that have been proposed this year would allow exceptions to key protections that the ACA affords in the arenas of pre-existing condition protections, essential health benefits, annual and lifetime limits, out-of-pocket maximums, prohibitions on gender rating, medical loss ratio requirements, and rate review. In addition, the FEHBP recommendation of the report will ensure patients are not left without coverage options in the marketplaces, while enabling patient choice of private health plans, ensuring physician freedom of practice, not requiring physician participation, and recognizing the value of payment rates being established through meaningful negotiations and contracts. As such, your Reference Committee recommends that the recommendations of Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

(7) COUNCIL ON MEDICAL SERVICE REPORT 7 - INSULIN AFFORDABILITY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Recommendation 5 in Council on Medical Service Report 7 be amended by deletion to read as follows:

5. That our AMA support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies ~~and the appropriate use of regular human insulin and neutral protamine Hagerdorn (NPH)~~. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 7 be adopted as amended and the remainder of the report be filed.

HOD ACTION: The recommendations in Council on Medical Service Report 7 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 7 recommends that our AMA encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate; disseminate model state legislation to promote increased drug price and cost transparency and to prohibit "clawbacks" and standard gag clauses in contracts between pharmacies and pharmacy benefit managers (PBMs) that bar pharmacists from telling consumers about less-expensive options for purchasing their medication; provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency; support physician education regarding drug price and cost transparency and challenges patients may encounter at the pharmacy point-of-sale; support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies and the appropriate use of regular human insulin and neutral protamine Hagerdorn (NPH); and reaffirm Policies H-110.992, H-110.987, H-100.980, H-125.979, H-185.939, H-155.960, H-110.986 and H-110.990.

The preponderance of testimony was supportive of Council on Medical Service Report 7. A member of the Council on Medical Service introduced the report, noting that a variety of factors contribute to increases in insulin prices, and emphasized that the report sets forth potential options for improving insulin affordability. A member of the Council on Legislation testified that federal and state governments and patient advocates are currently engaged in actions in response to the trend of increasing insulin prices. The Council member also noted that the AMA recently developed model state legislation that

encourages prescription drug price and cost transparency among pharmaceutical companies, PBMs, and health insurance companies.

A speaker on behalf of the American Association of Clinical Endocrinologists expressed appreciation for the report and introduced a series of amendments, proposing that the AMA disseminate additional model state legislation, seek legislation or regulations that advance formulary transparency, and convene a summit to identify solutions to ease the financial burden on patients due to costs of insulin. The American Association of Clinical Endocrinologists also testified that newer insulin is superior to older insulin because of decreased incidence of hypoglycemia, which is particularly important for elderly patients. Similarly, a speaker on behalf of the Endocrine Society applauded the report, supported the amendments offered by the American Association of Clinical Endocrinologists, and emphasized the appropriate use of older insulin, as stated in the report. The Council on Medical Service testified that the goals sought in the proposed amendment that are consistent with AMA policy have already been achieved via previous and ongoing AMA activity. For example, testimony continued, the AMA developed model state legislation that requires that health plans offer the same formulary throughout the plan year, be transparent about what their formularies include when patients purchase plans, and not increase patient cost-sharing during a plan year if the health plan or PBM removes a medication from its formulary or moves the medication to a higher cost-sharing tier during a plan year. Several states have enacted and/or are considering similar legislation, and the AMA continues to urge state medical associations to have the AMA Model Act introduced. Other goals sought by the proposed amendment, while understandable, are not consistent with AMA policy. The Council of Medical Service explained that AMA policy favors consumer choice and broadly advocates for improved access to affordable prescription drugs without prioritizing any one prescription drug over others. The Council of Medical Service cautioned against convening a summit specifically on insulin affordability, as this could establish a precedent by which summits on countless other essential drugs could become necessary. Your Reference Committee agrees that a summit would not necessarily effect change since only the House of Delegates, not summit participants, can adopt AMA policy. Your Reference Committee notes that later this month, the AMA will be convening members of the Federation to coordinate a response to the White House's Blueprint to Lower Drug Prices.

Your Reference Committee believes that Council on Medical Service Report 7 builds upon our AMA's strong policy and advocacy foundation addressing drug pricing and contains strong recommendations to respond to insulin pricing specifically. In response to testimony regarding the use of older insulins, your Reference Committee recommends that Recommendation 5 be amended by deletion of reference to the appropriate use of regular human insulin and neutral protamine Hagerdorn. Your Reference Committee recommends that the recommendations of Council on Medical Service Report 7 be adopted as amended and the remainder of the report be filed.

(8) JOINT REPORT OF THE COUNCIL ON MEDICAL SERVICE AND THE COUNCIL ON SCIENCE AND PUBLIC HEALTH - COVERAGE FOR COLORECTAL CANCER SCREENING.

