Reference Committee A

CMS Report(s)
01 Council on Medical Service Sunset Review of 2007 AMA House Policies
03 Ensuring Continuity of Care Protections During Active Courses of Treatment
06* Expansion of US Veterans' Health Care Choices
09 Capping Federal Medicaid Funding

Joint Report(s)
- CMS / CSAPH Report - Value of Preventive Services

Resolution(s)
101 Eliminating Financial Barriers for Evidence-Based HIV Pre-Exposure Prophylaxis
102 Establishing a Market System of Health System Financing and Delivery
103 Benefit Payment Schedule
104 Consultation Code Reinstatement
105 Opposition to Price Controls
106 Medical Loss Ratio
107 Repeal and Replace Our Outdated Refundable Advanceable Tax Credit Policy
109 Simplify Medicare Face-to-Face Requirement
110 Over-the-Counter Contraceptive Drug Access
111 VA Technology-Based Eye Care Services
112 CMS Must Publish All Values for Non-Covered and Bundled Services
113 The AMA Will Support Payment Parity at Medicare Levels for All Medicaid Services
114 Coverage for Preventive Care and Immunizations
115 Out-of-Network Care
116 Medicare Advantage Payment Policies
117 Expansion of U.S. Veterans' Healthcare Choices
118 Third Party Patient Reimbursement for Out-of-Network Physicians
119 Support Efforts to Improve Access to Diabetes Self-Management Training Services
120 National Pressure Ulcer Advisory Panel Recommendation for Pressure Ulcer Nomenclature Change
121 Advanced Care Planning Codes
122* Reimbursement for Pre-Colonoscopy Visit
123* Improving the Prevention of Colon Cancer by Insuring the Waiver of the Co-Payment in all Cases
124* Emergency Medical Services Reimbursement for On-Site Treatment and Transport to Non-Traditional Destinations
125* Medicaid Substance Use Disorder Coverage
126* Insurance Coverage for Compression Stockings
127* Balance Billing State Regulation

* Contained in Handbook Addendum
In 1984, the House of Delegates established a sunset mechanism for House policies (Policy G-600.110). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to re-establish it.

The objective of the sunset mechanism is to help ensure that the American Medical Association (AMA) Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House deliberations.

Modified by the House on several occasions, the policy sunset process currently includes the following key steps:

- Each year, the House policies that are subject to review under the policy sunset mechanism are identified, and such policies are assigned to the appropriate AMA Councils for review.
- Each AMA Council that has been asked to review policies develops and submits a separate report to the House that presents recommendations on how the policies assigned to it should be handled.
- For each policy under review, the reviewing Council recommends one of the following alternatives: (a) retain the policy; (b) rescind the policy; or (c) retain part of the policy.
- For each recommendation, the Council provides a succinct but cogent justification for the recommendation.
- The Speakers assign the policy sunset reports for consideration by the appropriate reference committee.

RECOMMENDATION

The Council on Medical Service recommends that our American Medical Association (AMA) policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of the report be filed. (Directive to Take Action).

Fiscal Note: Less than $500.
## Appendix

### Recommended Actions on 2007 Socioeconomic Policies

<table>
<thead>
<tr>
<th>Policy #</th>
<th>Policy Title</th>
<th>Recommended Action and Rationale</th>
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<tbody>
<tr>
<td>H-70.937</td>
<td>Bundling and Downcoding of CPT Codes</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-70.949</td>
<td>Bundling of Codes for Physician Services</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-70.950</td>
<td>Unacceptable Editing of the CPT-4 Code Book</td>
<td>Retain. Still relevant.</td>
</tr>
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</table>
| H-70.956 | Coding for Medically Indicated Diagnostic and Surveillance Services          | Retain-in-part. Under ICD-10-CM, these services will be reported under a new set of codes-Z codes. Modify policy to read as follows:  
The AMA will continue to advocate to third party payers’ acceptance of symptoms, signs, ill-defined conditions, and supplementary classification of factors influencing health status (V Z codes), as valid, medically necessary reasons for patient encounters, work toward expansion of these codes for screening examinations where appropriate, and urge payers to provide reimbursement for these services within the parameters of the patient’s health insurance coverage. |
<p>| H-70.986 | CPT Coding Initiatives                                                      | Retain. Still relevant.                                                                          |
| H-70.991 | Coding and Payment for Patient Management in Ambulatory Settings and Skilled Nursing Facilities | Retain. Still relevant.                                                                          |
| H-70.998 | Revision of CPT                                                             | Retain. Still relevant.                                                                          |
| H-90.978 | Community Mobility Devices                                                  | Retain. Still relevant.                                                                          |
| H-110.991| Price of Medicine                                                           | Retain. Still relevant.                                                                          |
| H-125.990| Medicaid Payment for Over-The-Counter Drugs When They are the Drug of Choice | Retain. Still relevant.                                                                          |</p>
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<tr>
<td>H-160.923</td>
<td>Offsetting the Costs of Providing Uncompensated Care</td>
<td>Retain-in-part. Clarify that (1) refers to disproportionate share hospital (DSH) payments, and delete Texas example as it is limiting. Modify policy to read as follows: Our AMA: (1) supports the transitional redistribution of public funds currently spent on uncompensated care provided by institutions disproportionate share hospital (DSH) payments for use in subsidizing private health insurance coverage for the uninsured; (2) supports the use of innovative federal- or state-based projects that are not budget neutral, such as the Texas Designated Trauma Facility and Emergency Medical Services Account, for the purpose of supporting physicians that treat large numbers of uninsured patients, as well as EMTALA-directed care; and (3) encourages public and private sector researchers to utilize data collection methodologies that accurately reflect the amount of uncompensated care (including both bad debt and charity care) provided by physicians.</td>
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<tr>
<td>H-160.943</td>
<td>Definition of “Principal Care”</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-160.969</td>
<td>Tax Deduction for Care Provided the Indigent</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-160.975</td>
<td>Planning and Delivery of Health Care Services</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-180.960</td>
<td>Insurance Company Medical Test Disclosures</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-180.965</td>
<td>Income Tax Credits or Deductions as Compensation for Treating Medically Uninsured or Underinsured</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-180.980</td>
<td>Sexual Orientation and/or Gender Identity as Health Insurance Criteria</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-185.960</td>
<td>Support for the Inclusion of the Benefit for Screening for Colorectal Cancer in All Health Plans</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-195.993</td>
<td>Oversight of Medicare Managed Care Plans</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-205.994</td>
<td>Definition of Health Care Facilities</td>
<td>Retain. Still relevant.</td>
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<td>H-220.971</td>
<td>Joint Commission Medical Staff Standard on the Amendment of Bylaws</td>
<td>Retain-in-part. Update policy to read as follows: The AMA formally expresses its support for maintaining Joint Commission Standard MS.01.01.03, which establishes that neither the medical staff nor the hospital governing body may unilaterally amend the medical staff bylaws.</td>
</tr>
<tr>
<td>H-220.972</td>
<td>Medical Staff Participation in the Joint Commission Site Surveys</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-225.963</td>
<td>Unilateral Imposition of Medical Staff Development Plans and Economic Credentialing Controlled by the Hospital</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-230.983</td>
<td>Credentials Files for Members of Hospital Medical Staffs</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-230.986</td>
<td>JCAHO Recognition of Specialty Boards Recognized by American Board of Medical Specialties and AMA and AOA</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-235.984</td>
<td>Hospital Medical Directors Designated as the Representative of the Medical Staff</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-280.957</td>
<td>Continuity of Care in Nursing Homes</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-285.960</td>
<td>Incorporation of Organized Medical Staff in Managed Care Accreditation Standards</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-285.964</td>
<td>Admitting Officer and Hospitalist Programs</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-285.981</td>
<td>Fair Market Practices</td>
<td>Retain-in-Part. Delete (2), which refers to obsolete federal legislation from 1994, as follows. Our AMA+(4) continues to advocate for the enactment of state and federal laws and regulations that would provide for patient protection and physician fairness, including …(c) providing enrollees and participating physicians with the opportunity to complete a “report card” at regular intervals for appropriate dissemination regarding the quality of service rendered by the managed care organization; and,(2) continues to encourage all state medical associations and national medical specialty societies to advocate vigorous support of the Patient Protection Act.</td>
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<tr>
<td>H-285.986</td>
<td>Standardization of Managed Care Office Safety Standards</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-290.986</td>
<td>Medicaid and Efforts to Assure it Maintains its Role as a Safety Net</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-290.993</td>
<td>Coverage of Drugs by Medicaid</td>
<td>Retain-in-part. Modify (1) by replacing “drugs necessary to treat life-threatening and other serious medical conditions” to “medically necessary drugs” and modify (2) editorially, to read as follows: Our AMA (1) urges CMS to develop meaningful guidelines for state Medicaid agencies to pay for drugs necessary to treat life-threatening and other serious medical conditions medically necessary drugs, even if such drugs are manufactured/distributed by non-rebating firms, and (2) asks CMS to grant states reasonable autonomy in decisions to cover these medically necessary drugs without retroactive economic penalty.</td>
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<tr>
<td>H-315.990</td>
<td>Confidentiality of Computerized Patient Records</td>
<td>Retain-in-Part. Delete (3), which has been accomplished with Ethical Opinion E-3.3.2, to read as follows: The AMA (1) reaffirms the importance of confidentiality of patient records regardless of the form in which they are stored; and (2) will study and incorporate into its model legislation, Confidentiality of Health Care Information, a provision regulating third parties’ use of computerized patient records in physicians’ offices; and (2) will develop guidelines for physicians using computerized medical record systems to protect the confidentiality, integrity and security of patient records.</td>
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| H-320.947 | Third Party Intervention Requests                                                                | Retain-in-part. Delete (2) because intervention examples are no longer being provided to the AMA.  
1. AMA policy is that physicians only should be asked to effect clinical interventions on behalf of their patients as requested by third parties when such interventions are evidence-based and appropriately compensated.  
2. Our AMA encourages physicians to submit it instances of inappropriate interventions by health insurance plans, disease management companies, radiology benefit managers, or pharmacy benefit managers; and, if warranted, consider developing AMA resources to stem future requests that are not evidence-based and appropriately compensated. |
<p>| H-330.895 | Medicare Beneficiary Access to Pulmonary Rehabilitation Services                                | Rescind. Medicare Part B covers comprehensive pulmonary rehabilitation for patients with moderate to very severe chronic obstructive pulmonary disease (COPD). These services may be provided in a doctor’s office or a hospital outpatient setting that offers pulmonary rehabilitation programs. |</p>
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| H-365.981 | Workers’ Compensation                                                        | Retain-in-part. In (3), model legislation was developed; (5) and (6) were accomplished; and (7) is dated. Modify only these clauses as follows:  

The AMA:…(3) will develop model state legislation mandating the appropriate encourages the use of the Guides to the Evaluation of Permanent Impairment… (5) will work with state medical societies to educate physicians about workers’ compensation and state workers’ compensation laws. Physicians treating injured workers should be aware of the state workers’ compensation act in order to understand the patient’s rights and the physician’s responsibilities. Knowledge of the law and an increased understanding of the system may also result in an increased willingness, on the part of physicians, to participate in the workers’ compensation system. One means of educating physicians which is being investigated is the development of an AMA publication which would provide an overview of workers’ compensation in general (background on the system’s history, the physician’s role, problems with the system, and potential solutions). State medical societies could then be encouraged to develop more specific workers’ compensation publications detailing individual state law. (6) will work with state medical societies and other responsible entities to develop workers’ compensation medical care data collection systems to improve the quality and efficiency of state workers’ compensation systems. (7) encourages the use of uniform claim forms (CMS 1500, UB04), electronic billing (with appropriate mechanisms to protect the confidentiality of patient information, and familiar diagnostic coding guidelines (ICD-9-CM, CPT; ICD-10-CM, CPT), when appropriate, to facilitate prompt reporting and payment of workers’ compensation claims. |
<p>| H-375.963 | Reduced Physician Role in Governance of Federally Contracted Quality Improvement Organizations | Retain. Still relevant.                                                                                                                                       |
| H-385.944 | Insurance Company Denial of Payment for Office Visit and Invasive Procedure Done on the Same Day | Retain. Still relevant.                                                                                                                                      |
| H-385.945 | Equal Payment for Services                                                   | Retain. Still relevant.                                                                                                                                      |</p>
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<tr>
<td>H-390.851</td>
<td>Changes to the Medical Profession Resulting from Medicare Administrative Contracting Reforms</td>
<td>Retain-in-Part. Modify (1) to reflect change in nomenclature as follows:</td>
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<td>1. Our AMA will review and monitor the impacts of the Medicare Administrative Contracting reforms as they evolve over the next several years with periodic reports to the House of Delegates, to include at a minimum: (a) growth, nature and outcomes of actions against physicians by Payment Safeguard Contractors, Zone Program Integrity Contractors, and Recovery Audit Contractors;…</td>
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<tr>
<td>H-390.856</td>
<td>Eliminate Medicare's &quot;Limiting Charge&quot;</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-390.972</td>
<td>Special Payment Arrangements for Low-Income Medicare Beneficiaries</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-425.992</td>
<td>Coverage of Preventive Medical Services by Medicare</td>
<td>Rescind. Medicare now covers preventive services recommended with a grade of A or B by the USPSTF.</td>
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<tr>
<td>H-450.988</td>
<td>Guidelines for Quality Assurance</td>
<td>Retain. Still relevant</td>
</tr>
<tr>
<td>H-465.980</td>
<td>Rural Community Health Networks</td>
<td>Retain. Still relevant</td>
</tr>
<tr>
<td>H-465.996</td>
<td>Change in Criteria for Rural Referral Center Designation</td>
<td>Retain. Still relevant</td>
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<tr>
<td>D-70.975</td>
<td>Appropriate Reimbursements and Carve-Outs for Vaccines</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>D-75.997</td>
<td>Access to Emergency Contraception</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>D-120.964</td>
<td>Standardized Pharmacy Telephone Answering Machines</td>
<td>Rescind. Directive accomplished. The AMA sent a letter asking the National Association of Chain Drug Stores (NACDS) to work with their member chain pharmacies to implement “standardized” telephone answering system to allow physicians to bypass messages.</td>
</tr>
<tr>
<td>D-130.975</td>
<td>Advocacy Efforts to Persuade All Health Payers to Pay for EMTALA-Mandated Services</td>
<td>Retain. Still Relevant.</td>
</tr>
<tr>
<td>D-160.984</td>
<td>CMS Rule 4105F: Notification of Hospital Discharge Appeal Rights</td>
<td>Rescind. No longer relevant. Inclusion of hospital discharge appeal notices in the Important Message from Medicare (IM) and Detailed Notice of Discharge (DND) provided to hospital inpatients has been the standard for 10 years.</td>
</tr>
<tr>
<td>D-220.984</td>
<td>Use of Physicians as Surveyors in Hospital Surveys</td>
<td>Rescind. Joint Commission hospital survey teams nearly always include a physician. Additionally, Joint Commission seeks to include surveyors who are active in their fields; at a minimum, physician surveyors must complete continuing medical education work.</td>
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<tr>
<td>D-225.980</td>
<td>Confidentiality of Medical Staff Members' Personal Proprietary Financial Information</td>
<td>Rescind. The Joint Commission Standards for Management of Information underwent substantive revisions that make this policy obsolete. The principles in this policy have also been superseded in part by Policy H-225.955.</td>
</tr>
<tr>
<td>D-225.981</td>
<td>Marketing Low Cost Internet-Based Education Programs for Medical Staff Leadership</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>D-225.984</td>
<td>Hospitalists and the Changing Hospital Environment</td>
<td>Rescind. Directive accomplished. The AMA endorses the <em>Principles for Developing a Sustainable and Successful Hospitalist Program</em>, developed by the AMA Organized Medical Staff Section, the American Hospital Association, The Joint Commission, and the Society of Hospital Medicine, and included in the <em>AMA Physician’s Guide to Medical Staff Organization Bylaws, Sixth Edition</em>.</td>
</tr>
<tr>
<td>D-285.969</td>
<td>Inaccurate Health Plan Physician Directories</td>
<td>Rescind. Directive accomplished. The AMA solicited through various AMA communication vehicles member complaints regarding inaccuracies contained in each health plan's physician provider listings. Additionally, AMA solicited feedback from the Federation for their current efforts or interest in collaboratively addressing inaccurate health plan physician provider listings.</td>
</tr>
<tr>
<td>D-330.929</td>
<td>Medicare Abdominal Aortic Aneurysm Screening</td>
<td>Rescind. Medicare now covers preventive services recommended with a grade of A or B by the USPSTF.</td>
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<tr>
<td>D-335.992</td>
<td>Medicare Carrier Medical Directors</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>D-390.967</td>
<td>Elimination of Subsidies to Medicare Advantage Plans</td>
<td>Retain-in-part. The SGR has been repealed. Modify policy to read as follows: [1.] Our AMA will seek to have all subsidies to private plans offering alternative coverage to Medicare beneficiaries eliminated, that these private Medicare plans compete with traditional Medicare fee-for-service plans on a financially neutral basis and have accountability to the Centers for Medicare and Medicaid Services, and that any savings from the elimination of subsidies to private plans be used to address the Sustainable Growth Rate (SGR). [2.] Our AMA will seek to prohibit all private plans offering coverage to Medicare beneficiaries from deeming any physician to be a participating physician without a signed contract specific to that product, and that our AMA work with CMS to prohibit all-products clauses from applying to Medicare Advantage plans and private fee-for-service plans.</td>
</tr>
<tr>
<td>D-406.997</td>
<td>One Fee, One Number</td>
<td>Rescind. Directive accomplished. The AMA also drafted Board of Trustees Report 5-I-08 completing the request study. The AMA also sent the DEA a letter that advocates for physicians to have only one DEA number that is physician-specific and not site-specific.</td>
</tr>
<tr>
<td>D-450.973</td>
<td>Certification and Accreditation Programs for Disease-Specific Care</td>
<td>Rescind. Directive accomplished. PCPI has developed measurement sets for at least 47 clinical conditions.</td>
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<tr>
<td>D-478.991</td>
<td>Consequences of Accepting Hospital and Health Care System Based EMRs/EHRs</td>
<td>Rescind (1) as follows since the contracting guidelines have been developed. Our AMA will: (1) develop contracting guidelines for physicians considering accepting or donating Electronic Medical Records and Electronic Health Records systems (EMRs/EHRs) from or to hospitals and health care systems; (2) (1) educate physicians regarding the potential adverse consequences of receiving EMRs/EHRs from hospitals and health care systems; and (3) (2) encourage interoperability of information systems used by hospitals and health care facilities.</td>
</tr>
<tr>
<td>D-480.997</td>
<td>Teleconsultations And Medicare Reimbursement</td>
<td>Retain. Still relevant.</td>
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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-A-17

Subject: Ensuring Continuity of Care Protections during Active Courses of Treatment (Resolution 108-A-16)

Presented by: Peter S. Lund, MD, Chair

Referred to: Reference Committee A (John Armstrong, MD, Chair)

At the 2016 Annual Meeting, the House of Delegates referred Resolution 108, “Continued Surgical Care,” which was sponsored by the New York Delegation. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2017 Annual Meeting. Resolution 108-A-16 asked:

That our American Medical Association (AMA) seek legislation/regulation which would allow a physician who has performed an initial surgical procedure, to continue to follow the patient and perform any necessary follow-up surgery, regardless of the physician’s change in participation status; and

That any follow-up surgery performed by a physician whose participation status changed after the initial surgery was performed, be reimbursed appropriately based on their current participation status.

