Online Member Forum Summary Report
Reference Committee J
2018 Interim Meeting
November 5, 2018

BOT 9 - Hospital Closures and Physician Credentialing

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Fri, 09/14/2018 - 10:52 #1

Roger Brown

BOT 9 - Hospital Closures and Physician Credentialing

PDF version

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 716-A-18 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-230.956, which states that the governing body of the hospital, ambulatory surgery facility, nursing home, or other health care facility should be responsible for making arrangements for the disposition of physician credentialing records upon the closing of a facility and should make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, and medical staff status. (Reaffirm HOD Policy)

2. That our AMA develop model state legislation and regulations that would require hospitals to: (a) implement a procedure for preserving medical staff credentialing files in the event of the closure of the hospital; and (b) provide written notification to its state health agency and medical staff before permanently closing its facility indicating whether arrangements have been made for the timely transfer of credentialing files and the exact location of those files. (Directive to Take Action)
3. That our AMA: (a) continue to monitor the development and implementation of physician credentialing repository databases that track hospital affiliations; and (b) explore the feasibility of developing a universal clearinghouse that centralizes the verification of credentialing information as it relates to physician practice and affiliation history, and report back to the House of Delegates at the 2019 Interim Meeting. (Directive to Take Action)

Top

Sat, 10/27/2018 - 18:41

DAVID WELSH

RE: BOT 9 - Hospital Closures and Physician Credentialing

As more hospitals close, this problem only grows. I thank our BOT for their hard work and this report. I thank them for stepping up.

Opinion Type: My post is my personal opinion

Top

Add new comment

Your name Courtney Perlino

Subject

RE: BOT 9 - Hospital Closures and Physician Credentialing

Comment *

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Prescription Drug Importation for Personal Use

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Thu, 10/11/2018 - 13:44 #1

Carla Frenzel

Prescription Drug Importation for Personal Use

PDF version

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 226-I-17, and that the remainder of the report be filed.

That our American Medical Association (AMA) support the in-person purchase and importation of prescription drugs obtained directly from a licensed Canadian pharmacy when product integrity can be assured, provided such drugs are for personal use and of a limited quantity. (New HOD Policy)

That our AMA advocate for an increase in funding for the US Food and Drug Administration to administer and enforce a program that allows the in-person purchase and importation of prescription drugs from

Canada, if the integrity of prescription drug products imported for personal use can be assured. (New HOD Policy)

That our AMA reaffirm Policy D-100.983, which outlines criteria for supporting the legalized importation of prescription drug products by wholesalers and pharmacies, and opposes the personal importation of prescription drugs via the Internet until patient safety can be assured. (Reaffirm HOD Policy)

That our AMA reaffirm Policy D-100.985, which opposes the illegal importation of prescription drugs and drug counterfeiting, and supports working with Congress, federal agencies and other stakeholders to ensure that these illegal activities are minimized.

Resolution:
1

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Tue, 10/30/2018 - 14:59

Paul Wertsch

RE: Prescription Drug Importation for Personal Use

Good start advocating for legal importation of prescription drugs through a license Canadian pharmacy. But I would expand it to include the mail-order purchase of prescription drugs through a certified licensed Canadian pharmacy? The only way we're going to get any movement on the price of pharmaceuticals is to develop more of a market. Allowing competition will bring needed reform to the system. It should not be hard to devise a system to make sure that we're

dealing with a certified licensed legitimate Canadian pharmacy. We want to avoid having illegitimate schemes take advantage of people. People are doing this already. Let's just have a better way for people to be sure they're dealing with it legitimate certified Canadian pharmacy and make it legal for people to do what they have been doing.

Opinion Type: My post is my personal opinion

Top

Add new comment

Your name Courtney Perlino

Subject

RE: Prescription Drug Importation for Personal Use

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Air Ambulance Regulations and Payments

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Thu, 10/11/2018 - 13:45 #1

Carla Frenzel

Air Ambulance Regulations and Payments

PDF version

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

That our American Medical Association (AMA) amend Policy H-130.954, "Non-Emergency Patient Transportation Systems," by addition as follows:

The AMA: (1) supports the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.. (Modify Current HOD Policy)

That our AMA support increased data collection and data transparency of air ambulance providers and services to the appropriate state and federal agencies, particularly increased price transparency. (New HOD Policy)

That our AMA work with relevant stakeholders to evaluate the Airline Deregulation Act as it applies to air ambulances. (New HOD Policy)

That our AMA support stakeholders sharing air ambulance best practices across regions. (New HOD Policy)

That our AMA rescind Policy D-130.964, which directed the AMA to conduct the study herein.