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Joint Report of the Council on Medical Service and the Council on Science and Public Health be amended by deletion of Recommendation 4 as follows:

~~4. That our AMA reaffirm Policy H-390.849, which advocates for physician payment reform consistent with: promoting improved patient access to high-quality, cost-effective care, promoting designs that incorporate input from the physician community, and providing patients with information and incentives to encourage appropriate utilization of preventive services. (Reaffirm HOD Policy)~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Joint Report of the Council on Medical Service and the Council on Science and Public Health be amended by deletion of Recommendation 5 as follows:

~~5. That our AMA reaffirm Policy H-425.992, which advocates for revision of current Medicare guidelines to include coverage of appropriate preventive services. (Reaffirm HOD Policy)~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Recommendation 7 of the Joint Report of the Council on Medical Service and the Council on Science and Public Health be amended by addition and deletion to read as follows:

7. That our AMA ~~encourage the development of a coding guide to help providers appropriately bill for various colorectal cancer screening services and promote common understanding among health care providers, payers, and patients so that all know what will be covered at given cost-sharing levels.~~ seek to eliminate cost-sharing in all health plans for the full range of colorectal cancer screening and all associated costs, including colonoscopy that includes a "diagnostic" intervention (i.e. the removal of a polyp or biopsy of a mass), as defined by Medicare. To further this goal, the AMA will develop a coding guide to promote common understanding among health care providers, payers, health care information technology vendors, and patients. (Directive to Take Action)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Recommendation 8 of the Joint Report of the Council on Medical Service and the Council on Science and Public Health be amended by addition and deletion to read as follows:

8. That Policy H-55.981, "Carcinoma of the Colon and Rectum," be amended by addition and deletion to read as follows:

Our AMA supports: (1) Recognizing colon cancer as a leading cause of cancer deaths in the United States and encouraging appropriate screening programs to detect colorectal cancer. ~~Appropriate screening programs to detect colorectal cancer in individuals who are older than 50 years of age or have risk factors.~~ ~~(2) The general recommendations of major health care organizations for colorectal cancer (CRC), which are as follows: annual fecal occult blood testing, beginning at age 50, and flexible sigmoidoscopy every 3 to 5 years from age 50, for persons at average risk. Colonoscopy and/or double-contrast barium enema procedures, which~~ screen ~~the entire colon, should be considered as appropriate alternatives. (3)~~ (2) Persons at increased risk for CRC (family history of CRC, previous adenomatous polyps, inflammatory bowel disease, previous resection of CRC, genetic syndromes) receiving more intensive screening efforts. ~~(4)~~ (3) Physicians becoming aware of genetic alterations that influence the development of CRC, and of diagnostic and screening tests that ~~may become~~ are available in this area. (4) Physicians engaging their patients in shared decision-making, including consideration of both clinical and financial patient impacts, to determine at what age to begin screening for colorectal cancer and which screening method (or sequence of methods) is most appropriate. (Modify Current HOD Policy)

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that the Joint Report of the Council on Medical Service and the Council on Science and Public Health be amended by addition of a new Recommendation to read as follows:

That our AMA reaffirm Policy H-330.877, which states that our AMA supports requiring Medicare to waive the coinsurance for colorectal screening tests, including therapeutic intervention(s) required during the procedure.

RECOMMENDATION F:

Madam Speaker, your Reference Committee recommends that the recommendations in the Joint Report of the Council on Medical Service and the Council on Science and Public Health be adopted as amended and the remainder of the report be filed.

HOD ACTION: The recommendations in the Joint Report of the Council on Medical Service and the Council on Science and Public Health adopted as amended and the remainder of the report filed.

The Joint Report of the Council on Medical Service and the Council on Science and Public Health recommends that our reaffirm Policies D-330.935, D-330.967, H-185.960, H-390.849 and H-425.992; amend Policy H-55.981 by deletion to remove "(2) The general recommendations of major health care organizations for colorectal cancer (CRC), which are as follows: annual fecal occult blood testing, beginning at age 50, and flexible sigmoidoscopy every 3 to 5 years from age 50, for persons at average risk. Colonoscopy and/or double-contrast barium enema procedures, which screen the entire colon, should be considered as appropriate alternatives."; continue to support Medicare coverage for colorectal cancer screenings consistent with ACA-compliant plan coverage requirements; and encourage the development of a coding guide to help providers appropriately bill for various colorectal cancer screening services and promote common understanding among health care providers, payers, and patients so that all know what will be covered at given cost-sharing levels.

Testimony on the Joint Report of the Council on Medical Service and the Council on Science and Public Health was supportive. A member of the Council on Medical Service introduced the report and offered several amendments to strengthen the recommendations in the report, including striking the fourth and fifth recommendations, observing that while very important, the policies recommended for reaffirmation are peripheral to the colorectal cancer screening issue. Second, the Council member recommended amending the seventh recommendation, noting that the coding guide will advance the goal of eliminating cost-sharing for the full range of colorectal cancer screening, including colonoscopies that include removal of a polyp or biopsy of a mass. Third, the Council member recommended amending the eighth recommendation to recognize that clinical practice guidelines for colorectal cancer screening will continue to evolve over time, as well as support physicians and patients engaging in joint decision-making that considers both clinical and financial patient impacts, to determine at what age to begin screening for colorectal cancer and which screening method (or sequence of methods) is most appropriate. Finally, the Council member recommended adding a new recommendation which reaffirms Policy H-330.877, emphasizing that this policy continues to be highly relevant. A member of the Council on Science and Public Health testified in support of these amendments. Your Reference Committee accepts these

amendments. A member of the American Society of Anesthesiologists testified that cost-sharing should be waived for all of the costs associated with a screening colonoscopy. Your Reference Committee accepts this amendment and included it in the seventh recommendation of the report.