This report provides background on health plan continuity of care processes; highlights the Health Benefit Plan Network Access and Adequacy Model Act of the National Association of Insurance Commissioners (NAIC); outlines continuity of care protections of marketplace, Medicare Advantage and Medicaid health plans; summarizes relevant AMA policy and model state legislation; and presents policy recommendations.

BACKGROUND

When patients transition between health plans, or when providers, including physicians, leave or are terminated from health plan networks, patients with usual sources of care face potential care disruptions due to the need to find new in-network physicians and hospitals. Such care disruptions can be especially detrimental to patients in the middle of a course of treatment.

Some health plans have implemented continuity of care processes to prevent care disruptions for enrollees undergoing active courses of treatment. Health plan continuity of care processes can provide eligible new enrollees of a health plan undergoing an active course of treatment with a pathway to continue to receive care from non-participating providers accessed prior to health plan enrollment at in-network cost-sharing levels. For existing plan enrollees in an active course of treatment, continuity of care processes can provide a mechanism to access the care of providers no longer in the network at in-network cost-sharing levels. There are outlined time limitations for such continuity of care periods, which vary based on the health plan, physician discretion and patient needs. State and federal laws and regulations, and model laws, also provide parameters and
guidance for health plan continuity of care processes and protections. Ultimately, the goal of  
continuity of care processes is to transition affected plan enrollees to new in-network providers.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS MODEL ACT

The Health Benefit Plan Network Access and Adequacy Model Act of the NAIC, ¹ which provides a model for state legislation and regulations, contains provisions to assure continuity of care protections for health plan enrollees in an active course of treatment whose provider leaves or is removed from the plan’s network without cause. A health plan enrollee who has been treated on a regular basis by a provider removed from or leaving the network is considered under the model act to be in an active course of treatment. The following treatments and conditions meet the definition of “active course of treatment” under the model act:

- An ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted;
- An ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care that the covered person is currently receiving, such as chemotherapy, post-operative visits or radiation therapy;
- The second or third trimester of pregnancy; and
- An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

The act also states that when a provider of a health plan enrollee leaves or is removed from the network, the health plan should establish reasonable procedures to transition the plan enrollee in an active course of treatment to a participating provider in a manner that provides for continuity of care. In addition to providing the plan enrollee with notice of the provider leaving or being removed from the plan network, the model act states that the health plan also should make available to the patient a list of available participating providers in the same geographic area who are of the same provider type. Importantly, the model act stipulates that the health plan must provide information about how the plan enrollee may request to continue care with a provider that is no longer participating in the plan. The model act stresses that any health decisions made with respect to a request for continuity of care should be subject to the health benefit plan’s internal and external grievance and appeal processes in accordance with applicable state or federal law or regulations. The care to be continued must also be medically necessary.

Time limitations for the continuity of care period for health plan enrollees undergoing an active course of treatment are also outlined in the model act. Under the model act, the period should extend to the earlier of:

- The termination of the course of treatment by the covered person or the treating provider;
- A time period determined by the state, while noting that the current accreditation standard for the length of the continuity of care period is 90 days, unless the health plan’s medical director determines that a longer period is necessary;
- The date that care is successfully transitioned to a participating provider; or
• Benefit limitations under the plan are met or exceeded.

For health plan enrollees who are in their second or third trimester of pregnancy, the model act stipulates that the continuity of care period should extend through the postpartum period. Twenty-nine states have laws consistent with this provision of the model act.1

Under the model act, granting continuity of care requests is contingent upon the provider accepting certain payment and billing parameters. First, the provider must agree in writing to accept the same payment from and abide by the same terms and conditions with respect to the health plan for that patient as provided in the original provider contract. Second, the provider must agree in writing not to seek any payment from the health plan enrollee for any amount for which the enrollee would not have been responsible if the physician or provider were still a participating provider.

HEALTH PLAN CONTINUITY OF CARE PROTECTIONS

Health Insurance Marketplaces

The final rule outlining the HHS Notice of Benefit and Payment Parameters for 2017 purposefully aligns with the NAIC model act. The final rule included a new continuity of care protection for patients enrolled in plans in federally facilitated marketplaces (FFMs) undergoing an active course of treatment. The rule requires health plans participating in FFMs, in cases where a provider is terminated without cause, to allow a health plan enrollee in an active course of treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates. The regulation used the definition of “active course of treatment” included in the NAIC model act, and added that ongoing treatments for mental health and substance use disorders also fall within the definition.2

Addressing physician payment and balance billing, the Center for Consumer Information and Insurance Oversight (CCIIO) of the Centers for Medicare & Medicaid Services (CMS) stated in its 2017 letter to issuers in FFMs that it expected health plans to negotiate with a provider for payment of services under the new continuity of care protection. However, if a provider agrees to provide continuity of care under this new requirement, health plans in FFMs would only be responsible for paying a provider what was previously paid under the same terms and conditions of the provider contract, including any protections against balance billing. That being said, CCIIO also stated that it cannot require non-contracted providers to accept a particular payment rate, and as such, cannot prohibit balance billing for non-contracted providers.3

As outlined in the final rule outlining the HHS Notice of Benefit and Payment Parameters for 2017 and subsequent letters to issuers in FFMs, the new continuity of care standards for FFMs are not intended to, and do not, preempt state provider transition notices and continuity of care requirements, and CMS intends to defer to a state’s enforcement of substantially similar or stronger standards.3,4 As of April 2016, 39 states and the District of Columbia have continuity of care standards similar to those outlined in federal rules. However, the length of the continuity of care protection varies from state to state. Sixteen states extend continuity of care protections to enrollees that have switched to a new health plan, which is stronger than current federal rules. Eleven states do not have continuity of care protections as defined in the federal rule, but patients enrolled in plans offered through FFMs in some of these states will still have some continuity of care protections.2 To review the status of continuity of care protections by state, please refer to http://www.commonwealthfund.org/publications/blog/2016/apr/continuity-of-care-protections.
Medicare Advantage

Continuity of care protections for patients enrolled in Medicare Advantage (MA) plans are largely limited to cases of significant no-cause provider terminations. CMS has stated that, as a best practice, MA plans should include certain information in notices to health plan enrollees in addition to identifying the provider(s) being terminated from the network, including names and phone numbers of in-network providers that enrollees may access for continued care, and information regarding how enrollees may request continuation of ongoing medical treatment or therapies with their current providers. CMS has stated that in the case of significant no-cause provider terminations, it may be necessary for MA plans to allow care to continue to be provided on an interim, transitional basis, by providers who have been terminated from the network in order to address continuity of care needs of affected enrollees. In addition, MA plan enrollees substantially affected by a significant no-cause provider termination during a plan year may be afforded a special election period, so they can switch plans prior to the next open enrollment period.6

Medicaid

Under Medicaid, states are required to have a transition of care policy in effect to ensure continuity of care during Medicaid program transitions when an enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. The transition of care policy would be applicable during a transition from a Medicaid fee-for-service program to a Medicaid managed care plan, or a transition from one Medicaid managed care plan to another. The transition of care policy must ensure that enrollees have access to services consistent with the access they previously had, and are permitted to retain their current provider for a period of time if their providers are not in the Medicaid managed care plan’s network. In addition, enrollees must be referred to appropriate providers of services that are in the network.7

RELEVANT AMA POLICY AND ADVOCACY

Policy H-285.952 states that patients should have the opportunity for continued transitional care from physicians and hospitals whose contracts with health plans have terminated for reasons other than loss of/restrictions on their licenses/certifications or fraud. The policy states that patients eligible for transitional care should specifically include, but not be limited to those who are: undergoing a course of treatment for a serious or complex condition, undergoing a course of institutional or inpatient care, undergoing non-elective surgery, pregnant, or are terminally ill at the time that they receive notice of the termination. The policy stipulates that transitional care should be provided at the physicians’ and hospitals’ discretion, and should continue for an appropriate length of time. Physicians and hospitals also should continue to receive payment for the services provided during this transitional period. Policy H-285.924 states that health plans should continue to cover services provided by physicians who involuntarily leave a plan, for reasons other than loss of/restrictions on their medical licenses/certifications or fraud, until a new printed directory is distributed. Policy H-385.936 advocates for appropriate reimbursement for follow-up care of complications and staged procedures from payers, including state and federal agencies.

In addition, Policy H-285.952 states that when a participating physician leaves a managed care plan, patients of the physician be informed, in a timely manner, of the departure by the physician and/or the managed care plan, and, if applicable, of their right to elect continued transitional care from that physician. Policy H-285.908 supports requiring 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 selecting and enrolling in a health insurance plan.

Based on existing AMA policy, the AMA has model state legislation addressing network access and adequacy, which contains provisions to assure continuity of care protections for health plan enrollees in an active course of treatment. These provisions of the model bill largely align with those contained in the NAIC model act. In the arena of provider payment, like the NAIC model bill, AMA’s model state legislation underscores that granting continuity of care requests is contingent upon the provider accepting certain payment and billing parameters. While the NAIC model act states that the provider must agree in writing to accept the same payment from and abide by the same terms and conditions with respect to the health plan for that patient as provided in the original provider contract, the AMA model bill builds upon this language and states that the provider can also accept new payment and terms agreed to by the provider and health plan.

DISCUSSION

The Council believes that additional measures are needed to prevent disruptions in care for patients in an active course of treatment, both for new enrollees in a health plan, and existing enrollees receiving care from providers whose contracts with health plans have terminated for reasons other than loss of or restrictions on their licenses and/or certifications, or fraud. As an underlying principle, as outlined in Policy H-285.911, health insurance provider networks should be sufficient to provide meaningful access to all medically necessary and emergency care, at the preferred, in-network benefit level, on a timely and geographically accessible basis. Overall, patients, including those in an active course of treatment, should have continued access throughout the coverage year to the network they reasonably relied upon when selecting and enrolling in a health insurance plan. To achieve that goal, the Council recommends reaffirming Policy H-285.908, which supports requiring that provider terminations without cause be done prior to the enrollment period. In cases in which provider terminations without cause happen over the course of the coverage year, the Council also recommends the reaffirmation of Policy H-285.952, which states that patients should have the opportunity for continued transitional care from physicians and hospitals whose contracts with health plans have terminated for reasons other than loss of or restrictions on their licenses and/or certifications, or fraud.

The Council proposes the modification of Policy H-285.924[4] to ensure that health plans continue to cover services provided by physicians who involuntarily leave a plan without cause, until the provider directory is updated online and a new printed directory is distributed. This amendment to Policy H-285.924 not only provides needed updates to the policy to account for the existence of online provider directories, but the proposed new wording of the policy would provide patients in an active course of treatment with strong continuity of care protections. To ensure physician payment for any transitional care associated with complications and staged procedures is adequate, the Council recommends modifying Policy H-385.936, which currently only advocates for appropriate payment for follow-up care in such scenarios.

The Council recognizes that current AMA policy addressing continuity of care for patients in an active course of treatment focuses on existing health plan enrollees receiving care from providers whose contracts with health plans have terminated for reasons other than loss of or restrictions on their licenses and/or certification, or fraud. Patients in an active course of treatment who switch to a new health plan should also have the opportunity to receive continued transitional care from their treating out-of-network physicians and hospitals at in-network cost-sharing levels. Following what is already outlined in Policy H-285.952, continued transitional care for new health plan enrollees should be provided at the physicians’ and hospitals’ discretion, and should continue for an
appropriate length of time. Such care should only be provided after payment terms have been
agreed to with the health plan. Moving forward, the AMA should continue to provide assistance
upon request to state medical associations in support of state legislative and regulatory efforts, and
disseminate relevant model state legislation, to ensure continuity of care protections for patients in
an active course of treatment – both for existing and new health plan enrollees.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution
108-A-16, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policy H-285.911, which states that
health insurance provider networks should be sufficient to provide meaningful access to all
medically necessary and emergency care, at the preferred, in-network benefit level on a timely
and geographically accessible basis. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-285.908, which 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 selecting and enrolling in a health insurance plan. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-285.952, which states that patients should have the
opportunity for continued transitional care from physicians and hospitals whose contracts with
health plans have terminated for reasons other than loss of or restrictions on their licenses
and/or certifications, or fraud. (Reaffirm HOD Policy)

4. That our AMA modify Policy H-385.936 by addition and deletion to read as follows:
Our AMA advocates for appropriate reimbursement payment for follow-up care of, and
transitional care associated with, complications and staged procedures from payers, including
state and federal agencies. (Modify HOD Policy)

5. That our AMA modify Policy H-285.924[4] by addition to read as follows:
It is the policy of our AMA that health plans: ... (4) should continue to cover services provided
by physicians who involuntarily leave a plan, for reasons other than loss of/restrictions on their
medical license/certification or fraud (i.e., with cause), until the provider directory is updated
online and a new printed directory is distributed. (Modify HOD Policy)

6. That our AMA support patients in an active course of treatment who switch to a new health
plan having the opportunity to receive continued transitional care from their treating out-of-
network physicians and hospitals at in-network cost-sharing levels. Transitional care should be
provided at the physicians’ and hospitals’ discretion, after having agreed to payment terms with
the health plan. (New HOD Policy)

7. That our AMA continue to provide assistance upon request to state medical associations in
support of state legislative and regulatory efforts, and disseminate relevant model state
legislation, to ensure continuity of care protections for patients in an active course of treatment.
(Directive to Take Action)

Fiscal Note: $5,000
REFERENCES


7 Centers for Medicare & Medicaid Services. Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule. May 6, 2016. Available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf.
EXECUTIVE SUMMARY

This report responds to referred Resolution 229-A-16, “Expansion of US Veterans’ Health Care Choices,” which asked the American Medical Association (AMA) to: (1) adopt policy that the Veterans Health Administration (VHA) expand all eligible veterans’ health care choices by permitting them to use funds currently spent on them through the Veterans Affairs (VA) system, through a mechanism known as premium support, to purchase private health care coverage, and for veterans over age 65 to use these funds to defray the costs of Medicare premiums and supplemental coverage; and (2) actively support federal legislation to achieve this reform of veterans’ health care choices.

In 2014, it was discovered that thousands of veterans were waiting excessive amounts of time to access health care through the US Department of Veteran Affairs (VA). To address access issues, the Veterans Access, Choice and Accountability Act of 2014 created the Veterans Choice Program (VCP), which authorized the VA to contract with physicians in private practice to provide care to veterans who either live too far away from a VA facility or cannot access care in a VA facility in a timely manner. The VCP was set to expire in August 2017. Implementation of the VCP was challenging. The VA was given just 90 days to fully implement the nationwide program. The VA recognized continued access issues early in the implementation stage and has been working with stakeholders, including the American Medical Association (AMA), to make needed changes.

Suggesting premium support for veterans to purchase health care in the private sector is not a new concept. However, the VHA is not a health insurance plan with a tangible amount of money to give veterans to purchase private health care. The VHA is the largest integrated health care system in the US and provides highly specialized and comprehensive care that is not available to the same extent in the private sector. Importantly, feedback from veterans on the care they receive through the VHA is mostly positive and some veterans have expressed gratitude for the camaraderie they experience while receiving treatment alongside fellow veterans.

The Administration, Congress and the VA are now working together to reform the VCP rather than let it expire or privatize it. Recent legislation was enacted into law to extend the VCP beyond the sunset date of August 2017. The extension allows the program to use the remaining appropriated funds and give Congress and the VA time to work on a comprehensive reform plan.

This report provides background on the creation of the VCP; outlines efforts to redesign the VA health care delivery system; highlights stakeholder input; explains the difficulty of providing premium support to veterans; summarizes legislative activity; explains how to become a VA provider; summarizes AMA policy, advocacy and resources; discusses avenues to improve access to care for veterans; and proposes recommendations.
At the 2016 Annual Meeting, the House of Delegates referred Resolution 229-A-16, “Expansion of US Veterans’ Health Care Choices,” which was sponsored by the Ohio Delegation. Resolution 229-A-16 asked the American Medical Association (AMA) to:

1. adopt policy that the Veterans Health Administration (VHA) expand all eligible veterans’ health care choices by permitting them to use funds currently spent on them through the Veterans Affairs (VA) system, through a mechanism known as premium support, to purchase private health care coverage, and for veterans over age 65, to use these funds to defray the costs of Medicare premiums and supplemental coverage; and
2. actively support federal legislation to achieve this reform of veterans’ health care choices.

The majority of testimony on Resolution 229-A-16 requested referral for study to review the implications of allowing veterans to access health care outside of the VA through premium support, which was viewed as complicated and controversial with implications not only for the VA, but also for Medicare, the private health insurance market and the entire health care system.

This report provides background on the creation of the Veterans Choice Program (VCP); outlines efforts to redesign the veterans’ health care delivery system; highlights stakeholder input; explains the difficulty of providing premium support to veterans; summarizes legislative activity; explains how to become a VA provider; summarizes AMA policy, advocacy and resources; discusses avenues to improve access to care for veterans; and proposes a series of recommendations.

BACKGROUND

In 2014, it was discovered that thousands of veterans were waiting excessive amounts of time to access health care through the VA. To address access issues, the Veterans Access, Choice and Accountability Act of 2014 (Public Law 113-146, “Choice Act”) created the VCP, which authorized the VA to contract with physicians in private practice to provide care to veterans who either live too far away from a VA facility or cannot access care in a VA facility in a timely manner. The VCP was set to expire in August 2017.

Implementation of the VCP was challenging. The VA was given just 90 days to fully implement the nationwide program. To achieve this short timeline, the VA modified existing purchased care contracts that were not designed to handle the scope of the VCP. In addition, the VA distributed nine million choice cards, mostly to veterans who were not immediately eligible for the VCP. The
VA recognized these problems early in the implementation stage and has been working with stakeholders, including the AMA, to make needed changes.

REDESIGNING THE VETERANS’ HEALTH CARE DELIVERY SYSTEM

Blueprint for Excellence

In 2014, the VA issued a “Blueprint for Excellence,” which identified strategies to improve the performance of VHA health care, develop a positive service culture, transition from a focus on “sick care” to “health care,” and develop business systems and management processes that are efficient, transparent and accountable. In addition to the VCP, the VA maintains the following community care programs: Emergency Care, Preauthorized Care, Patient-Centered Community Care, State Veterans Home, Indian Health Services/Tribal Health Program and other benefits and services.

The Blueprint for Excellence includes a recommendation to consolidate all of the community care programs into one streamlined program and make improvements to information and billing systems. The VA has decided that maintaining all of the community care programs is unsustainable given the following challenges: varied eligibility criteria; multiple referral and authorization requirements; lack of standard care coordination model; multiple local provider contracting approaches; variable payment rates and structures; and multiple programs that result in confusion for veterans and providers. In 2015, the VA submitted a plan to Congress to consolidate the community care programs into a community care network, which is expected to be fully operational in June 2018.