Resolution:
2

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Tue, 10/30/2018 - 15:34

Paul Wertsch

RE: Air Ambulance Regulations and Payments

Good report. I agree with the request to get better data and better price transparency. It would be nice to see the outcomes. What happened to the patients after the air ambulance ride? Survival data, percentage going to surgery, etc? This would help in determining the necessity for the air ambulance services. It would also be nice to compare prices. If there are several different air ambulances services covering a district. If one charges twice as much as the other for a ride

that would be important for us to know. Sharing best practices would be valuable.

Opinion Type: My post is my personal opinion

Top

Sun, 11/04/2018 - 22:08

Tom Plagge

RE: Air Ambulance Regulations and Payments

Tom Plagge, medical student from Ohio, speaking on behalf of the Medical Student Section in support of the recommendations of the Council on Medical Service Report 02.

Air ambulance bills are an expense that the average American is unprepared to face. A quick search shows stories from across the country of patients facing bills between $40,000 and $50,000 that are not covered by insurance.The median household income in the US is $59,039. The debt faced by patients after using an air ambulance can be crushing, and as the rural healthcare crisis deepens, over a quarter of Americans are now reliant on air ambulances for access to emergency hospital care. Taking action on this issue builds upon existing AMA policy that opposes penalizing patients for out-of-network costs, supports Medicare coverage of patients' full transportation cost, and promotes greater price transparency and education for patients and providers.

We believe that the Council's recommendations, especially regarding evaluation of the Airline Deregulation Act (ADA), will work towards these goals and contribute to decreased cost for patients. Competitive market forces unleashed by the ADA have produced lower prices elsewhere in the air carrier industry but, owing to consumers' poor bargaining power in emergency transport situations, have had the opposite effect on air ambulance pricing since state agencies are forbidden from enacting even the most common-sense regulation. Domination of the industry by a small number of private, for-profit operators and the growing interest of private equity firms are familiar signs that do not augur well for patients whose lives may depend on their services. Thoughtful examination of the Act and how

to resolve its unintended consequences will nicely complement the further recommendations addressing air ambulance education, data transparency, and best practice development in helping to stabilize air ambulance prices.

For these reasons, we thank the Council for its thorough and insightful report and stand in strong support of the recommendations therein. Thank you for your time and consideration of this testimony.

Opinion Type: My post reflects the opinion of my delegation or section

Signature Name: Tom Plagge

Delegation section or society: Medical Student Section

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Your name Courtney Perlino

Subject

RE: Air Ambulance Regulations and Payments

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Sustain Patient-Centered Medical Home Practices

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Tue, 10/16/2018 - 13:25 #1

Carla Frenzel

Sustain Patient-Centered Medical Home Practices

PDF version

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 813-I-17 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-160.919 that contains principles of the Patient-Centered Medical Home (PCMH) including that payment should appropriately recognize the added value provided to patients who have a PCMH and the additional physician and team work associated with participating in a PCMH. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-385.908 urging that financial risk should be limited to costs that physicians have the ability to influence or control. (Reaffirm HOD Policy)

3. That our AMA amend Policy, H-160.918, "The Patient-Centered Medical Home," by addition and deletion as follows:

Our AMA:

a. will urge the Centers for Medicare and Medicaid Services (CMS) to work with our AMA and national medical specialty societies to design incentives to enhance care coordination among providers who provide medical care for patients outside the medical home;

b. will urge CMS to assist physician practices seeking to qualify for and sustain medical home status with financial and other resources; and

c. will advocate that Medicare incentive payments associated with the medical home model be paid for through system-wide savings – such as reductions in hospital admissions and readmissions (Part A), more effective use of pharmacologic therapies (Part D), and elimination of government subsidies for Medicare Advantage plans (Part C) – and not be subject to a budget neutrality offset in the Medicare physician payment schedule.~~; and~~

~~d. will advocate that all health plans and CMS use a single standard to determine whether a physician practice qualifies to be a patient-centered medical home.~~ (Modify Current HOD Policy)

4. That our AMA advocate that all payers support and assist PCMH transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care recognizing that payer support is crucial to the long-term sustainability of delivery reform. (New HOD Policy)

5. That our AMA encourage health agencies, health systems, and other stakeholders to support and assist patient-centered medical home transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care. (New HOD Policy)

Resolution:
3

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Sat, 10/27/2018 - 18:44

DAVID WELSH

RE: Sustain Patient-Centered Medical Home Practices

Support.