An additional amendment was offered that called on the AMA to advocate for coverage of screening colonoscopies without cost-sharing, including when additional procedures (e.g. removal and biopsy of suspicious tissue) are required. Similarly, an amendment was offered which supported the "cascade of events" approach to screening outlined in the Joint Report. Your Reference Committee believes that the goals of both amendments are accomplished by the Joint Report, AMA policy, and the amendments offered by the member of the Council on Medical Service. Accordingly, your Reference Committee recommends adoption of the Joint Report as amended.

(9) RESOLUTION 103 - OPPOSE MEDICAID ELIGIBILITY LOCKOUT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 103 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association oppose 'lock-out' provisions that exclude Medicaid eligible persons for lengthy periods ~~merely for failing to meet paperwork burdens or deadlines~~, and support provisions that permit them to reapply immediately for redetermination. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 103 be adopted as amended.

HOD ACTION: Resolution 103 adopted as amended.

Resolution 103 asks that our AMA oppose 'lock-out' provisions that exclude Medicaid eligible persons for lengthy periods merely for failing to meet paperwork burdens or deadlines, and support provisions that permit them to reapply immediately for redetermination.

Your Reference Committee heard highly supportive testimony on Resolution 103. An amendment was offered to clarify that our AMA oppose 'lock-out' provisions, irrespective of the reason for their application. Testimony noted that lock-out provisions could be triggered for more reasons than when paperwork burdens and deadlines are not met. Rather, states have proposed that they be triggered for failure to comply with a multitude of administrative requirements. In states pursuing lock-outs, patients can be barred from Medicaid and lose important access to needed health care services for failing to meet deadlines, satisfy work requirements, or make premium payments on time – even if they

subsequently comply with the requirements within the lock-out period. In many cases, lock-outs will punish patients who fail to keep up with paperwork but otherwise continue to meet the underlying eligibility criteria for coverage. Accordingly, your Reference Committee recommends that Resolution 103 be adopted as amended.

(10) RESOLUTION 104 - EMERGENCY OUT OF NETWORK SERVICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 104 be amended by addition and deletion to read as follows:

~~RESOLVED, That our American Medical Association pursue legislation or regulation to require health plans not regulated by their states (such as ERISA plans) to pay physicians for emergency out of network care at least at the 80th percentile of charges for that particular geo-zip, as reported by the Fair Health database. (Directive to Take Action)~~

~~RESOLVED, That our American Medical Association advocate for health plans to cover out-of-network unanticipated or emergency care at a fair percentile of all charges for the particular health care service provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization unaffiliated with health insurance companies. (New HOD Policy)~~

RESOLVED, That our American Medical Association advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 104 be adopted as amended.

HOD ACTION: Resolution 104 adopted as amended.

Resolution 104 asks that our AMA pursue legislation or regulation to require health plans not regulated by their states (such as ERISA plans) to pay physicians for emergency out of network care at least at the 80th percentile of charges for that particular geo-zip, as reported by the Fair Health database.

There was mixed testimony on Resolution 104. Several speakers, including members of the Council on Medical Service and the Council on Legislation, testified in support of

removing specific reference to FAIR Health and the 80th percentile of charges, with the Council on Legislation introducing an amendment to achieve said objective. Another amendment introduced removed reference to FAIR Health but kept reference to the 80th percentile of charges, which some speakers stressed would undermine state laws and activities on this issue, as well as existing AMA policy.

The member of the Council on Legislation noted that our AMA already promotes the 80th percentile of charge data in our model state legislation on unanticipated out-of-network care. Importantly, the member of the Council on Legislation noted that requiring the use of FAIR Health in our policy could preclude the future use of other resources, including state all-payer claims databases, in the future. Your Reference Committee agrees, and believes our AMA should support legislation that uses such databases, as long as they are independent. Importantly, removing the explicit reference to FAIR Health and the 80th percentile of charges promotes the evergreen nature of our policy. Testimony also raised concerns that there could be legal concerns surrounding the intersection of ERISA plans and state laws. Your Reference Committee also believes that the amendment offered by the Council on Legislation would apply to all health plans, including ERISA plans, is consistent with existing Policy H-285.904, and does not raise legal concerns associated with ERISA. Accordingly, your Reference Committee recommends that Resolution 104 be adopted as amended.

(11) RESOLUTION 111 - MEDICARE COVERAGE FOR DENTAL SERVICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 111 be amended by addition and deletion to read as follows:

~~RESOLVED, That our American Medical Association reaffirm appreciation and gratitude for the valuable contributions dental health professionals make to Americans' health and well-being as members of our healthcare team (New HOD Policy); and be it further~~

RESOLVED, That our American Medical Association ~~AMA promote and support legislative and administrative action to include preventive and therapeutic dental services as a standard benefit for all Medicare recipients~~ explore opportunities to work with the American Dental Association to improve access to dental care for Medicare beneficiaries. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 111 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 111 be changed to read as follows:

ACCESS TO DENTAL SERVICES FOR MEDICARE BENEFICIARIES

HOD ACTION: Resolution 111 referred.