Veterans Choice Act Independent Assessment

The Choice Act called for an independent assessment of 12 areas of the VA’s health care delivery system and management processes. The “Veterans Choice Act Independent Assessment,” issued in 2015, identified the following four systemic problems: a disconnect in the alignment of demand, resources and authorities; uneven bureaucratic operations and processes; non-integrated variations in clinical and business data and tools; and leaders not fully empowered due to a lack of clear authority, priorities and goals. To address these issues, the independent assessment developed recommendations to improve the VHA system. A subsequent review found that the VHA is making progress on implementing the suggested changes.

Commission on Care

In accordance with the Choice Act, a “Commission on Care” (the Commission) was also established to evaluate the health care that veterans had been receiving. Released in 2016, the Commission’s final report concluded that although care delivered by the VA is in many ways comparable or better in clinical quality to that generally available in the private sector, it is inconsistent from facility to facility. The Commission outlined a series of recommendations, many of which are already being implemented as part of the ongoing “MyVA initiative.”

MyVA Initiative

The “MyVA initiative” is considered the largest department-wide transformation in the VA’s history and has reportedly been very successful. In 2016, the VHA scheduled about 58 million appointments, which accounts for 1.2 million more than were scheduled in 2015 and almost 3.2 million more than in 2014. In September 2016, about 96 percent of appointments were completed.
within 30 days of the clinically indicated or veteran’s preferred date. About 91 percent of these appointments were scheduled within 14 days, about 85 percent within 7 days and about 22 percent on the same day. The average wait time for primary care appointments was reportedly about five days, for specialty care about six days and for mental health care about two days.7

VHA and VCP contractors authorized appointments for more than 3 million veterans to receive care in the private sector from February 1, 2015, through January 31, 2016. The number of authorized appointments represents a 12 percent increase compared to the same time period a year earlier.8

STAKEHOLDER INPUT

Many veterans’ organizations (i.e., Disabled American Veterans, The American Legion, Military Order of the Purple Heart, Vietnam Veterans of America, Veterans of Foreign Wars, Paralyzed Veterans of America, AMVETS, and Iraq and Afghanistan Veterans of America) have emphasized that reform efforts should focus on strengthening the VA health care system, not dismantling it. These organizations specifically called for reform efforts to be based on veterans’ health care needs and preferences, and have voiced concerns about coordination of care, the quality of medical services and the health outcomes for veterans receiving health care in the private sector. The organizations concluded in a statement that “we are confident that any objective, unbiased analysis of all the relevant data and evidence about the VA health care system compared to private sector health care will demonstrate the benefits of maintaining and strengthening a dedicated veterans’ health care system.”9

PREMIUM SUPPORT FOR VETERANS

Suggesting premium support for veterans to purchase health care in the private sector is not a new concept. Proponents have suggested providing veterans with a choice of accessing private health care regardless of the distance from their residence to the nearest VA facility or how long it takes to make an appointment within the VA. Opponents have argued that premium support for veterans would essentially be a voucher and may not cover all necessary services. One proposal has suggested privatizing health care for all veterans by phasing out VA health care facilities over the next 20 years.10

The VHA is not a health insurance plan with a tangible amount of money to give veterans to purchase private health care. The VHA is the largest integrated health care system in the US, consisting of 150 medical centers, and approximately 1,400 community-based outpatient clinics, community living centers, vet centers and domiciliaries. The VHA medical centers provide a wide range of services including traditional hospital-based services, medical and surgical specialty services, and advanced services such as organ transplants and plastic surgery.

In addition, the VHA provides unique, highly specialized care for many medical conditions, such as spinal cord and traumatic brain injuries, which are not available to the same extent outside of the VHA. The VHA provides a comprehensive, multidisciplinary approach that allows providers to address the full spectrum of veteran needs beyond physical medical care, such as behavioral health care, rehabilitation, vocational training and educational assistance. Some veterans have expressed gratitude for the camaraderie they experience while receiving treatment alongside fellow veterans.

Veterans provided input on privatizing the VHA during the Commission’s evaluation. The majority opposed privatizing the VHA, with a minority wanting more access to non-VA providers. The Disabled American Veterans shared with the Commission a compilation of more than 4,000
verbatim comments on veterans’ health care experiences, which indicated that approximately 82 percent reported overall positive experiences.11

LEGISLATIVE ACTIVITY

The Administration, Congress and the VA are working together to reform the VCP rather than let it expire or privatize it. Recent legislation was enacted into law to extend the VCP beyond the sunset date of August 2017. The extension allows the program to use the remaining appropriated funds and give Congress and the VA time to work on a comprehensive reform plan.

BECOMING A VA PROVIDER

The AMA encourages physicians to become VA providers. Physicians can sign up on the following website: https://www.hnfs.com/content/hnfs/home/va/provider/options-for-providers.html

Interested physicians can register to become a provider for just the VCP or for all the community care programs. Physicians can download a non-VA provider fact sheet at https://www.ama-assn.org/sites/default/files/media-browser/public/washington/veterans-affairs-fact-sheet-for-non-va-medical-care-program_1.pdf for a summary of the conditions of participation and other requirements that are included in the VCP application process.

Adequate and prompt payments by the VA have been long-standing problems, which can deter physicians from providing services to veterans. The VCP pays Medicare rates, but the other community care programs pay less. To address payment delays, in 2012 the Veterans Benefits Administration created a new electronic claims processing system, the Veterans Benefits Management System, to process claims faster, more efficiently and more accurately. From 2013-2016, the new system allowed the VA to reduce the backlog of disability claims by 87 percent.12

RELEVANT AMA POLICY

The AMA supports providing full health benefits to eligible veterans to ensure they can access the medical care they need outside the VA in a timely manner (Policy H-510.986[2,3]).AMA Policy H-510.990 encourages the VA to continue exploring alternative mechanisms for providing quality health care coverage for veterans.

The AMA supports approaches that increase the flexibility of the VA to provide all veterans with improved access to health care services (Policy H-510.991). Policy H-510.985[1] calls on the AMA to continue advocating for improvements to legislation regarding veterans’ health care to ensure timely access to primary and specialty health care within close proximity to a veteran’s residence within the VA health care system. Policy H-510.985[2] calls on the AMA to monitor implementation of and support necessary changes to the VCP “Choice Card” to ensure timely access to primary and specialty health care within close proximity to a veteran’s residence outside of the VA health care system.

The AMA urges all physicians to participate, when needed, in providing health care to veterans (Policy H-510.986).AMA Policy H-510.985[4] advocates that the VA pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician. The AMA has long advocated that payers should pay for clean claims submitted electronically within 14 days and paper claims within 30 days (Policy H-190.981).
The AMA urges the VA to hire additional primary and specialty physicians as needed and to enhance its loan forgiveness efforts to help with physician recruitment and retention, and to improve patient access in VA facilities (Policies H-510.985[5] and D-510.990).

The AMA supports improved access to health care for veterans, including in the civilian sector, for returning military personnel when their needs are not being met by locally available resources through the Department of Defense or the VA (Policies H-510.985, H-510.990, H-510.991 and D-510.994). Policy H-510.986 encourages state and local medical societies to create a registry of physicians who are willing to provide health care to veterans in their community.

AMA ADVOCACY AND RESOURCES

The AMA strongly supported passage of the Choice Act, which created the VCP, and supports bipartisan efforts to make the VCP permanent, and to streamline the registration process for non-VA providers. The AMA has been actively involved in helping to shape and monitor implementation of the VCP. For example, the AMA sent a letter to the VA in March 2015, urging it to change the way it calculated the 40 mile distance criteria from a straight line to the time it takes for a veteran to travel to the nearest VA medical facility.\textsuperscript{13} AMA advocacy efforts were instrumental in influencing the VA to change the distance criteria in April 2015, which expanded eligibility for the VCP.\textsuperscript{14}

In addition to meetings and other communications with VA officials, the AMA submitted statements on proposed legislation to improve the VCP to the Senate Committee on Veterans’ Affairs in March 2016, and to the House Committee on Veterans’ Affairs in May 2016.\textsuperscript{15,16} The AMA continues to work with the Committees on Veterans’ Affairs to streamline programs, improve access to care and encourage participation by non-VA physicians and other providers. The AMA has communicated the following to the committees:

\textbf{Consolidation of Programs:} The AMA strongly supports the improvement and consolidation of the VCP to streamline and eliminate confusion and duplication between community care programs. The AMA believes that creating efficiencies and reducing administrative costs will benefit both veterans and physicians and encourage greater participation.

\textbf{Access to Specialty Care:} The AMA recognizes that a lack of access to specialty care in VA-based facilities is further complicated by provisions that require a minimum 40 mile driving distance, in addition to the lack of necessary specialists at VA community-based outpatient clinics.

\textbf{Agreements/Contracts with Providers:} The AMA supports using provider agreements between the VA and private physicians, similar to those for Medicare and Medicaid, which could help alleviate some of the burdensome compliance issues associated with federal contractors.

\textbf{Billing and Payment:} The AMA supports efforts to reform billing and reimbursement, such as to standardize provider payment rates using Medicare rates as a “floor” and not a “ceiling” (especially in regions with high demand and low supply of care specialists). Improving the VA’s reimbursement processes would alleviate complaints that physicians and other providers have tied to the VCP in terms of administrative hassles and payment delays.

\textbf{Electronic Billing:} The AMA does not advocate for the strict mandate that all claims should be submitted electronically. Rather, it encourages a system similar to Medicare that allows certain exceptions, especially for smaller practices.
Tiered Networks: The AMA is very concerned about proposed plans to create tiered networks, especially in the absence of clear guidelines about differentiations in “high-value care.” The AMA urges extreme caution that the VCP doesn’t experience problems similar to those sometimes resulting from the Affordable Care Act, in which tiering narrowed networks and reduced access.

Value-Based Payment Modifier: The AMA is strongly opposed to the use of a value-based payment modifier (VBM). Because the VBM was developed to measure hospital populations, it may be inadequate for accurately measuring services provided by physicians’ offices. Reports suggest that practices with the sickest patients fare poorly under the VBM. The AMA believes that more analysis of the VBM and its results are needed before it is applied to programs like the VCP.

The AMA has resources and advocacy materials located at: https://www.ama-assn.org/search/ama-assn/veterans. The AMA also has veterans’ health resources for medical professionals located at: https://www.ama-assn.org/delivering-care/veterans-health-resources-medical-professionals.

DISCUSSION

Since the access issues in 2014, the VA has made concerted efforts to improve the care it provides to veterans and has made substantial strides, but improvements are still necessary. Given the extensive input the AMA has been providing, and the progress that is being made by the VA, the Council recommends that the AMA continue to work with the VA to provide quality care, support efforts to improve the VCP, and make it a permanent program.

The VA is aware that veterans need to be able to access medical care in the private sector when it is not available through the VHA. The Council suggests reaffirming Policy H-510.985, which supports necessary changes to the VCP to ensure timely access to primary and specialty health care within close proximity to a veteran’s residence outside of the VA health care system. In addition, the Council believes the AMA should encourage the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care.

The Council suggests supporting consolidation of all the VA community care programs to streamline and eliminate confusion and duplication. Creating efficiencies and reducing administrative costs will benefit both veterans and physicians and encourage greater participation.

The VCP has been reviewed by numerous external agencies since implementation. The Council suggests the VA use external assessments as necessary to identify and address systemic barriers to care. The Council also suggests that the AMA support interventions to mitigate barriers to the VA from being able to achieve its mission.

The lack of adequate and prompt payments by the VA has been a long-standing problem that can deter physician participation. The VCP pays Medicare rates, but lower payment rates have been negotiated for the other community care programs by third party administrators based on regional/local trends. Other local contracts between VA medical centers and individual practices have also been negotiated at lower rates. The Council’s recommended reaffirmation of Policy H-510.985 reiterates AMA support for the VA to pay private physicians a minimum of 100 percent of Medicare rates.

While the VA has demonstrated progress in making prompt payments, there is room for improvement. The AMA has long advocated that payers should pay for clean claims submitted
electronically within 14 days and paper claims within 30 days (Policy H-190.981). The Council recommends that the VA provide payments within the same timeframe.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 229-A-16 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) continue to work with the Veterans Administration (VA) to provide quality care to veterans. (New HOD Policy)

2. That our AMA continue to support efforts to improve the Veterans Choice Program (VCP) and make it a permanent program. (New HOD Policy)

3. That our AMA reaffirm Policy H-510.985, which supports changes to the VCP to ensure timely access to primary and specialty health care within close proximity to a veteran’s residence outside of the VA health care system and advocates that the VA pay private physicians a minimum of 100 percent of Medicare rates. (Reaffirm HOD Policy)

4. That our AMA encourage the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care, and that the VA develop criteria by which individual veterans may request alternative pathways. (New HOD Policy)

5. That our AMA support consolidation of all the VA community care programs. (New HOD Policy)

6. That our AMA encourage the VA to use external assessments as necessary to identify and address systemic barriers to care. (New HOD Policy)

7. That our AMA support interventions to mitigate barriers to the VA from being able to achieve its mission. (New HOD Policy)

8. That our AMA advocate that clean claims submitted electronically to the VA should be paid within 14 days and that clean paper claims should be paid within 30 days. (New HOD Policy)

Fiscal Note: Less than $500
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13 AMA letter to the VA. Re: Expanded Access to Non-VA Care through the Veterans Choice Program. 2015.
EXECUTIVE SUMMARY

Expanding Medicaid eligibility to most individuals with incomes up to 138 percent of the federal poverty level was a key element of the strategy to expand health insurance coverage under the Affordable Care Act of 2010 (ACA, Public Law 111-148) and made the biggest impact by accounting for 63 percent of coverage gains in 2014. Medicaid expansion resulted in an estimated 11 million newly enrolled beneficiaries in 2015. The program currently covers approximately 73 million beneficiaries nationwide.

In March 2017, the American Health Care Act (AHCA), aimed to repeal and replace the ACA, was introduced in the US House of Representatives. The AHCA proposed to discontinue funding Medicaid expansion programs and cap federal Medicaid funding to states. At the time this report was written, there had been no vote on the proposed legislation. With this legislative proposal, in addition to others aimed at capping federal Medicaid funding, the Council has reviewed and identified potential issues that could arise if federal Medicaid funding is capped.

This report provides background on the Council’s previous consideration of Medicaid block grants; explains Medicaid funding; identifies the beneficiaries covered under Medicaid; outlines proposed mechanisms to cap federal Medicaid funding; highlights state and local input to congressional leaders and summarizes American Medical Association (AMA) policy and activity. The report discusses and recommends safeguards to ensure that patients have access to care, physicians are adequately paid, and states are able to provide care to their Medicaid beneficiaries in the event that federal Medicaid funding is capped.
Expanding Medicaid eligibility to most individuals with incomes up to 138 percent of the federal poverty level (FPL) was a key element of the strategy to expand health insurance coverage under the Affordable Care Act of 2010 (ACA, Public Law 111-148) and made the biggest impact by accounting for 63 percent of coverage gains in 2014. Medicaid expansion resulted in an estimated 11 million newly enrolled beneficiaries in 2015. The program currently covers approximately 73 million beneficiaries nationwide.

Proposals are being considered to reform Medicaid from an entitlement program, which covers all eligible individuals and guarantees federal funding for part of the cost of a state’s program, to a program with fixed federal funding. The recent proposed reforms would cap federal Medicaid funding either through block grants or per capita caps. The effects that such reforms would have on patient access to care, physician payment, and state Medicaid programs is uncertain and has led the Council to review and identify potential issues that could arise if federal Medicaid funding is capped.

This report provides background on the Council’s previous consideration of block grants; explains Medicaid funding; identifies the beneficiaries covered under Medicaid; outlines proposed mechanisms to cap federal Medicaid funding; highlights state and local input to congressional leaders; summarizes American Medical Association (AMA) policy and activity; discusses potential safeguards to ensure that patients have access to care, physicians are adequately paid and states are able to provide care to their Medicaid beneficiaries. The Council proposes a series of recommendations.

BACKGROUND

The Council previously considered Medicaid block grants in Council Report 5-I-11, “Medicaid Waivers and Maintenance of Effort Requirements.” The report included a recommendation for the AMA to support giving states the option to convert Medicaid from an entitlement program to a block grant program only if certain safeguards were in place. The reference committee and House of Delegates opposed the recommendation due to concerns about patient access to care and physician payment under a block grant scenario. Testimony focused on the merits of providing states with the option to convert funding for their Medicaid programs into block grants, but did not discuss the recommended safeguards.

In 2011, capping federal Medicaid funding was not being considered by Congress and the Administration as urgently as it has been this year. In March 2017, the American Health Care Act (AHCA), aimed to repeal and replace the ACA, was introduced in the US House of...
Representatives. The AHCA proposed to discontinue funding Medicaid expansion programs and cap federal Medicaid funding to states. At the time this report was written, there had been no vote on the proposed legislation. With this legislative proposal, in addition to others aimed at capping federal Medicaid funding, the Council believes it is timely to consider how to help ensure that low-income patients have health care coverage, physicians are able to continue to treat them, and states are financially able to pay for services.

**MEDICAID FUNDING**

The Federal Medical Assistance Percentage (FMAP) determines the amount of money the federal government contributes to a state’s Medicaid program and is designed so the federal government pays a larger percent of Medicaid costs in states with overall lower per capita incomes as compared to the national average. The FMAP contributes at least 50 percent of a state’s Medicaid expenses and no more than 83 percent. For fiscal year 2017, the District of Columbia and seven states (AL, ID, KY, MS, NM, SC, and WV) are receiving 70 percent or more of their Medicaid funding from the federal government. Under the ACA, Medicaid expansion states received an enhanced FMAP initially covering 100 percent of states’ costs for newly eligible beneficiaries. In 2017, as outlined in the ACA, the enhanced FMAP has phased down to cover 95 percent of expansion states’ Medicaid costs for newly eligible beneficiaries and will phase down to 90 percent in 2020. At least eight states (AR, AZ, IL, IN, MI, NH, NM and WA) that expanded Medicaid have statutory triggers to end their expansion programs if the enhanced federal match rates are decreased or discontinued.

**MEDICAID BENEFICIARIES**

Medicaid provides coverage to children, pregnant women, elderly adults, people with disabilities, and eligible low-income adults. About one-quarter of Medicaid beneficiaries are elderly and disabled and account for two-thirds of all Medicaid spending. While children account for about half of Medicaid enrollees, they account for only one-fifth of the program’s spending.

Medicaid is the largest insurer for children in the country. From 2013-2015, the rate of uninsured children decreased from 7.1 percent to 4.8 percent, thereby increasing health insurance coverage for children to 95 percent. The decrease in the number of uninsured children coincided with the implementation of the ACA. Approximately 35.7 million children receive their health care through Medicaid, which provides guaranteed coverage, comprehensive and preventive health care services through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, and cost-sharing protections. The long-term effects on children covered through Medicaid include better health and lower rates of mortality that last into adulthood.