Opinion Type: My post is my personal opinion

Top

Tue, 10/30/2018 - 20:23

Paul Wertsch

RE: Sustain Patient-Centered Medical Home Practices

Family Physicians and Pediatricians have been providing a medical home for many many years, far longer than there was a name for it. It

works well to take care of your patients through the continuity of time and following them through many of their illnesses with help of specialists when needed. But then the government decided that it was a good idea and that they would have to define it, qualify it, and certify people to participate in it with the hope of getting some extra reimbursement for being a medical home. The certifying agencies have set up their standards and charge a lot to certify that you for following their arbitrary rules and then charge you more to recerify you. The payoffs for the efforts have been more elusive.

So one appoach would be to recognize the value of the patient centered medicial home and reimburse practices for the expense required to be certifed and recertified. Better yet it would be to recognize the medical home by its output and stop the expensive and wasteful certifications. I don't think many practices improved their care for patients by becoming certified as a medical home but they have hired more staff, filled out alot more forms and had less time to help patients.

Opinion Type: My post is my personal opinion

Top

Sun, 11/04/2018 - 19:07

Pak

RE: Sustain Patient-Centered Medical Home Practices

Thomas Pak, medical student from Iowa, speaking on behalf of the Medical Student Section in SUPPORT of the Council on Medical Services Report 03.

Patient-Centered Medical Homes (PCMHs) plays an increasingly critical role in an evolving payment and delivery system. Evidence suggests that PCMHs improve quality of care, patient experience, and staff satisfaction, all while reducing costs and promoting coordination between providers.

However, as the Council notes in this report, practices need to overcome significant barriers, financial and otherwise, in order to obtain, and maintain, PCMH status. By calling on the Centers for Medicare and Medicaid Services (CMS) to assist practices that are struggling to sustain their PCMH status, and by suggesting we rescind previous AMA policy which imposed inflexible standards on these practices, the Council has recommended clear ways in which we can provide this support to PCMHs.

Our Medical Student Section has already supported the AMA in calling for increased financial support for practices trying to obtain PCMH status. Moreover, we have called for increased PCMH-related training in medical school and residency. More generally, we are committed to supporting any policies which promote the delivery of equitable healthcare to diverse patient populations.

Therefore, our MSS supports the recommendations made by the Council in this report and thanks them for addressing this important issue.

Opinion Type: My post reflects the opinion of my delegation or section

Signature Name: Pak

Delegation section or society: Medical Student Section

Top

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Your name [Courtney Perlino]

Subject

RE: Sustain Patient-Centered Medical Home Practices

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The Site-of-Service Differential

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Thu, 10/11/2018 - 13:46 **#1**

Carla Frenzel

The Site-of-Service Differential

PDF version

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 817-I-17, and the remainder of the report be filed:

That our American Medical Association (AMA) reaffirm Policy H-240.993, which urges more aggressive implementation by the US Department of Health and Human Services of existing provisions in federal legislation calling for equity in payment between services provided by hospitals on an outpatient basis and similar services in physician offices. (Reaffirm HOD Policy)

That our AMA reaffirm Policy D-330.997, which encourages the Centers for Medicare & Medicaid Services (CMS) to define Medicare services consistently across settings and adopt payment methodology

for hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) that will assist in leveling the playing field across all sites-of-service. (Reaffirm HOD Policy)

That our AMA reaffirm Policy H-400.957, which encourages CMS to expand the extent and amount of reimbursement for procedures performed in the physician office, to shift more procedures from the hospital to the office setting, which is more cost effective, and to seek to have practice expense relative value units reflect the true cost of performing office procedures. (Reaffirm HOD Policy)

That our AMA reaffirm Policy H-400.966, which directs the AMA to aggressively promote the compilation of accurate data on all components of physician practice costs, and the changes in such costs over time, as the basis for informed and effective advocacy concerning physician payment under Medicare. (Reaffirm HOD Policy)

That our AMA support Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments. (New HOD Policy)

That our AMA support Medicare payments for the same service routinely and safely provided in multiple outpatient settings (eg, physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the real costs of providing the service in each setting. (New HOD Policy)

That our AMA urge CMS to update the data used to calculate the practice expense component of the Medicare physician fee schedule by administering a physician practice survey (similar to the Physician Practice Information Survey administered in 2007-2008) every five years, and that this survey collect data to ensure that all physician practice costs are captured. (New HOD Policy)

That our AMA encourage CMS to both: a) base disproportionate share hospital payments and uncompensated care payments to hospitals on actual uncompensated care data; and b) study the costs to independent physician practices of providing uncompensated care. (New HOD Policy)

That our AMA collect data and conduct research both: a) to document the role that physicians have played in reducing Medicare spending; and b) to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery.