Resolution 111 asks that our AMA reaffirm appreciation and gratitude for the valuable contributions dental health professionals make to Americans' health and well-being as members of our healthcare team; and promote and support legislative and administrative action to include preventive and therapeutic dental services as a standard benefit for all Medicare recipients.

Testimony on Resolution 111 was generally mixed. Multiple speakers commended the intentions motivating Resolution 111, but they expressed concern about whether our dental colleagues would share these goals, as proposed, and the strain that Resolution 111 could impose upon the Medicare program. Accordingly, these speakers recommended that Resolution 111 be referred for study. A member of the Council on Medical Service testified that the concerns raised in testimony could be addressed by amending Resolution 111 to state that the AMA will explore opportunities to collaborate with the American Dental Association in efforts to improve access to dental care for Medicare beneficiaries, and that this amendment is preferable to a referral. Your Reference Committee notes that the Council's amendment is consistent with AMA policy and strikes a successful balance in responding to both the commendable intentions of Resolution 111 and the concerns raised in testimony. Accordingly, your Reference Committee recommends that Resolution 111 be adopted as amended, with a change in title to reflect the amendment made to the resolution.

(12) RESOLUTION 114 - INCLUSION OF BUNDLED PAYMENTS CARE IMPROVEMENT (BPCI) POST-ACUTE ONLY MODEL 3 IN ADVANCED BPCI

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 114 be amended by addition and deletion to read as follows:

~~RESOLVED, That our American Medical Association advocate for inclusion of the existing Bundled Payments Care Improvement (BPCI) Model 3 Post-Acute care bundle in the Advanced BPCI program so that physicians working in Skilled Nursing Facilities (SNFs) and SNFs are allowed to initiate episodes of care bundles. (New HOD Policy)~~

RESOLVED, That our American Medical Association work with interested national medical specialty societies to help develop and advocate for one or more Medicare alternative payment models focusing on post-acute and/or long-term care. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 114 be adopted as amended.

HOD ACTION: Resolution 114 adopted as amended.

Resolution 114 asks that our AMA advocate for inclusion of the existing Bundled Payments Care Improvement (BPCI) Model 3 Post-Acute care bundle in the Advanced BPCI program so that physicians working in Skilled Nursing Facilities (SNFs) and SNFs are allowed to initiate episodes of care bundles.

Your Reference Committee heard limited testimony on Resolution 114. Testimony from the Council on Legislation explained that one of the key differences between BPCI "classic" and BPCI Advanced is that BPCI-A is prospectively priced, and the need to know ahead of time what a participant's spending target is is very important to the participants. The Council member noted that there is no way for CMMI to prospectively set a price for an episode that does not begin until the patient is in the post-acute care phase. That being said, CMMI continues to explore episode payment models for post-acute as well as other Medicare services, and is interested in a model in the post-acute space that could support the IMPACT Act of 2014 goal of payment reform for post-acute services. As such, COL offered the amended language with which the author agreed. Accordingly, your Reference Committee recommends that Resolution 114 be adopted as amended.

(13) RESOLUTION 116 - BAN ON MEDICARE ADVANTAGE "NO CAUSE" NETWORK TERMINATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 116:

HOD ACTION: The following resolution adopted in lieu of Resolution 116:

RESOLVED, That our AMA develop a set of reform proposals addressing the way that Medicare Advantage plans develop and modify their physician networks with the aim of improving the stability of networks, the ability of patients to obtain needed primary and specialty care from in-network physicians, physician satisfaction, and communication with patients about network access with report back to the House of Delegates at the 2019 Annual Meeting (Directive to Take Action); and be it further

RESOLVED, That our AMA ~~reaffirm~~ amend Policy D-285.988, by addition and deletion to read as follows: ~~which states that o~~ Our AMA will seek legislation or regulation that would prohibit Medicare managed care companies from terminating without cause an enrollee's contracted physician before the enrollee's first subsequent open enrollment period (~~Reaffirm~~ Modify HOD Policy); and be it further

RESOLVED, That our AMA reaffirm Policy H-285.908, which supports requiring that provider terminations without cause be done prior to the enrollment period, and supports requiring that health insurers that terminate in-network providers: (a) notify providers of pending termination at least 90 days prior to removal from network; (b) give to providers, at least 60 days prior to distribution, a copy of the health insurer's letter notifying patients of the provider's change in network status; and (c) allow the provider 30 days to respond to and contest if necessary the letter prior to its distribution (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA reaffirm Policy H-285.991, which outlines that prior to initiation of actions leading to termination or nonrenewal of a physician's participation contract for any reason the physician shall be given notice specifying the grounds for termination or nonrenewal, a defined process for appeal, and an opportunity to initiate and complete remedial activities except in cases where harm to patients is imminent or an action by a state medical board or other government agency effectively limits the physician's ability to practice medicine. (Reaffirm HOD Policy)

Resolution 116 asks that our AMA advocate for legislation that would ban Medicare Advantage plans from issuing "no cause" network terminations, require a Medicare Advantage plan that terminates a physician from a network to provide substantive reasons for such termination, require such termination to be sent by certified mail, require that the Medicare Advantage plan provide at least sixty (60) days for physicians to appeal such termination; and require that the Medicare Advantage plan provide the

physician with a listing of the impacted patient names and a copy of the correspondence sent to impacted patients.