The expansion of Medicaid has been critical in helping many states cope with the increased demand for mental health and substance abuse treatment as a result of the ongoing crisis of opioid abuse and addiction. Low-income adults with serious mental health illnesses are 30 percent more likely to receive treatment if they are enrolled in Medicaid than if they are not enrolled. Medicaid expansion has provided an opportunity to improve the health of women, thereby ensuring healthy pregnancies and newborns.

**CAPping FEDERAL MEDICAID FUNDING**

Recent proposals to cap Medicaid funding seek to control federal Medicaid costs by providing less financial assistance to states in return for allowing more flexibility in administering their Medicaid programs. Federal savings would come from capping funding to states based on current or
Medicaid enrollment fluctuates and can change dramatically depending on factors outside of a
state’s control, such as economic downturns, natural disasters (e.g., Hurricane Katrina), epidemics
(e.g., HIV), or treatment innovations (e.g., for Hepatitis C). If Medicaid funding is capped through
block grants or per capita caps, the unpredictable fluctuations in state enrollment may make it
difficult for states to balance their budgets.

Capping federal Medicaid funding may be viewed as advantageous by some states and not by
others. While a cap may not provide as much financial support as some states want, other states
may welcome the opportunity for more flexibility in managing their programs. The impact of a
federal Medicaid funding cap could lead state Medicaid programs to cap enrollment, implement
wait lists, restrict eligibility, eliminate or restrict benefits, or decrease provider payment rates.
States could be permitted to impose work requirements, terminate coverage for beneficiaries who
are considered non-compliant, or begin charging significant cost-sharing amounts that may cause
low-income individuals to forgo coverage entirely or go without needed care.

STATE AND LOCAL INPUT

Governors, Medicaid directors, and mayors have all expressed concerns to Congress about the
potential change in Medicaid financing. The National Governors Association (NGA) has requested
that Congress maintain an open dialogue with governors and incorporate their suggestions
throughout the legislative process. Specifically, the NGA requested that a meaningful federal role
in the federal-state partnership be maintained and that costs do not shift to states. The National
Association of Medicaid Directors has requested that the Trump Administration and congressional
leaders form an expert workgroup of Medicaid Directors to provide technical expertise on any
Medicaid proposals. The United States Conference of Mayors has urged Congress to take into
consideration the impact that a repeal of the ACA would have on their residents and expressed their
opposition to converting Medicaid to block grants.

RELEVANT AMA POLICY

The AMA continues to assign a high priority to the problem of the uninsured and underinsured and
continues to work toward national consensus on providing access to adequate health care coverage
for all (Policy H-165.904[3]). The AMA supports continuous, affordable coverage and minimal, if
any, copays for low-income individuals (Policies H-165.920, H-165.855, H-290.982, and
H-165.845) and advocates for coverage that allows individual choice of health plans and benefits

Long-standing AMA policies support maintaining Medicaid as a safety net program for the
nation’s most vulnerable populations and eligibility expansions of Medicaid with the goal of
improving access to health care coverage to otherwise uninsured groups (Policies H-290.974 and
H-290.986). The AMA advocates that Medicaid reform not be undertaken in isolation, but rather in
conjunction with broader health insurance reform, in order to ensure that the delivery and financing
of care results in appropriate access and level of services for low-income patients (Policy
H-290.982).

The AMA opposes payment cuts in Medicaid budgets that may reduce patient access to care and
undermine the quality of care provided to patients; advocates that Medicaid budgets need to expand
adequately to adjust for factors such as cost of living, the growing size of the population, and the
The AMA advocates that state governments be given the freedom to develop and test different models for improving coverage for patients with low incomes, such as converting Medicaid from a categorical eligibility program to one that allows for coverage of additional low-income persons based solely on financial need. The AMA supports changes in federal rules and financing to support the ability of states to develop and test such alternatives without incurring new and costly unfunded federal mandates or capping federal funds (Policy D-165.966). The AMA encourages state waiver demonstrations for low income adults living between their state’s Medicaid income eligibility and 138 percent FPL (Policies H-290.966, H-165.855, D-165.966, and D-290.979).

Physician participation in the Medicaid program is encouraged by the AMA in order to support access to care (Policy H-290.982[12]). The AMA has long advocated that Medicaid payment rates for physician providers should be at minimum 100 percent of Medicare rates to increase and maintain access to health care for all (Policy H-385.921). The AMA will continue to advocate that the Centers for Medicare & Medicaid Services (CMS) provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services (Policy H-290.965[8]).

The AMA opposes any efforts to repeal the Medicaid maintenance of effort requirements as outlined in the ACA and American Recovery and Reinvestment Act, which mandate that states maintain eligibility levels for all children in Medicaid until 2019 (Policy H-290.969). The AMA recognizes the importance of the EPSDT program and advocates that children qualified for Medicaid receive benefits with no cost-sharing obligations (Policies H-165.855, D-290.987, D-290.985, and H-290.987).

Policy H-290.965[10] supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016 and supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the ACA’s Medicaid expansion exists.

AMA ACTIVITY

In January 2017, the AMA sent its health system reform objectives to members of Congress. Key objectives include ensuring that individuals currently covered do not become uninsured; that low/moderate income patients are able to secure affordable and adequate coverage; and that Medicaid and other safety net programs are adequately funded.

In response to the March 2017 release of the AHCA, the AMA sent a letter to congressional leaders outlining reasons for not supporting the proposed legislation as written. With respect to proposed changes to the Medicaid program, the AMA emphasized support for increased flexibility in the Medicaid program so that states may pursue innovations that improve coverage for patients with low incomes. The AMA indicated its concern with the proposed rollback of the Medicaid expansion under the ACA. Medicaid expansion has proven highly successful in providing coverage for lower income individuals. Beyond the expansion, the underlying structure of Medicaid financing ensures that states are able to react to economically driven changes in enrollment and increased health care needs driven by external factors. The Medicaid program, for example, has been critical in helping many states cope with the increased demand for mental health and substance abuse treatment as a result of the ongoing crisis of opioid use. Changes to the program,
therefore, that limit the ability of states to respond to changes in demand for services threaten to
force states to limit coverage and increase the number of uninsured. 17,18

The AMA has encouraged state medical associations to share their perspectives with their
governors. The AMA is working with states to identify common priorities across the Federation
and coordinate related advocacy activities.

DISCUSSION

Since capping federal Medicaid funding is being considered by Congress, the Council reviewed its
previously proposed, but not adopted, recommendation on capping federal Medicaid funding and
reconsidered it in the current context. Consistent with policy supporting state flexibility without
capping federal funds (D-165.966), the Council recommends that safeguards be established in the
event that federal funding is capped so that patients have access to care, physicians are adequately
paid, and states are able to sustain their Medicaid programs.

The Council believes that individuals, including children and adolescents, who are currently
eligible for Medicaid should not lose their coverage, and federal funding for the amount, duration,
and scope of currently covered benefits should not be reduced. This recommendation is aimed to
help ensure that all eligibility groups (low-income adults, children, pregnant women, elderly adults,
and people with disabilities) continue to receive the same level of services if federal Medicaid
funding is capped.19 Of importance, the positive impact that Medicaid has on children’s access to
health care needs to be preserved.

The Council believes that the amount of federal funding available to states must be sufficient to
ensure adequate access to all Medicaid statutorily required services, which include: hospital care;
nursing home care; physician services; laboratory and x-ray services; immunizations and other
EPSDT services for children; family planning services; federally qualified health center and rural
health clinic services; and nurse midwife and nurse practitioner services. In addition, the ten
essential health benefits the ACA requires for health plans are statutorily required for the Medicaid
expansion population.20

The Council believes that any cost savings mechanisms that are implemented due to capping
federal Medicaid funding should not decrease patient access to quality care or physician payment.
Section 1902(a)(30)(A) of the Social Security Act, also known as the “equal access” provision of
Medicaid, requires that states have procedures in place to ensure that provider payment rates are
“sufficient to enlist enough providers so that care and services are available under the plan at least
to the extent that such care and services are available to the general population in the geographic
area.” The AMA has advocated that CMS should provide strict oversight to ensure that states are
setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient
physician participation so that Medicaid patients can access necessary services in a timely
manner.21

The Council believes that the methodology for calculating the federal funding amount should take
into consideration the state’s ability to pay for health care services, the rate of unemployment, the
concentration of low income individuals, population growth, and overall medical costs. Currently,
the FMAP determines the amount of money the federal government contributes to a state’s
Medicaid program and is designed so the federal government pays a larger percent of Medicaid
costs for states with poorer populations. For fiscal year 2017, the District of Columbia and seven
states are receiving 70 percent or more of their Medicaid funding from the federal government. If
federal Medicaid funding is capped, states will still need adequate federal financial assistance to
provide care to their residents and some states will need more assistance than others. The FMAP is able to respond to fluctuations in the financial needs of state Medicaid programs, whereas block grants and per capita caps are not.

The Council believes that the federal funding amount should be based on the actual costs of health care services for each state. The federal government should continue to fund the ACA Medicaid expansion populations in states that have expanded Medicaid. States that have not expanded Medicaid should be given the opportunity to do so with additional federal funding to cover their newly eligible populations. To date, 31 states and the District of Columbia have expanded Medicaid, which has resulted in approximately 11 million newly insured individuals who are now able to access health care – some for the first time. Even with this coverage gain, approximately three million uninsured adults in non-expansion states fall into the “coverage gap” of earning too much to qualify for Medicaid in their states, but too little (i.e., less than 100 percent of the federal poverty level) to qualify for subsidies to purchase health insurance through the health insurance marketplace.

The Council believes that the federal funding amount should be indexed to accurately reflect changes in actual health care costs or state-specific trend rates, not on a preset growth index such as the consumer price index (CPI). Historically, US health care spending has grown faster than most other sectors of the economy. Some proposals to cap federal Medicaid funding suggest using the CPI to determine the yearly increase in federal funding to states. The CPI is the most widely used measure of inflation and represents goods and services purchased for consumption, such as medical care; but it also includes food and beverages, housing, apparel, transportation, recreation, education, communication, and additional goods and services.

The Council believes that maximum cost-sharing requirements should not exceed five percent of family income. Current federal regulations stipulate that Medicaid premiums and cost-sharing incurred by all individuals in the Medicaid household may not exceed an aggregate limit of five percent of the family’s income applied on either a quarterly or monthly basis, as specified by the relevant agency. Medicaid coverage should be affordable and cost-sharing mechanisms, such as premiums, deductibles and co-payments, should be calculated according to a sliding scale based on income.

The Council believes that the federal government should monitor the impact of capping federal Medicaid funding to ensure that patient access to care, physician payment, and the ability of states to provide health care to their residents has not been compromised.

Finally, the Council suggests urging Congress and the Department of Health and Human Services to take into consideration the concerns and input of the AMA and interested state medical associations, national medical specialty societies, governors, Medicaid directors, mayors, and other stakeholders in the process of developing federal legislation, regulations, and guidelines on capping federal Medicaid funding.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) advocate for the following safeguards if federal Medicaid funding is capped:
a. Individuals, including children and adolescents, who are currently eligible for Medicaid should not lose their coverage, and federal funding for the amount, duration, and scope of currently covered benefits should not be reduced;

b. The amount of federal funding available to states must be sufficient to ensure adequate access to all statutorily required services;

c. Cost savings mechanisms should not decrease patient access to quality care or physician payment;

d. The methodology for calculating the federal funding amount should take into consideration the state’s ability to pay for health care services, rate of unemployment, concentration of low income individuals, population growth, and overall medical costs;

e. The federal funding amount should be based on the actual cost of health care services for each state;

f. The federal funding amount should continue to fund the Affordable Care Act (ACA) Medicaid expansion populations in states that have expanded Medicaid and provide non-expansion states with the option to expand Medicaid with additional funding to cover their expansion populations;

g. The federal funding amount should be indexed to accurately reflect changes in actual health care costs or state-specific trend rates, not on a preset growth index (e.g., consumer price index);

h. Maximum cost-sharing requirements should not exceed five percent of family income; and

i. The federal government should monitor the impact of capping federal Medicaid funding to ensure that patient access to care, physician payment and the ability of states to sustain their programs has not been compromised. (New HOD Policy)

2. That our AMA advocate that Congress and the Department of Health and Human Services take into consideration the concerns and input of the AMA and interested state medical associations, national medical specialty societies, governors, Medicaid directors, mayors, and other stakeholders during the process of developing federal legislation, regulations, and guidelines on modifications to Medicaid funding. (New HOD Policy)

Fiscal Note: Less than $500
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EXECUTIVE SUMMARY

The Affordable Care Act (ACA) placed a high value on preventive services by requiring all individual and small group health plans to cover select preventive services with no cost-sharing. These “first-dollar” services are those recommended by the US Preventive Services Task Force, the Advisory Committee on Immunization Practices, the Health Resources and Services Administration Bright Futures Project, and the Institute of Medicine Committee on Prevention Services for Women (now called the Women’s Preventive Services Institute). The American Medical Association (AMA) and/or the Federation of medicine are involved in each of these four expert committees.

The combined recommendations for coverage from the four committees named by the ACA include more than 100 tests and treatments that are now free of any cost-sharing for appropriate populations. Policymakers have raised concerns that first-dollar coverage of such a high number of services results in misvaluation and a lack of prioritization of services that are most beneficial. In addition, concerns have been raised about the ACA’s value-based coverage of screening for chronic diseases (primary prevention), but lack of value-based coverage for treatment of discovered illness (secondary prevention). The Council on Medical Service and the Council on Science and Public Health collaborated to address these concerns, with the overarching goal of removing barriers to primary and secondary preventive services that are cost effective.

In this report, the Councils describe each of the four expert guidelines-recommending committees, including a comparison of the differences and synergies in their methods, and their AMA and Federation representation; provide a summary of secondary prevention; discuss evidence on the prioritization of preventive services, including the imperative to consider the cost of care; and highlight relevant AMA policy. The Councils present recommendations focused on facilitating the work of the expert committees, and also engagement from relevant national medical specialty societies, comparative-effectiveness researchers, and public and private payers.
JOINT REPORT OF THE COUNCIL ON MEDICAL SERVICE
AND THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CMS/CSAPH Joint Report A-17

Subject: Value of Preventive Services

Presented by: Peter S. Lund, MD, Chair, Council on Medical Service
S. Bobby Mukkamala, MD, Chair, Council on Science and Public Health

Referred to: Reference Committee A
(John Armstrong, MD, Chair)

The Affordable Care Act (ACA) focused on prevention by requiring all individual and small group non-grandfathered health insurance plans to cover the preventive services, with no cost-sharing, recommended by the US Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), the Health Resources and Services Administration (HRSA) Bright Futures Project, and the Institute of Medicine (IOM) Committee on Preventive Services for Women (now known as the Women’s Preventive Services Institute or WPSI).

Policymakers have raised concern that the number of preventive services covered with no cost-sharing is excessive and includes services that do not merit such “first dollar” coverage. At the same time, concerns have been raised that some high value services, such as secondary preventive services that reduce hospitalizations and morbidity, can be unaffordable for some patients, particularly with increased patient cost-sharing in the form of deductibles and coinsurance.

The Councils believe both concerns merit consideration and that the American Medical Association (AMA) is in a position to promulgate policies that remove barriers to preventive services that are evidence-based and cost effective. This report describes how preventive services are identified as such, notes the importance of secondary prevention, highlights concerns about health care costs, and includes a discussion regarding prioritization of preventive services. The Councils provide recommendations with the goal of right-sizing coverage of preventive services.

BACKGROUND

The combined recommendations for coverage from the four committees named by the ACA include more than 100 tests and treatments that are now free of any cost-sharing for appropriate populations (e.g., folic acid supplements for women of child-bearing age, diabetes screening in people who are over 40 and obese, age-specific vaccinations for infectious diseases, etc.). Each of these committees develops its own criteria for evaluating and recommending what constitutes preventive services.

Cost-sharing, particularly the growth of deductible amounts, has attracted the attention of policymakers and the media. Deductible growth was occurring prior to enactment of the ACA. In 2013, the year before the key coverage provisions of the ACA were implemented, the Urban Institute reported that 44.4 percent of adults with incomes above 138 percent of the federal poverty level with nongroup (individual) coverage had annual per-person deductibles of at least $2,000, compared with 23.3 percent of adults with employer-sponsored insurance (ESI).1
Under the ACA, the trend has continued for ESI as well as for ACA exchange policies. In the benchmark silver plans of the ACA marketplaces, combined medical and pharmaceutical deductibles grew 20 percent to $3,703 in 2017 (combined deductibles in gold and platinum plans declined in 2017, the first such decline since 2014). Individuals with incomes less than 250 percent of the federal poverty level receive cost-sharing subsidies that can substantially reduce their cost-sharing obligations.

Because of the preventive service benefits of the ACA, CMS estimates that exchange policies cover seven common health care services (most often generic drugs and primary care visits) in addition to preventive services, with no or low cost-sharing before patients meet their deductibles. Accordingly, deductibles may not apply to the most frequent health care needs of some patients. Non-grandfathered ESI plans also cover the ACA-mandated preventive services with no cost-sharing.

Recommendations for diagnostic tests and secondary prevention services that can reduce hospitalizations and morbidity typically are not developed by the four expert committees named in the ACA. Perhaps accordingly, cost-sharing for such services varies by plan, with no consensus that an evidence base exists to support value-based benefit design decisions.

During the drafting of this report, the ACA “repeal and replace” legislation, the American Health Care Act of 2017, would have removed the requirement that plans offer an essential health benefit package. Proponents of this approach believe that doing so would provide health insurers more flexibility in their plan designs, including offers of less comprehensive coverage at lower cost. The Congressional Budget Office (CBO) announced in December 2016 that in order for it to analyze the cost of any proposal, coverage will have to meet two criteria: 1) coverage must at a minimum cover high-cost medical events and various services, including those provided by physicians and hospitals; and 2) coverage must adhere to ACA regulations to the extent that the regulations are still in effect. Accordingly, CBO would not be able to score “mini-med” plans that offer limited benefits. Particularly given the uncertainty over what legislation will be introduced, the Councils agreed to proactively consider policy modifications that may be helpful in guiding AMA advocacy.

PREVENTIVE SERVICES GUIDELINES GROUPS

Under the ACA, recommendations of the USPSTF, ACIP, Bright Futures, and WPSI are required to be covered with no cost-sharing by private insurers. Even prior to the ACA, the Councils note that the recommendations of these committees resulted in significant benefits for public health, such as substantial reductions in pediatric morbidity and mortality after widespread implementation of childhood vaccine recommendations. Additional information about the four groups follows.

USPSTF. Administered and funded by the Agency for Healthcare Research and Quality, the USPSTF develops recommendations for preventive services performed mainly by primary care physicians, usually in asymptomatic pediatric and adult patient populations. The ACA mandates coverage of all “A” and “B” recommendations (those that recommend a service be performed). Currently, there are 50 “A” and “B” recommendations. Recommendations are updated on a rolling schedule, with a goal of every 5 years.