Resolution:
4

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Sat, 10/27/2018 - 18:45

DAVID WELSH

RE: The Site-of-Service Differential

Support.

Opinion Type: My post is my personal opinion

Top

Tue, 10/30/2018 - 20:42

Paul Wertsch

RE: The Site-of-Service Differential

Good and timely report. It makes no sense to have a different payment schedule for the same procedure depending on whether it is performed in a physician's office, an ambulatory surgery center, or a hospital outpatient department. It is the same procedure being done. If the patient is ill and requires extensive care requiring the hospital that ought to be documented and the extra care provided at it extra reimbursement. But if no extra care is required it does not make sense to pay a premium to have it done in the hospital outpatient dept. as opposed to a physician's office or surgery center. If the payment for the procedure being done at the hospital is going to be much greater this will steer all procedures to the hospital and increase the cost of care. Doing the procedure in the more expensive hospital outpatient department does provide the hospital with a great reimbursement to pay the proceduralist better and pay the hospital CEO better but the patient and the payer don't get any benefit and the costs of care go up.

Opinion Type: My post is my personal opinion

Top

Add new comment

Your name Courtney Perlino

Subject

RE: The Site-of-Service Differential

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Aligning Clinical and Financial Incentives for High-Value Care

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Tue, 10/16/2018 - 14:34 #1

Carla Frenzel

Aligning Clinical and Financial Incentives for High-Value Care

PDF version

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-155.960, which: supports "value-based decision-making" and reducing the burden of preventable disease as broad strategies for addressing rising health care cost; recognizes the important role of physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government in successful cost-containment and quality-improvement initiatives; and encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value

of a health care service or treatment, with consideration given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-185.939, which supports flexibility in the design and implementation of Value-Based Insurance Design (VBID) programs and outlines guiding principles including that VBID explicitly consider the clinical benefit of a given service or treatment when determining cost-sharing or other benefit design elements, and that practicing physicians, including appropriate specialists, must be actively involved in the development of VBID programs. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-165.856, which supports a regulatory environment that enables rather than impedes private market innovation in product development and purchasing arrangements. (Reaffirm HOD Policy)

4. That our AMA support VBID plans designed in accordance with the tenets of "clinical nuance," recognizing that (1) medical services may differ in the amount of health produced, and (2) the clinical benefit derived from a specific service depends on the person receiving it, as well as when, where, and by whom the service is provided. (New HOD Policy)

5. That our AMA support initiatives that align provider-facing financial incentives created through payment reform and patient-facing financial incentives created through benefit design reform, to ensure that patient, provider, and payer incentives all promote the same quality care. Such initiatives may include reducing patient cost-sharing for the items and services that are tied to provider quality metrics. (New HOD Policy)

6. That our AMA develop coding guidance tools to help providers appropriately bill for zero-dollar preventive interventions and promote common understanding among health care providers, payers, patients, and health care information technology vendors regarding what will be covered at given cost-sharing levels. (Directive to Take Action)

7. That our AMA develop physician educational tools that prepare physicians for conversations with their patients about the scope of preventive services provided without cost-sharing and instances where and when preventive services may result in financial obligations for the patient. (Directive to Take Action)

8. That our AMA continue to support requiring private health plans to provide coverage for evidence-based preventive services without imposing cost-sharing (such as co-payments, deductibles, or coinsurance) on patients. (New HOD Policy)

9. That our AMA continue to support implementing innovative VBID programs in Medicare Advantage plans. (New HOD Policy)

10. That our AMA support legislative and regulatory flexibility to accommodate VBID that

(a) preserves health plan coverage without patient cost-sharing for evidence-based preventive services; and (b) allows innovations that expand access to affordable care, including changes needed to allow High Deductible Health Plans paired with Health Savings Accounts to provide pre-deductible coverage for preventive and chronic care management services. (New HOD Policy)

11. That our AMA encourage national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services. (New HOD Policy)

Resolution:
1

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Tue, 10/30/2018 - 16:30

Paul Wertsch

RE: Aligning Clinical and Financial Incentives for High-Value Ca

This is an extremely important topic but I think it's simpler than the report suggests.