There was generally supportive testimony on the intent of Resolution 116. A member of the Council on Legislation noted that, as existing policy addresses the intent of Resolution 116, efforts should instead focus more on fixing the underlying problems that may have led to the introduction of the resolution. Accordingly, the Council member offered an amendment in support of our AMA developing a set of reform proposals addressing the way that Medicare Advantage plans develop and modify their physician networks. Your Reference Committee thanks the Council on Legislation for its amendment, and agrees with its direction, which will spur new AMA activity on this issue versus duplicating the intent of existing policy. Another amendment was offered that your Reference Committee found duplicative of existing policy. Your Reference Committee has crafted alternative language that includes the Council on Legislation amendment, and reaffirms critical policies that not only provide the criteria to follow for no-cause terminations, but explicitly state that our AMA will seek legislation that would prohibit Medicare managed care companies from terminating without cause an enrollee's contracted physician before the enrollee's first subsequent open enrollment period.

D-285.988 Managed Care Contract Deadline
1. Our AMA will draft model state legislation and amend the AMA's Model Managed Care Contract to reflect AMA policy regarding the marketing of physicians as network participants. 2. Our AMA will seek legislation that would prohibit Medicare managed care companies from terminating without cause an enrollee's contracted physician before the enrollee's first subsequent open enrollment period. (Sub. Res. 703, I-00; Reaffirmed: BOT Rep. 6, A-10; Appended: Res. 809, I-11)

H-285.908 Network Adequacy
1. Our AMA supports state regulators as the primary enforcer of network adequacy requirements. 2. Our AMA supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. Physicians may be added to the network at any time. 3. Our AMA supports requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy, including the number and type of providers that have joined or left the network; the number and type of specialists and subspecialists that have left or joined the network; the number and types of providers who have filed an in network claim within the calendar year; total number of claims by provider type made on an out-of-network basis; data that indicate the provision of Essential Health Benefits; and consumer complaints received. 4. Our AMA supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities. 5. Our AMA advocates for regulation and legislation to require that out-of-network expenses count toward a participant's annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due

to network inadequacies. 6. Our AMA supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities. 7. Our AMA supports health insurers paying out-of-network physicians fairly and equitably for emergency and out-of-network bills in a hospital. AMA policy is that any legislation which addresses this issue should assure that insurer payment for such care be based upon a number of factors, including the physicians' usual charge, the usual and customary charge for such service, the circumstances of the care and the expertise of the particular physician. 8. Our AMA provides assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure physicians and patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks. 9. Our AMA supports the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities. 10. Our AMA advocates for legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited. 11. Our AMA advocates that health plans should be required to document to regulators that they have met requisite standards of network adequacy including hospital-based physician specialties (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible. 12. Our AMA supports requiring that health insurers that terminate in-network providers: (a) notify providers of pending termination at least 90 days prior to removal from network; (b) give to providers, at least 60 days prior to distribution, a copy of the health insurer’s letter notifying patients of the provider’s change in network status; and (c) allow the provider 30 days to respond to and contest if necessary the letter prior to its distribution. (CMS Rep. 4, I-14; Reaffirmation I-15; Reaffirmed in lieu of Res. 808, I-15; Modified: Sub. Res. 811, I-15; Reaffirmed: CMS Rep. 03, A-17; Reaffirmed: Res. 108, A-17; Appended: Res. 809, I-17)

H-285.991 Qualifications and Credentialing of Physicians Involved in Managed Care

1. AMA policy on selective contracting is as follows: (a) Health plans or networks should provide public notice within their geographic service areas when applications for participation are being accepted. (b) Physicians should have the right to apply to any health care plan or network in which they desire to participate and to have that application approved if it meets physician-developed objective criteria that are available to both applicants and enrollees and are based on professional qualifications, competence and quality of care. (c) Selective contracting decisions made by any health delivery or financing system should be based on an evaluation of multiple criteria related to professional competency, quality of care, and the appropriateness by which medical services are provided. In general, no single criterion should provide the sole basis for selecting, retaining, or excluding a physician from a health delivery or financing system. (d) Prior to initiation of actions leading to termination or nonrenewal of a physician's participation contract for any reason the physician shall be given notice specifying the grounds for termination or nonrenewal, a defined process for appeal, and an opportunity to initiate and complete remedial activities except