ACIP. Administered and funded by the Centers for Disease Control and Prevention, the ACIP develops recommendations for immunizations in pediatric and adult populations. Currently, 14 adult and 15 child/adolescent immunizations are recommended. Recommendations are updated when new data become available.
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Bright Futures. Administered by the American Academy of Pediatrics (AAP) through funding by HRSA/Maternal and Child Health Bureau, Bright Futures is a compilation of guidelines on preventive screening and services for pediatric and adolescent populations, covering 10 health promotion themes. Bright Futures guidelines are updated approximately every 6-8 years, with the most recent edition having been released in February 2017.

WPSI. Administered by the American College of Obstetricians and Gynecologists (ACOG), WPSI develops women’s health-related preventive service recommendations in topic areas not already covered by the USPSTF, ACIP, or Bright Futures. In 2011, the IOM Committee on Preventive Services for Women released the first version of these recommendations. In 2016, HRSA awarded a five-year cooperative agreement to ACOG to form the WPSI and update the recommendations. The most recent update was released in December 2016. WPSI recommendations currently address nine topics.

Methods of the Guidelines Groups

Each of the four expert committees recognized by the ACA develops recommendations using separate approaches, some elements of which overlap. Each of the groups strives to adhere to principles that promote high-quality recommendations, such as transparency, conflict of interest mitigation, and use of best evidence possible. The USPSTF and WPSI have explicitly stated that they follow, to the best extent possible, recommendations for developing rigorous and trustworthy clinical practice guidelines set forth by the IOM in its 2011 report “Clinical Practice Guidelines We Can Trust.” Below, the methods of each group as they relate to principles for developing high-quality recommendations, are summarized.

Transparency. The methodologies and processes used by each of the four groups are publicly available on their respective websites. In addition, ACIP meetings are open to the public and meeting minutes are posted to the ACIP website. Once finalized, all recommendations and evidence summaries developed by each of the four groups are publicly available.

Conflict of Interest Management. Candidates for membership to each of the four groups must provide written disclosure of all potential conflicts of interest. For the ACIP, candidates with vaccine-related interests are not considered for appointment, and for the USPSTF, whenever possible, candidates do not have conflicts. Members of the USPSTF, ACIP, and WPSI with conflicts must disclose and discuss the conflicts prior to each meeting. Members of the USPSTF and ACIP with conflicts may not be permitted to participate in workgroup activities and topic discussions, and may be removed from the voting process. Members of the ACIP also are required to file confidential financial reports every year with the Office of Government Ethics.

Member Composition. USPSTF is comprised of 16 members who are experts in primary care, clinical preventive services, and evidence-based medicine, including methodological experts and clinicians. They are volunteers and are not federal employees. Currently, 13 of the 16 members are physicians. ACIP is comprised of 15 voting members who collectively have expertise in vaccinology, immunology, pediatrics, internal medicine, infectious disease, preventive medicine, or public health. Members must be U.S. citizens and must not be employed by the federal government. Currently, 13 of the 15 members are physicians. Bright Futures is comprised of expert panels covering infancy, childhood, middle childhood, and adolescence. Panel members are experts in pediatrics and primary care, and include physicians (23 of the 40 current expert panel members), dentists, nurses, physician assistants, and psychologists. WPSI members have expertise in the fields of women’s health, primary care, chronic disease management, mental health, and gerontology.
They include physicians (12 of 20 current members), nurses, public health professionals, and patient representatives.

Establishing Evidence Foundations. The USPSTF and WPSI commission independent systematic reviews on topics from Evidence-based Practice Centers. The ACIP reviews data on morbidity and mortality associated with the disease in the general U.S. population and in specific risk groups along with available scientific literature (both published and unpublished) on the safety, efficacy, effectiveness, cost-effectiveness, and acceptability of the immunizing agent, with consideration of the relevant quality and quantity of data. Bright Futures establishes an Evidence Panel, comprised of consultants who are experts in finding and evaluating evidence from clinical studies, to examine studies and systematic evidence. The Evidence Panel also uses systematic evidence reviews performed for the USPSTF and the Cochrane Collaboration.

The USPSTF and ACIP have established categories to denote the type and quality of the overall evidence for a service. Both consider randomized controlled trials to be in the highest category, with observational studies and randomized controlled trials with limitations being placed in middle categories, and expert opinion placed in the lowest category. Bright Futures evidence searches are limited to clinical trials, meta-analyses, and randomized controlled trials; recommended preventive services for which evidence is not as strong but the service is still likely to be beneficial include explanatory rationale. WPSI uses a “best evidence approach” that prioritizes randomized controlled trials and large prospective cohort studies; other study designs, such as case-control and modeling studies, are included when evidence is lacking or when they demonstrate new findings.

External Review/Stakeholder Engagement Opportunities. All four groups provide opportunity for external review by stakeholders at various points in their recommendation development process. The USPSTF posts draft research plans, draft evidence reviews, and draft recommendation statements for 30-day public comment periods. In addition, it solicits review and feedback from individuals who are scientific and clinical experts in the topic under study. ACIP draft recommendations are subjected to extensive review by scientific staff of the CDC, other relevant federal agencies, ACIP members, liaison representatives and external expert consultants. Public comments are solicited during each ACIP meeting and are considered in the decision-making process. Each edition of the Bright Futures Guidelines undergoes review by national organizations concerned with infant, child, and adolescent health and welfare; guidelines are refined based on feedback. WPSI releases a draft of each recommendation for a one-month online public comment period. WPSI also solicits input from a number of organizations and individuals that represent a broad array of perspectives and expertise on women’s preventive health care. It is currently exploring a process for in-person public comment.

AMA and Federation Representation. Three of the four guidelines groups, USPSTF, ACIP, and Bright Futures, have partner organizations on which they rely to provide feedback on draft recommendations, assist in the dissemination and implementation of recommendations, and provide input on topic priority. The USPSTF Dissemination and Implementation Partner group is comprised of organizations involved in primary care delivery, and includes the AMA and the following members of the Federation: AAP, American Academy of Family Physicians (AAFP), American College of Physicians (ACP), ACOG, American College of Preventive Medicine (ACPM), American Osteopathic Association (AOA), and American Psychiatric Association (APA). Representatives of the Dissemination and Implementation Partners are invited to attend each USPSTF meeting. ACIP Liaisons are comprised of health professional organizations and foundations that have broad responsibility for administration of vaccines to various segments of the population. ACIP Liaisons include the AMA and the following members of the Federation: AAP, AAFP, ACOG, ACP, AOA, Infectious Diseases Society of America (IDSA), and National Medical
Association (NMA). Representatives of the Liaison organizations are invited to attend ACIP meetings. The Bright Futures Project Implementation Advisory Committee is comprised of organizations involved in the promotion of children’s health. Members include the AMA and the following members of the AMA Federation: AAP and NMA. While the WPSI does not have a similar separate stakeholder group, its multi-disciplinary steering committee (the committee that develops and votes on recommendations), is made up of a number of professional societies involved in the delivery of women’s health. AMA is not represented on the steering committee, but the following members of the Federation are: AAFP, ACOG, ACP, American College of Radiology, AAP, AOA, APA, and ACPM.

SECONDARY PREVENTION

Prevention can be divided into three stages: primary, secondary, and tertiary.\(^{11}\) However, inconsistencies exist in the way that each term is used and the types of preventive services that characterize the categories.\(^{12}\) For the purposes of this report, we consider “secondary prevention” as interventions intended to slow or prevent the progression of early-stage disease, thereby reducing the risk of further, more serious health outcomes. By contrast, “tertiary prevention” refers to interventions that treat existing pathological disease with the goal of minimizing loss of function. Secondary prevention measures are intended to restore health by treating previously unrecognized disease before irreversible pathological changes take place. Examples of secondary prevention include statin therapy in those with established atherosclerotic cardiovascular disease to prevent myocardial infarction, stroke, or other cardiovascular events; or behavioral intervention programs to support weight loss and prevent type 2 diabetes and cardiovascular disease in patients with obesity. While the expert committees recognized by the ACA focus mainly on primary prevention recommendations, the USPSTF, Bright Futures, and WPSI also have made some secondary prevention recommendations, such as the USPSTF recommendation that patients at increased risk for breast cancer take a selective estrogen receptor modulator, and the WPSI recommendation that women at risk for domestic violence be provided with counseling, education, harm reduction strategies, and appropriate supportive services.

Health outcomes improvement and cost-effectiveness evidence is strong for many secondary prevention measures. For example, for those identified as having impaired glucose intolerance, treatment with lifestyle intervention programs delays or prevents progression to type 2 diabetes and results in cost savings.\(^{13,14}\) Similarly, treating adolescents with major depressive disorder with a collaborative care model both improves depressive symptoms and is cost effective.\(^{15,16,17}\) However, while evidence-based and cost-saving secondary prevention measures such as these are usually covered by a patient’s insurance, many are not covered without cost-sharing unless they fall within the recommendations of the expert committees named by the ACA. Patients without insurance or who are unable to afford co-pays and deductibles are therefore not always able to access secondary prevention measures. Given the health-improving and cost-saving potential of many secondary preventive measures, a need exists for a process by which such measures could be routinely and rigorously evaluated for coverage without cost-sharing, similar to the processes by which preventive services topics are evaluated by the committees named in the ACA.

PRIORITIZING PREVENTIVE SERVICES

A 2003 study estimated that a primary care provider would need to spend 7.4 hours per working day to deliver the preventive services recommended by the USPSTF,\(^{18}\) an estimate that has likely grown given the number of additional services recommended since that time. The reality of clinical time constraints and competing demands means that not every preventive service is delivered as recommended. On average, patients receive only approximately 55 percent of recommended
implying that physicians employ prioritization tactics to best determine which services to deliver. Given the near impossibility of delivering every preventive service to those for whom they are recommended, calls have been made for more systematic prioritization that takes into account factors such as health impact and cost-effectiveness.\textsuperscript{20,21,22,23}

Physicians’ clinical judgment is often adequate in determining which preventive services are most beneficial for each of their patients, especially for interventions that are strongly linked to the prevention of adverse health outcomes, like counseling about tobacco cessation, and for interventions that are appropriate for almost every person, such as immunizations.\textsuperscript{20} But estimating the benefit of some services is complex and challenging. For example, the benefit of screening for certain cancers can vary up to tenfold based on patient-specific demographic, clinical, behavioral, and genetic factors.\textsuperscript{20} Risk prediction calculators, such as those intended to determine cardiovascular disease risk, have been proposed as a tool to assist in revealing the relative benefit of different prevention measures, including blood pressure control, lipid control, and weight control.\textsuperscript{20} EHR- and web-based clinical decision support systems can run algorithms that take into account patient characteristics to predict individual risk level, thereby suggesting what type of intervention may be optimal.\textsuperscript{20,24,25} Patient preferences also are important to consider, since patients may be more willing to engage in some preventive services than others. For example, recommending that a patient undergo screening colonoscopy is more valuable for a patient who is willing to undergo the colonoscopy than for a patient who is not.\textsuperscript{20} EHR systems can track patient preferences and readiness for change over time so that physicians can address the specific concerns of the patient in their future conversations about prevention.

Prioritization using personalized decision-making at the point of care has been tested using mathematical modeling that measures increases in life expectancy when a number of recommended preventive services are delivered to patients with different clinical characteristics.\textsuperscript{22} For a hypothetical male patient who is 62 years of age and obese, smokes, and has high blood pressure, high cholesterol, and a family history of colorectal cancer, life expectancy is most increased by preventive services that encourage the patient to quit smoking, lose weight, and lower his blood pressure.\textsuperscript{22} For a patient with the same characteristics, but also with type 2 diabetes, controlling his blood sugar provides the largest increase in life expectancy. This kind of approach would likely be most effective with the use of an EHR system that can apply modeling to each patient’s personal characteristics and provide decision support about which preventive services will have the largest impact on life expectancy.

Others have included cost-effectiveness as a prioritization tactic. Maciosek et al. recently evaluated a large number of preventive services recommended by the USPSTF and the ACIP for their clinically preventable burden and cost-effectiveness, in an effort to determine high-priority preventive services.\textsuperscript{21} While several services were determined to be either cost-saving or to have the highest clinically preventable burden, only three were deemed to fit into both categories: the childhood immunization series, brief counseling about tobacco use in youth, and screening for and providing brief interventions to reduce tobacco use in adults. The study also found that, on average, preventive services that address health behaviors, such as alcohol misuse, diet, physical activity, and tobacco use provide the greatest opportunities to improve population health even when accounting for realistic levels of nonadherence.\textsuperscript{21}

While these studies should not be construed as definitive methods for determining which preventive services have the highest value, they present examples of mechanisms that might better ensure that patients receive the recommended preventive services most likely to benefit them. It is important to note that a number of complex factors figured into these prioritization mechanisms, so
application to local or regional populations would need to take into account local and regional utilization rates to more precisely determine value.

The Cost Imperative

Health care costs continue to rise precipitously despite widespread efforts to insert value into models of care delivery and benefit design. In 2015, the U.S. spent $3.2 trillion, or $9,990 per person on health care. Health care spending accounts for nearly 18 percent of the U.S. economy. Federal reform efforts have sought to address costs through delivery reform, payment reform, benefit design, and other initiatives.

With respect to preventive services, there is concern that an excessive number of preventive services are covered with no cost-sharing, potentially contributing to high premiums and health care spending. At the same time, concerns have been raised that some high value services, such as secondary preventive services that reduce hospitalizations and morbidity, can be unaffordable for some patients, particularly those with high deductibles.

Each year, chronic disease accounts for 70 percent of deaths, and about half of all adults have one or more chronic conditions. An emphasis on value-based insurance design could improve adherence to health benefits that best treat chronic conditions.

AMA POLICY

AMA Policy H-165.846 broadly defines the adequacy of health insurance coverage in the context of federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the U.S. Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations). It further specifies that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children.

Policy H-185.939, “Value-Based Insurance Design,” supports flexibility in the design and implementation of value-based insurance design (VBID) programs, which explicitly consider the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements. It calls for the active involvement of practicing physicians; the use of high-quality, evidence-based data; and transparency of both the methodology and criteria used to determine high- or low-value services or treatments and the coverage and cost-sharing policies. The policy states that VBID should not restrict access to patient care and must include an appeals process to enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties. The policy also calls for plan sponsors to engage in ongoing evaluation of the plan designs to ensure VBID coverage rules are updated in accordance with evolving evidence.

Various AMA policies call for first-dollar (free) coverage, including H-440.860 regarding adult vaccines, H-185.969 regarding immunizations, D-330.935 regarding Medicare preventive service benefits, H-290.972 regarding first-dollar preventive coverage for health savings account holders, and H-440.840 regarding tuberculosis testing. All of these policies are accomplished with the ACA preventive service requirement.

At the same time, AMA policy calls for benefit mandates to be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options (Policy H-165.856). Increasing the number of mandates included in the EHB package could result in an increase in the cost and reduce the affordability of health insurance coverage, in terms of both deductibles and other cost-sharing, and premiums.
Policy H-460.909 outlines AMA principles for comparative effectiveness research (CER), stating that CER entities (e.g., the Patient-Centered Outcomes Research Institute) must not have a role in making or recommending coverage or payment decisions for payers. However, Policy H-110.986 supports the inclusion of the cost of alternatives and cost-effectiveness analysis in CER. Accordingly, the AMA supports the use of cost as a factor in CER, but does not support CER entities making coverage or payment decisions. CER data that includes a consideration of cost would allow the expert committees that establish guidelines to have a better informed deliberation about value.

The CER policy calls for transparency, conflict disclosure, and physician and patient oversight. Policy H-410.953 similarly calls for processes that result in clinical practice guidelines that are trustworthy, rigorous, transparent, independent, and accountable. These processes include scientifically rigorous methods and standards for weighting evidence, access to appropriate expertise among members or consultants, procedures to minimize financial or other conflicts of interest, funding that is independent of entities that have an interest in the recommendations being developed, rigorous and independent peer review, and clear information about methodology.

DISCUSSION

A persistent criticism of the ACA, among most opponents and some supporters, has been that the broad scope of the preventive services covered with no cost-sharing contributed to premium and deductible increases and provided health plans with few options for varying their benefit designs. Alongside complaints that too many preventive services were being offered without cost-sharing, there are also concerns that some high-value secondary preventive services, such as treatment for diabetes and hypertension, may be avoided because of increasingly high health plan deductibles. The Councils acknowledge these concerns and present recommendations to better align preventive service coverage with evidence.

The preventive services covered without cost-sharing under the ACA rely on the recommendations of four expert committees, all of which are developed using rigorous but differing processes and methodologies. Since all four groups include participation by the AMA and/or members of federation of medicine, some of our recommendations aim to help the representatives to these committees lead an effort to promote transparency and uniformity in how the committees develop their recommendations. It is the hope of the Councils that the expert committees will work to align their methodologies. The expert committees regularly seek input from national medical specialty societies and the public during review and comment periods, and we encourage medical societies to participate in such opportunities.

We evaluated the possibility of making recommendations for health plans and payers to routinely consider evidence and cost-effectiveness in making coverage determinations, and believe AMA policy on benefit adequacy and value-based insurance design remain appropriate to address these concerns. In addition, policy supports federal responsibility to conduct comparative effectiveness research and promote uniformity in market rules, and state government responsibility to regulate markets and seek to minimize benefit mandates. However, public and private payers should be encouraged to prioritize coverage of preventive services. In addition, consensus on the value of secondary prevention will require a research focus on the long-term effects of early intervention for chronic diseases.

Consistent with Policy H-410.953, it is suggested that significant physician involvement should be required in all steps identified for determining relative levels of coverage of preventive services, and that the process be transparent and free of conflicts of interest.
RECOMMENDATIONS

The Council on Medical Service and the Council on Science and Public Health recommend that the following be adopted, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policy H-185.939, which supports the use of value-based insurance design in determining patient cost-sharing requirements based on the clinical value of a treatment. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-110.986, which supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-410.953, which calls for development processes that result in clinical practice guidelines that are trustworthy, rigorous, transparent, independent, and accountable. (Reaffirm HOD Policy)

4. That our AMA encourage committees that make preventive services recommendations to:
   a. Follow processes that promote transparency, clarity and uniformity among their methods;
   b. Develop evidence reviews and recommendations with enough specificity to inform cost-effectiveness analyses;
   c. Rely on the very best evidence available, with consideration of expert consensus only when other evidence is not available;
   d. Work together to identify preventive services that are not supported by evidence or are not cost-effective, with the goal of prioritizing preventive services; and
   e. Consider the development of recommendations on both primary and secondary prevention. (New HOD Policy)

5. That our AMA encourage relevant national medical specialty societies to provide input during the preventive services recommendation development process. (New HOD Policy)

6. That our AMA encourage comparative-effectiveness research on secondary prevention to provide data that could support evidence-based decision making. (New HOD Policy)

7. That our AMA encourage public and private payers to prioritize coverage of preventive services for which consensus has emerged in the recommendations of multiple guidelines-making groups. (New HOD Policy)

Fiscal Note: Less than $500.
REFERENCES


APPENDIX

Policies Recommended for Reaffirmation

H-185.939, Value-Based Insurance Design
Our AMA supports flexibility in the design and implementation of value-based insurance design (VBID) programs, consistent with the following principles: a. Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements. b. Practicing physicians must be actively involved in the development of VBID programs. VBID program design related to specific medical/surgical conditions must involve appropriate specialists. c. High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included in any targeted benefit design elements of a health plan. d. The methodology and criteria used to determine high- or low-value services or treatments must be transparent and easily accessible to physicians and patients. e. Coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Educational materials should be made available to help patients and physicians understand the incentives and disincentives built into the plan design. f. VBID should not restrict access to patient care. Designs can use incentives and disincentives to target specific services or treatments, but should not otherwise limit patient care choices. g. Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs that include higher cost-sharing or other disincentives to obtaining services designated as low-value must include an appeals process to enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties. h. Plan sponsors should ensure adequate resource capabilities to ensure effective implementation and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure VBID coverage rules are updated in accordance with evolving evidence. i. VBID programs must be consistent with AMA Pay for Performance Principles and Guidelines.