There are some treatments in medicine, often fairly low cost, that have proven benefit in terms of reducing morbidity and mortality. Examples that come to mind are the treatment of hypertension in reducing stroke, cardiac disease and renal failure. The treatment of asthma in reducing emergency room visits and sudden death. The preservation of renal function in early renal failure. The treatment of diabetes in preventing the sequelae of chronic disease. There are many examples of the secondary prevention were early effective treatment of a disease can prevent or delay very costly chronic diseases. This should almost be considered a public health issue as by treating the diseases and preventing chronic disease we can save money and improve people's lives.

There are also many cases were treatment is hard to prove long-term benefit or long-term cost savings. There are also many conditions were treatment probably has very little value at all although often generates a large amount of money in the treatment of it.

Our current Healthcare System is set up with its high deductible and high co-pay policies to encourage patients not to spend money on things of questionable value. The problem is the same system discourages or prevents people from spending money on the things that are truly valuable for them and for society. Reduction of chronic disease benefits all of us in the long run, because eventually we all pay for it, but we are discouraging the treatment of it.

The concept in the ACA of having no deductible preventive care was trying to get up this idea. But it screwed up by just concentrating on

primary preventive care practices, many of which are of questionable value, as opposed to the secondary preventive care where there is data to show that. early treatment can prevent chronic disease. This causes people to pay large sums of money for an insurance policy with high-deductible, high co-pay and expects them to pay out of pocket until the deductible is paid to manage conditions which will lead to chronic disease if untreated. Many people do not have the $1,000 to $3,000 in savings to pay for their hypertension, diabetes or asthma medicines by the time they buy their expensive insurance policies.

What we need is a list of diseases and conditions that have documented benefit of early treatment in prevention of chronic disease. Then we need to advocate that insurance policies cover these secondary prevention cases at no out of pocket cost for patients. We need to keep good data to evauate what works and what doesn't. Unfortunately the reduced costs in prevention of chronic disease will come later and the initial insurance company may not benefit but society will later benefit. This is the essence of value based insurance but the value benefits society not the insurance company.

We need to make a case for this concept for the insurance companies and for society to understand the we will later benefit by encouraging this early treatment.

Opinion Type: My post is my personal opinion

Top

Sat, 11/03/2018 - 09:08

Jim Rohack

RE: Aligning Clinical and Financial Incentives for High-Value Ca

I appreciate the hard work both Councils put in to create the report and the recommendations. It appears to me that the incentives suggested still rely on providing a service and there does not appear

to be a strong model to avoid disease by attacking the social determinates of health which account for 50% of disease burden.

Dr Wertch notes appropriately that true VBID should provide HT medications without cost to the patient but those who do not have HT balk at the increased cost they bear to subsidize those with chronic diseases like HT, Diabetes Mellitus and certain cancers. Reducing the costs to obtain healthy foods and provide safe enviornments to have quality movement would be a better spend for health utimately.

I hope this report is seen as a transition as to truly bend the cost curve downward, incentives for health and disease avoidance is needed. Right now, those profits only accrue to the insuror. Physicians, hospitals and patients only gain if under a non-profit capitation model. How to achieve that across the United States is the conundrum due to vested interests in maintaining status quo.

Opinion Type: My post is my personal opinion

Top

Sun, 11/04/2018 - 20:44

Abigail Solom

RE: Aligning Clinical and Financial Incentives for High-Value Ca

Abby Solom, medical student from Minnesota, speaking on behalf of the Medical Student Section in SUPPORT of the recommendations from the joint report of the Council on Medical Service and the Council on Science and Public Health.

Preventive and screening services are critical to our country in two ways. First, they keep patients healthy, prevent morbidity and mortality, and support patients in their ability to thrive. Second, they can prevent the need for more costly interventions later. Therefore, these services must be the cornerstone of any insurance plan if we are to achieve better care while also combating rising medical costs. However, as stated in the report, these services are not always covered fully, if at all, and many challenges remain for physicians in how to bill for these services and how to educate patients.

Our MSS supports reducing financial barriers to the delivery of cost-effective preventive health care services, and the implementation of financial incentives for cost-effective preventive medical care. This report outlines many key steps necessary to reduce these barriers and ensure complete coverage. As medical students, we see the frustrations of the physicians around us as they navigate challenges with insurance companies, either to get services covered or to receive fair compensation. The recommendations of this report will support our work as future physicians by easing the challenges of providing and billing for these services.