in cases where harm to patients is imminent or an action by a state medical board or other government agency effectively limits the physician's ability to practice medicine. Participation in a physician health program in and of itself shall not count as a limit on the ability to practice medicine. Our AMA supports the following appeals process for physicians whose health insurance contract is terminated or not renewed: (i) the specific reasons for the termination or nonrenewal should be provided in sufficient detail to permit the physician to respond; (ii) a name and address of the Director of Provider Appeals, or an individual with equivalent authority, should be provided for the physician to direct communications; (iii) the evidence or documentation underlying the proposed termination or nonrenewal should be provided and the physician should be permitted to review it upon request; (iv) the physician should have the right to request a hearing to challenge the proposed termination or nonrenewal; (v) the physician or his/her representative should be able to appear in person at the hearing and present the physician's case; (vi) the physician should be able to submit supporting information both before and at the fair hearing; (vii) the physician should have a right to ask questions of any representative of the health insurance company who attends the hearing; (viii) the physician should have at least thirty days from the date the termination or nonrenewal notice was received to request a hearing; and (ix) the hearing must be held not less than thirty days after the date the health insurer receives the physician's request for the review or hearing. 2. The qualifications, responsibilities, and duties of physicians employed as medical directors of managed care plans should be developed on an individual basis by the plan concerned. Physicians who participate in the plan, or the plan's medical staff, if one is so designated, should participate in developing such qualifications, responsibilities, and duties. (CMS Rep. B, A-93; BOT Rep. I-93-25; Reaffirmed: Sub. Res. 704, I-94; Reaffirmed: Sub. Res. 701, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 3, I-97; Reaffirmed by Res. 108, A-98; Reaffirmation A-01; Appended: CMS Rep. 8, A-10; Reaffirmed: Res 119, A-14; Modified: Res. 708, A-14; Reaffirmation A-14; Reaffirmed: CMS Rep. 4, I-14)

(14) RESOLUTION 108 - EXPANDING AMA'S POSITION ON HEALTHCARE REFORM OPTIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 108 be referred.

HOD ACTION: Resolution 108 referred.

Resolution 108 asks that our AMA rescind Policies H-165.844 and H-165.985; amend Policy H-165.888 by deletion to remove "1(B) Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be oppose;" and amend Policy H-165.838 by deletion to remove "12. AMA

policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform."

Your Reference Committee heard mixed testimony on Resolution 108. A member of the Council on Medical Service recommended reaffirmation of existing policy in lieu of Resolution 108, and shared the Council's belief that the current approach of our AMA's policy to health reform is the right one – emphasizing pluralism, freedom of choice, freedom of practice and universal access to patients. Another Council member noted that the Council has already studied international approaches to single payer. Testimony on both sides was passionate. Testimony in opposition raised concerns that Resolution 108 would open the door to the AMA supporting single payer, while testimony in support of the resolution noted the changes to policy outlined in the resolution would enable the AMA to participate in legislative discussions addressing single payer. An amendment was also offered to call for a study. Your Reference Committee underscores that this issue is highly complicated, and there is a need to examine AMA policy addressing health reform and single payer, study the pros and cons of single payer and alternative approaches to universal coverage, and study the impacts of single payer systems on physician practices and patients. As such, your Reference Committee recommends that Resolution 108 be referred.

(15) RESOLUTION 117 - SUPPORTING RECLASSIFICATION OF COMPLEX REHABILITATION TECHNOLOGY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 117 be referred.

HOD ACTION: Resolution 117 referred.

Resolution 117 asks that our AMA advocate for the Centers for Medicare & Medicaid Services to reclassify complex rehabilitation technology as a separate and distinct payment category to improve access to the most appropriate and necessary equipment to allow individuals with significant disabilities and chronic medical conditions to increase their independence, reduce their overall health care expenses and appropriately manage their medical needs.

Your Reference Committee heard supportive testimony on Resolution 117, but a member of the Council on Medical Service cautioned that it would be premature to adopt Resolution 117 without further study. In calling for referral, the Council member testified that Resolution 117 may have unintended impacts and consequences. Your Reference Committee commends the Council of Medical Service's testimony and recommends that Resolution 117 be referred.

(16) RESOLUTION 109 - MEDICAID COVERAGE OF FITNESS FACILITY MEMBERSHIPS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 109 not be adopted.

HOD ACTION: Resolution 109 not adopted.

Resolution 109 asks that our AMA support Medicaid coverage of fitness facility memberships as a standard preventive health insurance benefit for patients.

While testimony was mixed, the preponderance of the testimony was opposed to Resolution 109. Several speakers testified regarding the significant limitations on funding for the Medicaid program and expressed concerns that Resolution 109 would impose further strain on the Medicaid program. Additional testimony emphasized that there is insufficient evidence to support the efficacy of fitness facility membership as a preventive health benefit. A member of the Council on Medical Service offered an amendment to remove the resolution's specific reference to "fitness facility memberships," and generalize the language to support Medicaid coverage of prevention and wellness initiatives. Your Reference Committee agrees with the significant testimony expressing concern that Resolution 109 could further strain the resources of the Medicaid program and notes that AMA policy generally avoids mandating coverage of specific benefits, both to better allow markets to determine benefit packages and to avoid jeopardizing current coverage. Accordingly, consistent with AMA policy and the weight of the testimony, your Reference Committee recommends that Resolution 109 not be adopted.

(17) RESOLUTION 105 - USE OF HIGH MOLECULAR WEIGHT HYALURONIC ACID

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-165.856, H-185.964, H-385.942, H-410.961 and H-450.935 be reaffirmed in lieu of Resolution 105.