H-110-986, Incorporating Value into Pharmaceutical Pricing
1. Our AMA supports value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by the following principles: (a) value-based prices of pharmaceuticals should be determined by objective, independent entities; (b) value-based prices of pharmaceuticals should be evidence-based and be the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes; (c) processes to determine value-based prices of pharmaceuticals must be transparent, easily accessible to physicians and patients, and provide practicing physicians and researchers a central and significant role; (d) processes to determine value-based prices of pharmaceuticals...
should limit administrative burdens on physicians and patients; (e) processes to determine value-based prices of pharmaceuticals should incorporate affordability criteria to help assure patient affordability as well as limit system-wide budgetary impact; and (f) value-based pricing of pharmaceuticals should allow for patient variation and physician discretion.

2. Our AMA supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research.

3. Our AMA supports direct purchasing of pharmaceuticals used to treat or cure diseases that pose unique public health threats, including hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size.

H-410.953, Ethical Considerations in the Development of Clinical Practice Guidelines

Clinical practice guidelines are statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options. Clinical practice guidelines help inform physician judgment and decision making by physicians and patients. Clinical practice guidelines also have significant potential to meaningfully inform efforts to provide care of consistently high quality for all patients and to help shape development of sound public policy in health care. To achieve those ends, clinical practice guidelines must be trustworthy. Patients, the public, physicians, other health care professionals and health administrators, and policymakers must have confidence that published guidelines are the ethically and scientifically credible product of development processes that are rigorous, independent, transparent, and accountable. To that end, the development or updating of clinical practice guidelines should meet the following expectations:

1. Guidelines/updates are developed independent of direct financial support from entities that have an interest in the recommendations to be developed.

2. Formal, scientifically rigorous methods and explicit standards are adopted for the review and weighting of evidence, the integration of expert judgment, and the strength of clinical recommendations.

3. Guideline panels have access to appropriate expertise among members or consultants, including not only relevantly qualified clinical experts but also appropriately qualified methodologists, representatives of key stakeholders, and, ideally, one or more individuals skilled in facilitating groups.

4. Ideally, all individuals associated with guideline development will be free of conflicts of interest during the development process and will remain so for a defined period following the publication of the guideline.

5. Formal procedures are adopted to minimize the potential for financial or other interests to influence the process at all key steps (selection of topic, review of evidence, panel deliberations, development and approval of specific recommendations, and dissemination of final product). These should include: a) required disclosure of all potential conflicts of interest by panel members, consultants, staff, and other participants; b) clearly defined criteria for identifying and assessing the seriousness of conflicts of interest; and c) clearly defined strategies for eliminating or mitigating the influence of identified conflicts of interest (such as prohibiting individuals from participating in deliberations, drafting, or voting on recommendations on which they have conflicts) in those limited circumstances when participation by an individual with a conflicting interest cannot be avoided.

6. Guidelines are subject to rigorous, independent peer review.

7. Clear statements of methodology, conflict of interest policy and procedures, and disclosures of panel members’ conflicts of interest relating to specific recommendations are published with any guideline or otherwise made public.

8. Guidelines are in the first instance disseminated independent of support from or participation by individuals or entities that have a direct interest in the recommendations.
WHEREAS, Emtricitabine/tenofovir is an evidence-based component of HIV pre-exposure prophylaxis (PrEP); and

WHEREAS, PrEP reduces the risk of HIV infection among gay or bisexual men as well as transgender women by as much as 92% when used as prescribed; and

WHEREAS, In 2014, the Centers for Disease Control and Prevention issued guidelines stating that HIV PrEP should be considered for HIV-uninfected patients who are in an ongoing sexual relationship with an HIV-infected partner, are gay or bisexual men who have sex without a condom, or have a history of injection drug use; and

WHEREAS, Additional research indicates no new HIV infections with increasing use of HIV PrEP in a clinical practice setting; and

WHEREAS, There are reports of individuals being denied disability insurance due to concomitant HIV PrEP; and

WHEREAS, Insurance coverage for HIV PrEP often requires pre-authorization with no guarantee of insurance coverage; and

WHEREAS, Physicians commonly purchase disability insurance as means for long-term financial security; therefore be it

References:
RESOLVED, That our American Medical Association amend Policy H-20.895 by addition to read as follows:

H-20.895, Pre-Exposure Prophylaxis for HIV
1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
3. Our AMA advocates that individuals not be denied various financial products, including disability insurance, on the basis of HIV pre-exposure prophylaxis (PrEP) use. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 02/20/17

RELEVANT AMA POLICY

Health and Disability Coverage for Health Care Workers at Risk for HIV and Other Serious Infectious Diseases H-20.906
(1) Health Insurance
A currently held health insurance policy of a health care worker should not be terminated, coverage reduced or restricted, or premiums increased solely because of HIV infection.
(2) Disability Coverage
a) Each health care worker should consider the risks of exposure to infectious agents posed by his/her type of practice and the likely consequences of infection in terms of changes needed in that practice mode and select disability insurance coverage accordingly. The policy selected should contain a reasonable definition of "sickness" or "disability," an own-occupation clause, and guaranteed renewability, future insurability, and partial disability provisions;
b) In making determinations of disability, carriers should take into consideration the recommendations of the professional and institutional staff with whom an infected health care worker is associated, including the worker's own personal physician;
c) Since there are a variety of disability insurance coverages available and a diversity of practice modes, each health care professional should individually assess his/her risk of infection and that of his/her employees and select disability coverage accordingly. (CSA Rep. 4, A-03; Reaffirmed: CMS Rep, A-13)

Pre-Exposure Prophylaxis for HIV H-20.895
1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV, including use in women and minority populations, and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances (Res. 106, A-16; Modified: Res. 916, I-16)
Whereas, The effort to provide high quality care to all citizens of the USA continues to be a major problem for our health care system; and

Whereas, We have never yet succeeded in providing a true market approach to achieving cost effectiveness in our health care system; therefore be it

RESOLVED, That our American Medical Association reaffirm current policy, Patient Information and Choice H-373.998, advocating the following principles for achieving a realistic functional approach to a market system method of achieving cost-effectiveness in health care:

1. Greater reliance on market forces, with patients empowered with understandable fee/price information and incentives to make prudent choices, and with the medical profession empowered to enforce ethical and clinical standards which continue to place patients' interests first, is clearly a more effective and preferable approach to cost containment than is a government-run, budget-driven, centrally controlled health care system.

2. Individuals should have freedom of choice of physician and/or system of health care delivery. Where the system of care places restrictions on patient choice, such restrictions must be clearly identified to the individual prior to their selection of that system.

3. In order to facilitate cost-conscious, informed market-based decision-making in health care, physicians, hospitals, pharmacies, durable medical equipment suppliers, and other health care providers should be required to make information readily available to consumers on fees/prices charged for frequently provided services, procedures, and products, prior to the provision of such services, procedures, and products. There should be a similar requirement that insurers make available in a standard format to enrollees and prospective enrollees information on the amount of payment provided toward each type of service identified as a covered benefit.

4. Federal and/or state legislation should authorize medical societies to operate programs for the review of patient complaints about fees, services, etc. Such programs would be specifically authorized to arbitrate a fee or portion thereof as appropriate and to mediate voluntary agreements, and could include the input of the state medical society and the AMA Council on Ethical and Judicial Affairs.

5. Physicians are the patient advocates in the current health system reform debate. Efforts should continue to seek development of a plan that will effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients' freedom to select physicians and/or health plans of their choice.
6. Efforts should continue to vigorously pursue with Congress and the Administration the strengthening of our health care system for the benefit of all patients and physicians by advocating policies that put patients, and the patient/physician relationships, at the forefront. (Reaffirm HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 04/20/17

RELEVANT AMA POLICY

Patient Information and Choice H-373.998
Our AMA supports the following principles:
1. Greater reliance on market forces, with patients empowered with understandable fee/price information and incentives to make prudent choices, and with the medical profession empowered to enforce ethical and clinical standards which continue to place patients’ interests first, is clearly a more effective and preferable approach to cost containment than is a government-run, budget-driven, centrally controlled health care system.
2. Individuals should have freedom of choice of physician and/or system of health care delivery. Where the system of care places restrictions on patient choice, such restrictions must be clearly identified to the individual prior to their selection of that system.
3. In order to facilitate cost-conscious, informed market-based decision-making in health care, physicians, hospitals, pharmacies, durable medical equipment suppliers, and other health care providers should be required to make information readily available to consumers on fees/prices charged for frequently provided services, procedures, and products, prior to the provision of such services, procedures, and products. There should be a similar requirement that insurers make available in a standard format to enrollees and prospective enrollees information on the amount of payment provided toward each type of service identified as a covered benefit.
4. Federal and/or state legislation should authorize medical societies to operate programs for the review of patient complaints about fees, services, etc. Such programs would be specifically authorized to arbitrate a fee or portion thereof as appropriate and to mediate voluntary agreements, and could include the input of the state medical society and the AMA Council on Ethical and Judicial Affairs.
5. Physicians are the patient advocates in the current health system reform debate. Efforts should continue to seek development of a plan that will effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients’ freedom to select physicians and/or health plans of their choice.
6. Efforts should continue to vigorously pursue with Congress and the Administration the strengthening of our health care system for the benefit of all patients and physicians by advocating policies that put patients, and the patient/physician relationships, at the forefront.

Whereas, The term "Benefit Payment Schedule" is intended to describe a type of health insurance wherein the insurer pays for covered services according to a schedule of benefits, the physician, hospital or other provider charges a fee for those services and it is up to the patient and the provider to determine what to do about any difference between the fee and the payment; therefore be it

RESOLVED, That our American Medical Association adopt as policy the following definition: a Benefit Payment Schedule plan is a type of health insurance in which the insurer makes a payment for covered services according to a schedule of benefits, the physician, hospital or other provider charges a fee for those services and it is up to the patient and the provider to determine what to do about any difference between the fee and the payment (New HOD Policy);

and be it further

RESOLVED, That our AMA support the inclusion of Benefit Payment Schedule plans as one option in a pluralistic system of health care financing. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 04/20/17
Whereas, Our AMA’s CPT consultation codes were developed as a type of evaluation and
management service provided at the request of another provider to recommend care or accept
responsibility for ongoing management of a specific condition, documented in the medical
record and communicated by written report to the requesting provider; and

Whereas, Effective January 1, 2010, the Centers for Medicare & Medicaid Services eliminated
the payment of all CPT consultation codes (ranges 99241-99245 and 99251-99255) for
Medicare Part B payment (inpatient and office/outpatient codes), for various places of service
except for telehealth consultation Healthcare Common Procedure Coding System (HCPCS)
G-codes; and

Whereas, CMS instructed physicians (and qualified NPPs where permitted) billing under the
Physician Fee Service (PFS) to use other applicable E/M codes to report the services that could
be described by CPT consultation codes; and

Whereas, The loss of “consultation” codes makes difficult the ability to keep track of which
patients are seen from which providers to assist in awareness of the source of these patients,
sending of information about the evaluation and recommended management of these patients
to those providers to enhance communication, collaboration and coordination of care by the
referring providers, as well as for assisting in marketing efforts; and

Whereas, Effective communication to referring providers results in enhanced quality and safe
care of the patient and education of the referring provider concerning the patient condition
involved, helping to enhance compliance with treatment and/or avoidance of hospital
readmissions; and

Whereas, Some other payers continue to pay for these consultation-coded services, creating
confusion in billing practices as to which codes to use; therefore be it

RESOLVED, That our American Medical Association work with the Centers for Medicare &
Medicaid Services to reinstate in the Medicare fee schedule the AMA’s CPT codes for
consultation for the purposes of enhancing communication among providers, allowing the
tracking of patients seen on consultation from other providers, sending of information about the
evaluation and recommended management of these patients to those providers thereby
increasing collaboration and coordination of care by the consulting providers with resulting
improved quality of care and compliance with treatment recommendations. (Directive to Take
Action)

Fiscal Note: Modest – between $1,000 - $5,000
Received: 04/20/17
Whereas, Government imposed price controls have never worked in any economic system; and

Whereas, Government price controls in medicine have led to direct loss of access to health care in disadvantaged segments of our society without achieving cost effectiveness, therefore be it

RESOLVED, That our American Medical Association reaffirm our continued opposition to the use of price controls in any segment of the health care industry, and continue to promote market-based strategies to achieve access to and affordability of health care goods and services. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 04/20/17
Whereas, The term "Medical Loss Ratio" is used by medical insurance companies to refer to that portion of premium that goes to pay for services rendered; and
Whereas, Payment for services rendered is considered a good thing by patients and their physicians, hospitals and other providers; therefore be it
RESOLVED, That our American Medical Association encourage medical insurance companies to change the term "Medical Loss Ratio" to "Medical Benefit Ratio" and that insurance companies define the elements comprising the "Medical Benefit Ratio" (Directive to Take Action); and be it further
RESOLVED, That our AMA advocate that in the interest of full transparency, health financing plans, including insurance, prepaid care and value based payment models, should be required to publish their Medical Benefit Ratios. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 04/20/17
Whereas, The AMA has maintained a long-standing policy of refundable, advanceable tax credits inversely related to income for expanding coverage and patient choice; and

Whereas, Dramatic consolidation that has occurred in the health care market has virtually eliminated the ability of market-based solutions to expand coverage and improve patient choice; and

Whereas, The recent House health care proposal calling for refundable advanceable tax credits has demonstrated that such a system of health care financing, even if it was tied to income, would result in reduced coverage as well as increased disparities in coverage especially for lower income and elderly populations; and

Whereas, Current provider consolidation and the complete lack of an effective regulatory system for health care providers eliminates the possibility of managing health care costs as well as improving patient choice; and

Whereas, Most states when faced with the prospect of improving access generally expand their current Medicaid programs and require providers to accept Medicaid payments; therefore be it

RESOLVED, That our American Medical Association study whether our current advanceable refundable tax credit policy is feasible given the worsening health care market failure that has occurred since this policy was developed (Directive to Take Action); and be it further

RESOLVED, That our AMA study the feasibility of a Medicare public option model as a model to improve access to care, considering options for modifications to benefits package and cost sharing. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 04/25/17

RELEVANTAMA POLICY

Status Report On Expanding Coverage For The Uninsured D-165.984
Our AMA will continue to vigorously pursue its polices that support a system of refundable, advanceable tax credits inversely related to income for the purpose of expanding coverage and patient choice (Policies H-165.920, H-165.851, and H-165.865).
Whereas, Health insurance policies have until recently often provided the ability of a patient to be treated by a physician outside’s of the plan’s network, with coverage for such care based upon a percentage of the Usual Customary and Reasonable (UCR) charges; and

Whereas, Many health insurers have sought to eliminate and/or reduce this traditional benefit, with out-of-network insurance coverage scarcely available in many health insurance markets; and

Whereas, Inadequate networks offered by many health insurers impose a significant barrier for patients seeking to receive needed care in a timely and safe manner; and

Whereas, Organized medicine has consistently advocated for the ability of patients, consumers and employers to be able to have coverage to be treated by the physician of their choice; and

Whereas, There is no requirement at the federal level for out-of-network benefits for self-funded plans; therefore be it

RESOLVED, That our American Medical Association seek the availability of out-of-network benefits for all federally sponsored health insurance plans, federal exchange, and/or self-funded plans including plans utilizing usual, customary and reasonable (UCR) payment methodology.

(Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 04/28/17
Whereas, Home care services are a critical link in the continuum of healthcare delivery, reducing the cost of healthcare overall by reducing patient risk for hospitalization, re-hospitalization and nursing home care; and

Whereas, The need to assure appropriate home care services for patients is even greater for a patient who has been recently discharged from a hospital, including helping to assure discharge instructions are followed and reducing the risk of infection; and

Whereas, Medicare eligibility for coverage for home care services requires physician certification and documentation, including a “Face to Face” (F2F) requirement which can be burdensome to the physician, and as a result, is often not completed; and

Whereas, The US Department of Health and Human Services (HHS) Office of Inspector General reported in 2014 that there were nearly $2 billion in payments for home care services that should have not been made due to lack of compliance with the F2F requirement; and

Whereas, This has prompted HHS and CMS to undertake extensive audit and review to confirm the documentation of F2F certification of eligibility for home care by a physician; and

Whereas, Home care agencies are faced with significant financial challenges in providing care as a result of the significant number of claims which are not reimbursed due to lack of a F2F certification; and

Whereas, These financial pressures can in some instances cause home care agencies to avoid providing care to some patients where a F2F certification is not provided; and

Whereas, These financial pressures will cause in some instances home care agencies to make repeated contact to physicians to complete these forms to assure payment for care; and

Whereas, Physician time is already overburdened with needless administrative tasks that interfere with patient care delivery; and

Whereas, The new Trump Administration has publicly expressed a desire to reduce burdensome regulations; therefore be it

RESOLVED, That our American Medical Association advocate to simplify the Medicare requirements for a “Face to Face” visit with a patient by a physician as a precondition for Medicare home health coverage, including advocating for alternatives for such “Face to Face” visit such as by telehealth. (New HOD Policy)
Whereas, Our American Medical Association and the following organizations and societies endorse over-the-counter (OTC) emergency contraception access: the American Congress of Obstetricians and Gynecologists, the American Academy of Family Physicians, the American Academy of Pediatrics, the American Medical Student Association, and the U.S. Food and Drug Administration; and

Whereas, The aforementioned organizations have successfully advocated for responsible over-the-counter emergency contraception access; and

Whereas, The efficacy of several forms of contraception is thoroughly proven, and the quick return to fertility of most reversible medical contraception forms necessitates protection from medical interruption with timely, convenient access to these medicines; and

Whereas, The safety of oral contraceptive pills has been greatly studied; and

Whereas, Patients with sufficient information and/or counseling are capable of demonstrating safe personal decisions in birth control choice and use, patients utilizing OTC contraceptives have been shown to self-screen more conservatively for contraindications, and patients utilizing OTC contraceptives have similar or higher rates of medication adherence as those prescribed contraception; and

Whereas, Patient self-screening is capable of avoiding relative or absolute contraindications; and

Whereas, Routine gynecologic examination is not necessary for the prescription of oral contraceptives, and therefore OTC designation would not discourage current recommendations or frequency for health screening, counseling or exams; and

Whereas, The precedence for OTC contraception has been set in more than 100 other countries, and is expanding in others, including the United States; and

Whereas, The popularity of OTC contraception is high and increasing in the United States; and

Whereas, Access to safe, effective and affordable family planning methods are integral to reproductive rights and sexual and family health; and

Whereas, The minimal prevalence of FDA-approved over-the-counter contraceptives necessitates a responsible abbreviation of current prescription criteria to enjoy access improvements; therefore be it
RESOLVED, That our American Medical Association condemn age-based, cost-based, and
other non-medical barriers to contraceptive drug access (New HOD Policy); and be it further
RESOLVED, That our AMA adopt policy supporting equitable access to over-the-counter (OTC)
contraception, including those forms of contraception recommended for OTC sale, patient risk
assessment screening tools, and prescribing by non-physicians (New HOD Policy); and be it
further
RESOLVED, That our AMA support policy solutions that prohibit cost-sharing obstacles to OTC
contraceptive drug access, and full coverage of all contraception without regard to prescription
or OTC utilization, since all contraception is essential preventive health care (New HOD Policy);
and be it further
RESOLVED, That our AMA advocate for the legislative and/or regulatory mechanisms needed
to achieve improvements for OTC contraceptive drug access and quality. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/01/17
Whereas, The Department of Veterans Affairs’ Technology-Based Eye Care Services (TECS) program is designed to improve rural veterans’ access to comprehensive eye screening services for the most common causes of visual impairment: cataract, glaucoma, macular degeneration, and diabetic retinopathy; and

Whereas, The TECS program uses an ophthalmology technician in a rural primary care clinic to gather data following an eye screening protocol and asynchronous, store and forward technology; and

Whereas, The TECS program is currently operating from VA eye clinics in Georgia, Illinois, Nebraska, South Carolina, and Virginia; and

Whereas, An ophthalmologist at the main eye clinic reads the gathered data remotely, develops an assessment and plan, prescribes eyeglasses, and makes a determination on which patients require a face-to-face exam in the eye clinic; and

Whereas, Two years of quality data from the TECS program demonstrates the potential to improve operational efficiency, reduce cost, significantly improve access to care, and help prevent avoidable vision loss; and

Whereas, The quality data has shown abnormal findings were noted in 36.8% of patients and there was >90% agreement between the TECS reading and the face-to-face findings of the physician; and

Whereas, The remake rate for eyeglasses through TECS versus the main eye clinic, has been comparable; and

Whereas, Both the total patient and physician time spent in a TECS appointment has been shorter than in the main eye clinic; and

Whereas, The wait time and no-show rate for TECS appointments has been considerably less when compared with the main eye clinic; and

Whereas, The TECS program is estimated to have saved the VA system $52 per patient from mileage reimbursements alone; and

Whereas, A survey of TECS program participants has shown a high level of patient satisfaction; and
Whereas, Organized optometry is, nevertheless, lobbying Congress and the Department of Veterans Affairs to oppose the TECS program and any potential expansion of that program, arguing that only a dilated, comprehensive eye exam can adequately serve all veterans; therefore be it

RESOLVED, That our American Medical Association encourage the Department of Veterans Affairs to continue to explore telemedicine approaches that increase access to quality health care to U.S. Veterans, including the Technology-Based Eye Care Services (TECS) program; (Directive to Take Action); and be it further

RESOLVED, That our AMA work with Congress to ensure that U.S. Veterans can access eye care through the Technology-Based Eye Care Services (TECS) program. (Directive to Take Action)

REFERENCES

Evolving Impact of Telemedicine H-480.974

RELEVANT AMA POLICY

Veterans Administration Health System H-510.991
Our AMA supports approaches that increase the flexibility of the Veterans Health Administration to provide all veterans with improved access to health care services.


See also:
Evolving Impact of Telemedicine H-480.974
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 112
(A-17)

Introduced by: American Academy of Pediatrics

Subject: CMS Must Publish All Values for Non-Covered and Bundled Services

Referred to: Reference Committee A
(John H. Armstrong, MD, Chair)

Whereas, CMS represents both Medicare and Medicaid services; and

Whereas, CMS will only publish the Relative Update Committee (RUC) recommended values for services that are covered for Medicare recipients; and

Whereas, Medicaid and private payers who cover children’s services are not provided the validated RVU’s for these services, and consequently can choose also not to cover these services or under reimburse these services for children; therefore be it

RESOLVED, That our American Medical Association advocate that the Centers for Medicare and Medicaid Services must publish the RUC recommended values for ALL services, including non-covered and bundled services. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/03/17
Whereas, AMA policy supports the timely, equitable and affordable access to necessary acute and preventive care for all patients; and
Whereas, Unlike the uniform Medicare provider payment model regardless of state of residence, comparable Medicaid fee schedules have varied widely across each state; and
Whereas, These lower Medicaid provider payments have been consistently shown to impair patient access to cost effective preventive services through a medical home, other primary care, as well as specialty care for the sickest patients; therefore be it
RESOLVED, That our American Medical Association support fair payment equity for all Medicaid providers at Medicare rates to assure that all Medicaid patients have access to a medical home and affordable, timely access to primary and specialty care services. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 05/03/17
Whereas, Infants, children, adolescents, and young adults should be given the opportunity to attain optimal physical, mental, and social health and are best served through effective preventive health care; and

Whereas, Immunizations are an essential component of our public health and prevent significant potential morbidity and mortality from vaccine preventable diseases; and

Whereas, Our AMA supports health insurance for children on a family plan be extended to age 28, without preexisting condition limitation (H-180.964); and

Whereas, Our AMA endorses laws requiring health insurance companies to provide coverage for immunization schedules with no co-pays or deductible (H-185.969); and

Whereas, Our AMA actively encourages health insurance companies to offer products that include coverage for general preventive services (H-425.987); and

Whereas, Our AMA has policy about Medicaid Health Savings Accounts that includes providing first-dollar coverage of preventive services regardless of whether the beneficiary has met the deductible (H-290-972); therefore be it

RESOLVED, That our American Medical Association identify as policy that routine preventive pediatric care, as recommended by the American Academy of Pediatrics (AAP), and immunizations, as recommended by the Centers for Disease Control and Prevention with approval of the AAP and American Academy of Family Physicians, be a required benefit of any public or private health insurance product and that it has first dollar coverage, without copays or deductibles. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 05/03/17
Whereas, Health care costs are being increasingly borne by patients as health care consumers; and

Whereas, Health care insurers have increased co-payments and deductibles in recent years, passing more of the cost of health care on to patients; and

Whereas, Patients frequently choose high-deductible health care plans offered by insurers based on a low monthly premium without realizing the potential magnitude of their out-of-pocket expenses and the minimal coverage provided; and

Whereas, Insurers have narrowed provider networks to control costs, causing increasing numbers of physicians to be “out-of-network” and resulting in more of the cost of care being borne by patients; and

Whereas, These large gaps in insurance coverage have resulted in “surprise coverage gaps” discovered by patients when they receive a bill from a physician; and

Whereas, These surprise coverage gaps are being unfairly portrayed as “surprise bills”; and

Whereas, Many states have taken or are contemplating taking action to stop patients from receiving “surprise bills”; therefore be it
RESOLVED, That our American Medical Association adopt the following principles related to unexpected out-of-network care:

1. Patients should not be financially penalized for receiving unexpected care from an out-of-network provider.
2. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should uphold such standards in approving health insurance company plans.
3. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
4. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
5. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
6. Out-of-network payments must not be based on a contrived Medicare rate or a rate completely under the control of the insurance company.
7. In lieu of balance or surprise billing of patients, an appropriate and fair minimum benefit standard for unexpected out-of-network services should be created. The minimum benefit standard should accurately reflect reasonable physician charges, such as through the establishment of a charge-based reimbursement schedule connected to an independently recognized and verified database that is geographically specific, completely transparent, and independent of the control of either payers or providers. (New HOD Policy); and be it further


Fiscal Note: Minimal – less than $1,000

Received: 05/03/17

RELEVANT AMA POLICY

Value-Based Insurance Design H-185.939
Our AMA supports flexibility in the design and implementation of value-based insurance design (VBID) programs, consistent with the following principles:
a. Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements.
b. Practicing physicians must be actively involved in the development of VBID programs. VBID program design related to specific medical/surgical conditions must involve appropriate specialists.
c. High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included in any targeted benefit design elements of a health plan.
d. The methodology and criteria used to determine high- or low-value services or treatments must be transparent and easily accessible to physicians and patients.
e. Coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Educational materials should be made available to help patients and physicians understand the incentives and disincentives built into the plan design.
f. VBID should not restrict access to patient care. Designs can use incentives and disincentives
to target specific services or treatments, but should not otherwise limit patient care choices.
g. Physicians retain the ultimate responsibility for directing the care of their patients. Plan
designs that include higher cost-sharing or other disincentives to obtaining services designated
as low-value must include an appeals process to enable patients to secure care recommended
by their physicians, without incurring cost-sharing penalties.
h. Plan sponsors should ensure adequate resource capabilities to ensure effective
implementation and ongoing evaluation of the plan designs they choose. Procedures must be in
place to ensure VBID coverage rules are updated in accordance with evolving evidence.
i. VBID programs must be consistent with AMA Pay for Performance Principles and Guidelines
(Policy H-450.947), and AMA policy on physician economic profiling and tiered, narrow or

Reaffirmed: CMS Rep. 05, I-16 Reaffirmation I-16

Pay-For-Performance, Physician Economic Profiling, and Tiered and Narrow Networks H-
450.941
1. Our AMA will collaborate with interested parties to develop quality initiatives that exclusively
benefit patients, protect patient access, do not contain requirements that permit third party
interference in the patient-physician relationship, and are consistent with AMA policy and Code
of Medical Ethics, including Policy H-450.947, which establishes the AMA’s Principles and
Guidelines for Pay-for-Performance and Policy H-406.994, which establishes principles for
organizations to follow when developing physician profiles, and that our AMA actively oppose
any pay-for-performance program that does not meet all the principles set forth in Policy H-
450.947.
2. Our AMA strongly opposes the use of tiered and narrow physician networks that deny patient
access to, or attempt to steer patients towards, certain physicians primarily based on cost of
care factors.
3. Our AMA pledges an unshakable and uncompromising commitment to the welfare of our
patients, the health of our nation and the primacy of the patient-physician relationship free from
intrusion from third parties.
4. Because there are reports that pay-for-performance programs may pose more risks to
patients than benefits, our AMA will prepare an annual report on the risks and benefits of pay-
for-performance programs, in general and specifically the largest programs in the country
including Medicare, for the House of Delegates over the next three years, beginning at the 2007
Interim Meeting. This report shall clearly delineate between private pay-for-performance
programs and voluntary public pay-for-reporting and other related quality initiatives.
5. Our AMA will continue to work with other medical and specialty associations to develop
effective means of maintaining high quality medical care which may include physician
accountability to robust, effective, fair peer review programs, and use of specialty-based clinical
data registries.
6. As a step toward providing the Centers for Medicare and Medicaid Services (CMS) with data
on special populations with higher health risk levels and developing variable incentives in
achieving quality, our AMA will continue to work with CMS to encourage and support pilot
projects, such as the Physician Quality Reporting Initiative (PQRI), by state and specialty
medical societies that are developed collaboratively to demonstrate effective incentives for
improving quality, cost-effectiveness, and appropriateness of care.
7. Our AMA will advocate that physicians be allowed to review and correct inaccuracies in their
patient specific data well in advance of any public release, decreased payments, or forfeiture of
opportunity for additional compensation.
824, I-10
Tiered, Narrow, or Restricted Physician Networks D-285.972

Our AMA will:
(1) seek to have third party payers disclose, in plain language, the criteria by which the carrier creates a tiered, narrow or restricted network;
(2) monitor the development of tiered, narrow or restricted networks to ensure that they are not inappropriately driven by economic criteria by the plans and that patients are not caused health care access problems based on the potential for a limited number of specialists in the resulting network(s); and
(3) seek legislation or regulation which prohibits the formation of networks based solely on economic criteria and ensures that, before health plans can establish new panel networks, physicians are informed of the criteria for participating in those networks, with sufficient advance time to permit them to satisfy the criteria.

Whereas, The Medicare fee-for-service program establishes payment policies for reimbursement of provider services through local coverage determinations and the national correct coding initiative; and

Whereas, Medicare Advantage private health plans do not always follow the same local coverage determinations and correct coding initiative when reimbursing physicians according to the Medicare fee-for-service fee schedule; and

Whereas, Some Medicare Advantage health plans are denying Medicare fee-for-service payments to contracting physicians for various professional services including, but not limited to, advanced care planning, conscious sedation, EKG interpretation, transfusions and ultrasound interpretation; and

Whereas, Some Medicare Advantage health plans unnecessarily profit by denying such payment for valuable physician services; and

RESOLVED, That our American Medical Association urge the Centers for Medicare and Medicaid Services (CMS) to require Medicare Advantage plans to abide by all traditional Medicare Fee-for-Service payment and medical policies when reimbursing physicians on a fee-for-service basis to ensure uniformity in Medicare benefits and to reduce physician burdens. This policy is not intended to impact capitation rates that are agreed to between a Medicare Advantage plan and a physician or physician organization. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 05/03/17

RELEVANT AMA POLICY

Include Physicians in CMS Rate Increases to Medicare Advantage Plans H-390.842
Our American Medical Association (1) encourages Medicare Advantage plans to be transparent with respect to the allocation of their rate increases, and (2) encourages individual physicians to negotiate rate increases that parallel or improve upon the percentage increases received by the Medicare Advantage plans with which they contract.

Sub. Res. 128, A-15
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 117
(A-17)

Introduced by: Ohio

Subject: Expansion of U.S. Veterans’ Healthcare Choices

Referred to: Reference Committee A
(John H. Armstrong, MD, Chair)

Whereas, Concerns about quality of and access to health care for U.S. veterans through the Veterans Health Administration and its preceding entities have arisen intermittently since the founding of our Republic, followed by attempts at reforms; and

Whereas, Whistleblower claims in 2014 that dozens of veterans at a single VA hospital died waiting for medically necessary care while on manipulated wait lists led to definitive determinations that the majority of VA hospitals were using some form of a manipulated wait list to hide the true wait times for their patients and that hundreds of thousands of vets still wait long periods to access needed health care, which determinations forced the resignations of the secretary of the VA, the Under Secretary for Health for the VA, and other top VA officials nationwide; and

Whereas, Survey of United States armed forces veterans revealed that 89% of veterans are in favor of reforming veterans’ health care, including increasing health care choices for veterans; 86% believe they should have the right to choose a private physician, and 77% believe they should be given this choice even if it involves some financial contribution out of pocket; and

Whereas, Most Americans, including VA employees, enjoy the right to choice of private health care, and our veterans deserve this same choice, and

Whereas, At its 2016 Annual House of Delegates Meeting, the Ohio State Medical Association (OSMA) adopted as policy that the Veterans Health Administration expand all eligible veterans’ health care choices by permitting them to use funds currently spent on them through the VA system, through a mechanism known as premium support, to purchase private health care coverage, and for veterans over age 65, to use these funds to defray the costs of Medicare premiums and supplemental coverage; and

Whereas, A resolution carried from the OSMA delegation to our American Medical Association House of Delegates 2016 Annual meeting regarding this expansion of health insurance choices with further request that our AMA actively support federal legislation to achieve this reform was referred, and the problem remains unresolved; and

Whereas, The OSMA, by means of the OSMA website as well as written letters to elected federal legislators and the U.S. President, actively supported federal legislation to achieve this reform of veterans’ health care choices; therefore be it
RESOLVED, That our American Medical Association adopt as policy that the Veterans Health Administration expand all eligible veterans’ health care choices by permitting them to use funds currently spent on them through the VA system, through mechanisms such as premium support, to purchase private health care coverage, and for veterans over age 65 to use these funds to defray the costs of Medicare premiums and supplemental coverage (New HOD Policy); and be it further

RESOLVED, That our AMA actively support federal legislation to achieve this expansion of healthcare choices for Veterans Administration eligible veterans. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 05/03/17

Reference: Fixing Veterans Health Care, a Bipartisan Policy Taskforce, Concerned Veterans for American, February 2015

RELEVANT AMA POLICY

Access to Health Care for Veterans H-510.985
Our American Medical Association: (1) will continue to advocate for improvements to legislation regarding veterans' health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the Veterans Administration health care system; (2) will monitor implementation of and support necessary changes to the Veterans Choice Program's "Choice Card" to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the Veterans Administration health care system; (3) will call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans; (4) will advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician; (5) will advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans; and (6) will support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation’s veterans.

Sub. Res. 111, A-15

Ensuring Access to Care for our Veterans H-510.986
1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.
2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.
3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans.
4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration.