HOD ACTION: Policies H-165.856, H-185.964, H-385.942, H-410.961 and H-450.935 reaffirmed in lieu of Resolution 105.

Resolution 105 asks that our AMA advocate for reimbursement and national coverage for high molecular weight hyaluronic acid intraarticular injections as appropriate care and treatment for patients with mild to moderate osteoarthritis of the knee.

Your Reference Committee heard mixed testimony on Resolution 105. A member of the Council on Medical Service testified that AMA policy on clinical practice guidelines raises concerns with such guidelines being used inappropriately as the basis for payment decisions, and that AMA policy generally avoids mandating coverage of specific benefits, both to better allow markets to determine benefit packages and to avoid jeopardizing current coverage. Accordingly, the member of the Council on Medical Service called for

reaffirmation of Policies H-165.856 and H-185.964 addressing benefit mandates, and H-385.942, H-410.961 and H-450.935 addressing the use of clinical practice guidelines. Your Reference Committee agreed with the Council's recommendation. As such, your Reference Committee recommends that Policies H-165.856, H-185.964, H-410.961, H-410.997 and H-450.935 be reaffirmed in lieu of Resolution 105.

H-165.856 Health Insurance Market Regulation
Our AMA supports the following principles for health insurance market regulation: (1) There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan. (2) State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection. (3) Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges. (4) Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium. (5) Insured individuals should be protected by guaranteed renewability. (6) Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices. (7) Guaranteed issue regulations should be rescinded. (8) Health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability. (9) Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage. (10) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically: (a) legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed; (b) benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and (c) any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed. (CMS Rep. 7, A-03 Reaffirmed: CMS Rep. 6, A-05 Reaffirmation A-07 Reaffirmed: CMS Rep. 2, I-07 Reaffirmed: BOT Rep. 7, A-09 Appended: Res. 129, A-09 Reaffirmed: CMS Rep. 9, A-11 Reaffirmed in lieu of Res. 811, I-11 Reaffirmed in lieu of Res. 109, A-12 Reaffirmed in lieu of Res. 125, A-12 Reaffirmed: Res. 239, A-12 Reaffirmed: CMS Rep. 9, A-14 Reaffirmation: A-17 Reaffirmed: Res. 518, A-17)

H-185.964 Status Report on the Uninsured
Our AMA opposes new health benefit mandates unrelated to patient protections, which jeopardize coverage to currently insured populations. (CMS Rep. 2, A-99 Reaffirmed: CMS Rep. 5, A-09)

H-410.961 Adding a Disclaimer to Clinical Practice Guidelines

Our AMA recommends that all specialty and subspecialty societies the placement of a disclaimer on each clinical practice guideline reaffirming that guidelines are not a substitute for the experience and judgment of a physician and are developed to enhance the physicians' ability to practice evidence-based medicine. (Res. 806, A-02 Reaffirmation A-06 Reaffirmed: CMS Rep. 01, A-16)

H-410.997 Practice Parameters and Review Criteria
Our AMA believes that variations from medical practice guidelines and parameters are not, except in very limited circumstances, per se indicators of quality or medical necessity problems. Only where a variation involves provision of a service or procedure deemed by the preponderance of medical opinion to be inappropriate in any clinical situation should it be used as a per se indicator for judgments regarding quality or payment denials. Otherwise, variations from the guidelines and parameters should constitute only a signal for further peer-to-peer considerations relative to quality or payment issues. (Consolidated by CMS Rep. 8, I-96 Reaffirmed and Modified: CSAPH Rep. 3, A-06 Reaffirmed: CMS Rep. 01, A-16)

Health Care Standards H-450.935
Our AMA: (1) supports the ability of non-governmental organizations to evaluate appropriate medical diagnosis or therapy or current or new diagnostic or therapeutic tests, procedures, medications or other procedures that improve the quality of patient care; (2) supports the position that any practice guidelines, parameters, best practices models, or similar set of principles or clinical recommendations, whether developed or issued by government or non-government organizations, including those that result from any comparative effectiveness research or evidence-based medicine system, do not, and should expressly state that they do not, establish standard of care or create specific requirements for physicians that restrict the exercise of their clinical judgment; (3) urges any organization, whether governmental or non-governmental, promulgating any practice guidelines, parameters, best practices models, or similar set of principles or clinical recommendations, to include a statement that they are guidelines only; and (4) urges any organization, whether governmental or non-governmental, promulgating any practice guidelines, parameters, best practices models, or similar set of principles or clinical recommendations, to set and make publicly available a regular schedule for review and update and to include the level of evidence supporting the guidelines. (Res. 205, A-10 Reaffirmation I-10)

(18) RESOLUTION 118 - PAYMENT FOR ADVANCE CARE PLANNING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-390.916 be reaffirmed in lieu of Resolution 118.

HOD ACTION: Policy H-390.916 reaffirmed in lieu of Resolution 118.

Resolution 118 asks that our AMA seek federal legislation to require Medicare Advantage, Medicaid, and commercial insurance to pay for advance care planning whenever the patient's physician believes that it is appropriate.