Policy Timeline
Whereas, Many third party payers compensate patients at extremely low rates and require drastic increases in deductibles and co-payments in instances where an out-of-network physician is their only choice, their most immediate choice, or in the best interest of their health; and

Whereas, Some of these reimbursement amounts are even less than Medicaid reimbursements; and

Whereas, Many insurers do not have enough participating physicians in all different specialties (for whatever reason, but likely to enhance their own profit) and do not have any penalty for failure to provide care; and

Whereas, Many insurers do not have qualified physicians in the vicinity of patients; and

Whereas, Many patients require immediate and life-saving care that might not be readily available from participating and in-network physicians; and

Whereas, Many insurers and third-party payors are reimbursing patients unfairly and inappropriately, forcing them to take measures adversely affecting their health; and

Whereas, Some insurers and third-party payors are not reimbursing non-participating emergency physicians and hospitals in full usual customary charge as required by law in emergency situations; and

Whereas, Many insurers and third-party payors are not reimbursing in full usual customary charge if patients undergo surgery in urgent and emergent situation from non-participating network physician and/or specialist; it is difficult to obtain follow-up care from another surgeon and or specialist; and

Whereas, The AMA should come to the defense of our handicapped patients and or any patient who needs treatment urgently and/or emergently from nonparticipating physicians; therefore be it

RESOLVED, That our American Medical Association policy seek to require insurers and third-party payors to properly reimburse patients and/or out-of-network physicians their usual charges, and that there be no increase in deductibles or co-payments for those patients requiring care from out-of-network physicians because of urgent and emergent treatment needed in emergency rooms and hospitals and/or seek federal legislation addressing these issues. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000
Received: 05/03/17
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 119
(A-17)

Introduced by: Endocrine Society
Obesity Medicine Association
American Association of Clinical Endocrinologists

Subject: Support Efforts to Improve Access to Diabetes Self-Management Training Services

Referred to: Reference Committee A
(John H. Armstrong, MD, Chair)

Whereas, Nearly 26 million Americans have diabetes; of those, 18.8 million people are diagnosed and 7 million are undiagnosed; and

Whereas, Diabetes is the leading cause of kidney failure, non-traumatic lower limb amputations and new cases of blindness, as well as a major cause of heart disease and stroke; and

Whereas, Diabetes Self-Management Training (DSMT) is an effective, proven, evidence-based collaborative process through which people with diabetes or those at high risk for diabetes gain the knowledge and skills needed to modify their behavior and manage their diabetes and its complications; and

Whereas, The Centers for Disease Control and Prevention (CDC) recommends that individuals with diabetes should see a health care provider who specializes in diabetes care, and also notes the role of dieticians and diabetes educators to help individuals learn to manage their diabetes; and

Whereas, Despite its proven cost-effective benefits, only 5% of Medicare beneficiaries use DSMT services; and

Whereas, The Centers for Medicare & Medicaid Services (CMS) has noted the importance of DSMT and solicited feedback on existing barriers contributing to its underutilization; and

Whereas, The American Medical Association (AMA) Physician Consortium for Performance Improvement (PCPI) and the National Committee for Quality Assurance (NCQA), in its 2014 recommendations for adult diabetes care, noted the importance of DSMT as well as its current underutilization, and existing barriers to care; and

Whereas, Major stakeholders in the diabetes community have identified five key barriers contributing to the underutilization of DSMT, noted below; and

Whereas, Current Medicare policy requires a patient to be referred for DSMT by the patient’s ‘treating provider’, despite the fact that the patient’s diabetes may be diagnosed by a specialty area who cannot refer to DSMT, or the patient may even wish to refer himself for DSMT; and
Whereas, Current Medicare policy restricts the ability of hospital outpatient departments to expand into more convenient community based locations in order to increase access to DSMT; and

Whereas, The DSMT benefit is subject to the Medicare Part B deductible and a 20% beneficiary coinsurance, despite evidence showing that reducing or eliminating patient cost-sharing for DSMT increases utilization, improves patient health status, and accrues cost savings to the Medicare program through reducing diabetes-related complications; and

Whereas, Current Medicare policy restricts the ability of patients to receive DSMT and Medical Nutrition Therapy (MNT) on the same day, despite the fact that MNT and DSMT are often complementary services for patients with certain diabetes-related medical conditions, thus placing an unnecessary burden on those patients who require both services; and

Whereas, Many patients with diabetes require additional DSMT that exceed Medicare's prescribed policy, or they are not able to complete a DSMT program within the constraints dictated by Medicare policy, namely: 10 hours of initial DSMT within 12 months of the first DSMT visit and an additional 2 hours of DSMT per subsequent calendar year, and thus are not able to achieve full benefit from this service; therefore be it

RESOLVED, That our American Medical Association actively support regulatory and legislative actions that will mitigate barriers to Diabetes Self-Management Training (DSMT) utilization (Directive to Take Action); and be it further

RESOLVED, That our AMA support outreach efforts to foster increased reliance on DSMT by physician practices in order to improve quality of diabetes care. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 05/03/17
Whereas, The National Pressure Ulcer Advisory Panel has issued new recommendations that will change the nomenclature for naming and diagnosing all forms and stages of pressure ulcers to use the term “pressure injury” instead of “pressure ulcer”; and

Whereas, The terms pressure “ulcer” and pressure “injury” are both imprecise terms. While “ulcer” is at times inaccurate, the terminology has widespread use among practitioners. However, its replacement with the term “injury” is equally imprecise and as well prejudicial, as the term is variously defined as “harm” or “hurt,” usually applied to damage inflicted to the body by an external force; and

Whereas, The term “injury” is widely used as a legal term, which is likely to have unintended consequences in malpractice suits and regulatory actions (Barios OWM 2016;62:Issue 7); and

Whereas, There is considerable concern among wound healing specialists and wound care organizations (e.g., American Association for the Advancement of Wound Care position statement, American College of Clinical Wound Specialists) that a change to the term “injury” will produce unintended consequences (Bolton 2016;62:Issue 6) as the term is not consistent with current understanding of pressure ulcer etiology. Research suggests that development of a pressure ulcer is not due only to application of external force, but depends in large part on patient intrinsic factors unique to each individual; and

Whereas, There is a clash between “injury” and “unavoidable” in the current dialog about etiology of pressure ulcers. Unavoidable, in terms of Federal guidelines, means that the resident developed a pressure ulcer even though the facility had evaluated the resident's clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with resident needs, goals, and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate. Labeling every pressure ulcer as an “injury” obscures this distinction; and

Whereas, Redefining ICD-10 codes is a major undertaking, and will be problematic for the vast majority of providers. A major educational initiative will be required among practitioners nationwide and is likely to sow confusion. This proposed change in terminology is neither helpful nor necessary, and is likely to make the situation worse; therefore be it

RESOLVED, That our American Medical Association formally oppose a change in nomenclature from “pressure ulcer” to “pressure injury” in the ICD-10 and other diagnostic catalogues and classification systems. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000
Received: 05/01/17
WHEREAS, The Current Procedural Terminology (CPT) advance care planning codes 99497 and 99498 were recently created and the Centers for Medicare & Medicaid Services has now assigned fees associated with providing these services; and

WHEREAS, The complexity of advanced care planning and completion of an advanced directive may require the assistance of multiple health professionals over multiple visits, (i.e., physician, nurse-practitioner or physician's assistant, social worker or case manager); and

WHEREAS, Anecdotal evidence suggests that this complexity and other barriers may still be hindering physicians and other health care professionals from having advanced care planning discussions with their patients and being properly reimbursed; therefore be it

RESOLVED, That our American Medical Association assess the degree of use of CPT Codes 99497 and 99498 since they were established (Directive to Take Action); and be it further

RESOLVED, That our AMA study the barriers to discussion about advanced care planning by physicians and patients (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the expanded use of CPT Codes 99497 and 99498 when sufficient time and effort is spent in face-to-face contact with patients and families and when spread out over multiple clinical visits in order to satisfy the time requirements, due to the complexity of the subject matter. (New HOD Policy)

Fiscal Note: Not yet determined

Received: 05/01/17
Whereas, It has been our AMA policy since 2004 that the pre-colonoscopy visit should be reimbursable by Medicare and other insurers, but there has been no action to bring this policy to fruition; and

Whereas, Colonoscopy is an invasive procedure which has been demonstrated to save lives by preventing colon cancer and by finding lesions in an early stage so that endoscopic procedures can be curative; and

Whereas, Due to this benefit, colonoscopy was approved by the Centers for Medicare & Medicaid Services for prevention of colon cancer in average risk individuals beginning on July 1, 2001; and

Whereas, Patients should see the doctor who is performing an invasive procedure prior to preparing for an elective procedure; and

Whereas, The doctor should have the opportunity to evaluate the patient for an invasive procedure if he feels that it is necessary; and

Whereas, The preparation of the colon is a vital part of the procedure in that good preparation enables the endoscopist the ability to detect small polyps and flat lesions; and

Whereas, The preparation of the colon is a quality issue for the doctor performing the colonoscopy; and

Whereas, The interval of ten years between colonoscopies has been demonstrated to be safe and cost effective in patients with good preparation; and

Whereas, The Secretary of Health and Human Services has been granted extraordinary powers under the Affordable Care Act; and

Whereas, The current Secretary of Health and Human Services has a strong understanding of the deliberative processes of our AMA; and

Whereas, In the State of South Carolina, the state insurance fund already pays for this pre-colonoscopy visit; therefore be it
RESOLVED, That our American Medical Association request that the Secretary of Health and Human Services consider allowing Medicare to pay for the pre-colonoscopy consultation to ensure that patients are well chosen, well informed about their choices and well versed in preparation for their colonoscopies. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 05/08/17
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 123
(A-17)

Introduced by: American Society for Gastrointestinal Endoscopy
American College of Gastroenterology
American Gastroenterological Association

Subject: Improving the Prevention of Colon Cancer by Insuring the Waiver of the Co-Payment in all Cases

Referred to: Reference Committee A
(John H. Armstrong, MD, Chair)

Whereas, It has been our AMA policy since 2004 that all methods for prevention of colon cancer that are approved by the United States Preventive Services Task Force should be included in all health plans; and

Whereas, Colonoscopy is an invasive procedure which has been demonstrated to save lives by preventing colon cancer and by finding lesions in an early stage so that endoscopic procedures can be both preventative and curative; and

Whereas, Due to this benefit, colonoscopy was approved by the Centers for Medicare & Medicaid Services for prevention of colon cancer in average risk individuals beginning on July 1, 2001; and

Whereas, Current reimbursement practice is that the copay is waived for preventive services such as colonoscopy; and

Whereas, There are proposals to not include all approved services in insurance plans; and

Whereas, For Medicare patients, when a polyp is removed as part of the procedure to prevent the development of colon cancer, the patient is charged a co-payment; therefore be it

RESOLVED, That our American Medical Association strongly advocate that all approved preventive services be included in all health plans (New HOD Policy); and be it further

RESOLVED, That our AMA strongly urge members of the Congress and the President to support legislation to correct the oversight in the original legislation providing the benefit of colonoscopy screening with the inducement that the copay would not be required when a polyp or other lesion is found as part of the screening process. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/08/17
Whereas, The Centers for Medicare and Medicaid Services (CMS) will only cover the costs of emergency medical services (EMS) transport of patients, not treatment without transport, and such ambulance transports are further restricted to defined locations, not necessarily to the most appropriate and beneficial location for the patient; and

Whereas, Paramedics and other EMS personnel can often provide on-site, community-based evaluation, and triage health care services in a more cost-effective manner than the emergency room setting or traditional CMS defined transport destinations; and

Whereas, EMS could transport patients directly to the appropriate next site of care such as a psychiatric hospital, a detoxification unit, or other site, thus providing more cost-effective care; and

Whereas, EMS companies providing transportation of patients to the appropriate next site of care, other than to CMS approved destinations, incur the expense of the care and the transport with no opportunity to recoup this revenue loss; therefore be it

RESOLVED, That our American Medical Association amend existing AMA Policy H-240.978, “Medicare’s Ambulance Service Regulations,” by addition to read as follows:

The AMA supports changes in Medicare regulations governing ambulance service coverage guidelines that would expand the term "appropriate facility" to allow full payment for transport to facilities other than the closest based upon the physician's judgment and to expand the list of eligible transport locations from the current three sites of care (nearest hospital, critical access hospital, or skilled nursing facility) based upon the on-site evaluation and consulting physician’s judgement (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA work with the Centers for Medicare & Medicaid Services (CMS) to reimburse emergency medical services providers for the evaluation and transport of patients to the appropriate next site of care rather than only to CMS defined and limited transport locations.

(Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17
RELEVANT AMA POLICY

Medicare's Ambulance Service Regulations H-240.978
The AMA supports changes in Medicare regulations governing ambulance service coverage guidelines that would expand the term "appropriate facility" to allow full payment for transport to facilities other than the closest based upon the physician's judgment.

On-Site Emergency Care H-130.976
(1) The AMA reaffirms its policy endorsing the concept of appropriate medical direction of all prehospital emergency medical services. (2) The following factors should be considered by prehospital personnel in making the decision either to provide extended care in the field or to evacuate the trauma victim rapidly: (a) the type, severity and anatomic location of the injury; (b) the proximity and capabilities of the receiving hospital; (c) the efficiency and skill of the paramedic team; and (d) the nature of the environment (e.g., rural or urban). (3) Because of the variability of these factors, no single methodology or standard can be applied to all accident situations. Trauma management differs markedly between locales, settings, and types of patients receiving care. For these reasons, physician supervision of prehospital services is essential to ensure that the critical decision to resuscitate in the field or to transfer the patient rapidly is made swiftly and correctly.

Reference
Whereas, The Centers for Disease Control and Prevention (CDC) has declared an opioid misuse epidemic in the United States; and

Whereas, The need for medical management and treatment of substance use disorders (SUD), including opioid misuse and alcohol misuse, far exceeds the current availability of Addiction Medicine specialty physicians; and

Whereas, On January 1, 2016, Medicaid began allowing physicians and non-physician practitioners providing medical management of SUD to use an Opioid Use Disorder code for relevant office visits, thus providing payment coverage for these services (known as Office-Based Opioid Treatment or OBOT); and

Whereas, Medicaid currently covers payment for naltrexone (Vivitrol, a monthly injectable medication) for the treatment of both Alcohol Use Disorder and Opioid Use Disorder; and

Whereas, Medicaid does not cover payments for office visits related to the medical management of other substance use disorders, including Alcohol Use Disorder; and

Whereas, Access to medical treatment for SUD for persons with Medicaid coverage is already very limited; and

Whereas, The limited payment coverage for medical management of SUD to OBOT serves as a deterrent to primary care physicians who might consider improving access by providing SUD services for their patients; and

Whereas, The appropriate billing and coding processes for medical management and treatment of SUD is unclear for both addiction medicine specialty physicians and primary care physicians, leading to poor payment coverage for these services, again limiting access; therefore be it

RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services (CMS) to provide expanded Medicaid payment coverage for the medical management and treatment of all substance use disorders (Directive to Take Action); and be it further

RESOLVED, That our AMA work with CMS to establish clear billing and coding processes regarding the medical management and treatment of all substance use disorders. (Directive to Take Action)
RELEVANT AMA POLICY

Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs H-185.974
Our AMA supports parity of coverage for mental illness, alcoholism, substance use, and eating disorders.

Advocating for Reform in Payment of Mental Health and Substance Use Disorder Services H-345.980
Our AMA advocates that funding levels for public sector mental health and substance use disorder services not be decreased in the face of governmental budgetary pressures, especially because private sector payment systems are not in place to provide accessibility and affordability for mental health and substance use disorder services to our citizens.
Res. 205, A-06 Modified: CMS Rep. 01, A-16

Substance Use and Substance Use Disorders D-95.984
Our AMA:
(1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders;
(2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and
(3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.
CSAPH Rep. 8, A-08
Whereas, Venous disorders of the leg constitute a large financial burden ($2.5-$3.5 billion annually for venous stasis ulcers alone\(^1\)) on the health care system and produce substantial morbidity rates; and

Whereas, Compression stockings have been shown to prevent deep vein thrombosis, to reduce symptoms of various venous disorders including varicose veins and phlebitis, and to prevent venous stasis ulcers\(^2\); and

Whereas, Medicare currently covers compression stockings only when open venous stasis ulcers are already present\(^3\); and

Whereas, The over-the-counter cost of gradient compression stockings can be up to or exceeding sixty-five dollars; and

Whereas, Patient non-compliance with compression stockings for chronic venous disease may be as high as 63 percent due to factors such as cost and difficulty or lack of knowledge of how to apply the stockings\(^4\); and

Whereas, Existing research suggests patient compliance with compression stocking therapy increases when physicians offer education regarding venous disease and the use of compression stockings\(^5\); and

Whereas, Michigan Medicaid currently covers compression stockings, if deemed medically necessary by a physician for lymphedema, chronic venous insufficiency, thrombophlebitis, burns or post-surgical care\(^6\); therefore be it

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RESOLVED, That our American Medical Association engage all relevant stakeholders in ensuring unconditional Medicare compensation for gradient compression stockings as prescribed by a physician under the durable medical equipment portion of coverage, including for cases of preventative use and for patients without a present venous stasis ulcer. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17

RELEVANT AMA POLICY

Appropriateness of National Coverage Decisions D-330.918

1. Our AMA will work with the national medical specialty societies and the Centers for Medicare and Medicaid Services (CMS) and their intermediaries to identify outdated coverage decisions that create obstacles to clinically appropriate patient care.
2. Our AMA will work with CMS to suspend recovery actions for technologies and treatments for which sufficient comparative effectiveness research or other quality evidence exists to update a National Coverage Determination (NCD) or Local Coverage Determination (LCD) to reflect the available scientific evidence and contemporary practice.

Sub. Res. 120, A-11 Reaffirmed in lieu of Res. 125, A-12
REFERRAL CHANGE:  
WAS RESOLUTION 204

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 127  
(A-17)

Introduced by: Washington

Subject: Balance Billing State Regulation

Referred to: Reference Committee A  
(John H. Armstrong, MD, Chair)

Whereas, Balance billing occurs when an out-of-network physician bills a patient for the outstanding balance of the entire charge after the insurance company submits its portion of the bill; and

Whereas, Median physician charges have been recently reported to vary greatly across the nation and average 2.5 times higher than what Medicare pays (JAMA;317(3):315-317); and

Whereas, Nearly 7 in 10 of individuals with unaffordable out-of-network medical bills did not know the health care provider was not in their plan’s network at the time they received care; and

Whereas, The ACA requires health plans to provide coverage for out-of-network emergency care services and apply in-network levels of cost sharing for emergency services, even if the plan otherwise provides no out-of-network coverage; and

Whereas, CMS has issued rules to begin to address surprise medical bills for non-emergency services for individuals covered by qualified health plans offered through the Health Insurance Marketplace; and

Whereas, The National Association of Insurance Commissioners has proposed changes to its health plan network adequacy model act to address surprise medical bills; and

Whereas, Most states are either contemplating or have passed balance billing limits or mandatory dispute resolution processes between payers and providers in balance billing cases; therefore be it

RESOLVED, That our American Medical Association report on the status of the various current efforts across the country, including the many state legislative efforts, to limit non-Medicare balance billing (Directive to Take Action); and be it further

RESOLVED, That our AMA develop model state legislation to assist its component members in their advocacy efforts against current efforts to regulate balance billing (Directive to Take Action); and be it further

RESOLVED, That the Board of Trustees report back to the House of Delegates at the 2017 Interim Meeting according to AMA Policy D-380.996. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 04/25/17
RELEVANT AMA POLICY

Balance Billing for All Physicians D-380.996
1. Our AMA will devote the necessary political and financial resources to introduce national legislation at the appropriate time to bring about implementation of Medicare balance billing and to introduce legislation to end the budget neutral restrictions inherent in the current Medicare physician payment structure that interferes with patient access to care.
2. This national legislation will be designed to pre-empt state laws that prohibit balance billing and prohibit inappropriate inclusion of balance billing bans in insurance-physician contracts.
3. Our AMA will develop model language for physicians to incorporate into any insurance contracts that attempt to restrict a physician's right to balance bill any insured patient.
4. Our AMA Board of Trustees will report back to our AMA House of Delegates electronically by March 15, 2008 and at every HOD meeting its progress toward the completion of all of these goals.
Res. 925, I-07

Medicare Balance Billing D-390.985
Our AMA will work on behalf of physicians to regain the right to balance bill Medicare patients for the full reasonable fees as they determine appropriate.

Medicare Balance Billing D-390.986
Our American Medical Association: (1) advocate that physicians be allowed to balance bill Medicare recipients to the full amount of their normal charge with the patient responsible for the difference between the Medicare payment and the physician charges; (2) seek introduction of national legislation to bring about implementation of balance billing of Medicare recipients; and (3) further advocate that such federal laws and regulations pre-empt state laws that prohibit balance billing.

Balance Billing H-385.991
Our AMA supports the right of the physician to balance bill a patient for any care given, regardless of method of payment, where permissible by law or contractual agreement.