Your Reference Committee heard limited testimony on Resolution 118. Speakers noted that existing policy addresses the intent of the resolution, including a member of the Council on Medical Service. Your Reference Committee agrees that existing AMA policy appropriately responds to the issues raised in Resolution 118, and can be used to support future advocacy efforts. As such, your Reference Committee recommends that Policy H-390.916 be reaffirmed in lieu of Resolution 118.

> H-390.916 Payment for Patient Counseling Regarding Advance Care Planning
> Our AMA encourages all public and private health insurers to be required to pay, at a reasonable payment rate, for counseling with patients and/or relatives and guardians regarding advance care planning, including goals of care, as an accepted and integral part of good medical care, particularly as it relates to the discussion of advance directives (e.g., living wills and durable powers of attorney for health care). (Res. 1, I-90; Reaffirmed: Sunset Report, I-00; Modified in lieu of Res. 101, A-07; Reaffirmation A-09; Modified: Res. 107, A-15)

(19) RESOLUTION 119 - PAYMENT FOR PALLIATIVE CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-70.915, H-85.951 and H-85.966 be reaffirmed in lieu of Resolution 119.

HOD ACTION: Policies H-70.915, H-85.951 and H-85.966 reaffirmed in lieu of Resolution 119.

Resolution 119 asks that our AMA seek federal legislation to require Medicare, Medicare Advantage, Medicaid, and commercial insurance to pay for palliative care, regardless of site of care, whenever the patient's physician believes that it is appropriate and the patient, or surrogate decision maker, agrees.

Your Reference Committee heard limited yet mixed testimony on Resolution 119. There was a call for referral. Importantly, testimony from the Council on Medical Service highlighted that existing policy addresses the intent of Resolution 119. Your Reference Committee agrees, and as such recommends that Policies H-70.915, H-85.951 and H-85.966 be reaffirmed in lieu of Resolution 119.

> H-70.915 Good Palliative Care
> Our AMA: (1) encourages all physicians to become skilled in palliative medicine; (2) recognizes the importance of providing interdisciplinary palliative care for patients with disabling chronic or life-limiting illness to prevent and relieve suffering and to support the best possible quality of life for these patients and their families; (3) encourages education programs for all appropriate health care professionals, and the public as well, in care of the dying patient; and the care of

patients with disabling chronic or life-limiting illness; (4) supports improved reimbursement for health care practices that are important in good care of the dying patient, such as the coordination and continuity of care, "maintenance" level services, counseling for patient and family, use of multidisciplinary teams, and effective palliation of symptoms; (5) encourages physicians to become familiar with the use of current coding methods for reimbursement of hospice and palliative care services; (6) advocates for reimbursement of Evaluation and Management (E/M) codes reflecting prolonged time spent on patients' care outside of the face-to-face encounter in non-hospital settings; (7) continues to monitor the development and performance on the CMS 30-day mortality measures and enrollments in the Medicare hospice program and the VA hospice programs and continues to work to have CMS exclude palliative patients from mortality measures; (8) supports efforts to clarify coding guidance or development of codes to capture "comfort care," "end-of-life care," and "hospice care;" (9) encourages research in the field of palliative medicine to improve treatment of unpleasant symptoms that affect quality of life for patients; and (10) encourages research into the needs of dying patients and how the care system could better serve them. (CCB/CLRPD Rep. 3, A-14; Reaffirmed: BOT Rep. 05, I-16)

H-85.951 Concurrent Hospice and Curative Care
1. Our AMA supports continued study and pilot testing by the Centers for Medicare & Medicaid Services (CMS) of a variety of models for providing and paying for concurrent hospice, palliative and curative care. 2. Our AMA encourages CMS to identify ways to optimize patient access to palliative care, which relieves suffering and improves quality of life for people with serious illnesses, regardless of whether they can be cured, and to provide appropriate coverage and payment for these services. 3. Our AMA encourages physicians to be familiar with local hospice and palliative care resources and their benefit structures, as well as clinical practice guidelines developed by national medical specialty societies, and to refer seriously ill patients accordingly. (CMS Rep. 04, I-16)

H-85.966 Hospice Coverage and Underutilization
The policy of the AMA is that: (1) The use of hospice care be actively utilized to provide the patient and family with appropriate physical and emotional support, but not preclude or prevent the use of appropriate palliative therapies to continue to treat the underlying malignant disease, if the patient is showing response to such palliative therapy; (2) The goal of terminal care is to relieve patient suffering and not necessarily to cure incurable disease; (3) Appropriate active palliation should be a covered hospital benefit; and (4) The initiation of hospice care may be done at the discretion of the attending physician without stopping whatever medical care is being rendered if the physician believes the patient is in the last six months of life. (Res. 515, A-94; Reaffirmed: CMS Rep. 5, A-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: CMS Rep. 04, I-16)

Madam Speaker, this concludes the report of Reference Committee A. I would like to thank Lase Ajayi, MD, Peter Aran, MD, Micah Beachy, DO, Christine Pabin Bishof, MD, Maryanne Bombaugh, MD, Beverly Collins, MD, and all those who testified before the Committee. I would also like to thank AMA staff: Courtney Perlino, MPP, Julie Marder, JD, and Rebecca Gierhahn, MS.

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