It is all too often that we meet patients whose health has deteriorated due to lack of access to preventive services or lack of coverage of these services. The MSS would like to applaud the Councils for their work on this important issue and support their recommendations. Thank you for your consideration.

Opinion Type: My post reflects the opinion of my delegation or section

Signature Name: Abigail Solom

Delegation section or society: MSS

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Your name [Courtney Perlino]

Subject

RE: Aligning Clinical and Financial Incentives for High-Value Ca

Comment *

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The AMA promotes the art and science of medicine and the betterment of public health.

Encourage Final Evaluation Reports of Section 1115 Demonstrations at the End of the Demonstration Cycle

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Fri, 09/28/2018 - 11:27 #1

Carla Frenzel

Encourage Final Evaluation Reports of Section 1115 Demonstrations at the End of the Demonstration Cycle

PDF version

RESOLVED, That our American Medical Association encourage the Centers for Medicare & Medicaid Services to establish written procedures that require final evaluation reports of Section 1115 Demonstrations at the end of each demonstration cycle, regardless of renewal status.

Resolution:
801

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Sun, 11/04/2018 - 19:05 (new)

Nonie Arora

RE: Encourage Final Evaluation Reports of Section 1115 Demonstra

Nonie Arora, Delegate from Michigan, speaking on behalf of the Medical Student Section in strong SUPPORT as sponsors of Resolution 801. The resolution hopes to increase accountability in Medicaid waiver programs to best serve our low-income patients. Section 1115 of the Social Security Act allows the US Department of Health and Human Services to approve state waivers for Medicaid demonstration projects that are experimental and that can be used for many purposes, such as to expand coverage, change delivery systems, and alter benefits. Currently, these demonstration projects are only required to undergo evaluation only after the final expiration of the demonstration, rather than at the end of each 3 to 5 year demonstration cycle. Demonstrations may also be renewed for multiple cycles without any requirement for interim data reporting or evaluation. This can lead to a demonstration project that runs for years without proper data measurement of the effectiveness of the project.

In just one of multiple examples, one demonstration project submitted to the Centers for Medicare and Medicaid Services (CMS) was initially approved in 1997 and totaled near $700 million in costs to fund a new hospital Medicaid payment delivery system. The report submitted almost 20 years later in 2016 did not demonstrate the effectiveness of this project. The Government Accountability Office (GAO) has already recommended that CMS establish written procedures for final evaluation reports at the end of each demonstration cycle. While CMS officials have said they are planning

to require appropriate evaluation at the end of each demonstration cycle, CMS has yet to establish any written procedure for implementing such evaluations. This resolution asks the AMA to formally encourage CMS to establish these written requirements so that the effectiveness of programs under 1115 waivers can be properly evaluated at appropriate intervals. This active advocacy expands beyond existing policy to encourage actionable and overdue changes. The Medical Student Section believes that appropriate accountability is necessary to ensure that state and federal resources are used in a way that effectively serves our patients. Thank you for your consideration.

Opinion Type: My post reflects the opinion of my delegation or section

Signature Name: Nonie Arora

Delegation section or society: Medical Student Section

Top

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Your name Courtney Perlino

Subject

RE: Encourage Final Evaluation Reports of Section 1115 Demonstra

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The AMA promotes the art and science of medicine and the betterment of public health.

Due Diligence for Physicians and Practices Joining an ACO with Risk Based Models (Up Side and Down Side Risk)

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Tue, 10/02/2018 - 13:05 #1

Carla Frenzel

Due Diligence for Physicians and Practices Joining an ACO with Risk Based Models (Up Side and Down Side Risk)

PDF version

RESOLVED, That our American Medical Association advocate for the continuation of up side only risk Medicare Shared Savings ACO (MSSP ACO) program as an option from the Centers for Medicare and Medicaid Services, particularly for physician owned groups; and be it further

RESOLVED, That our AMA develop educational resources and business analytics to help physicians complete due diligence in evaluating the performance of hospital integrated systems before considering consolidation. Specific attention should be given to the evaluation of

transparency on past savings results, system finances, quality metrics, physician workforce stability and physician job satisfaction, and the cost of clinical documentation software; and be it further

RESOLVED, That our AMA evaluate the characteristics of successful physician owned MSSP ACOs and participation in alternative payment models (APMs) to create a framework of the resources and organizational tools needed to allow smaller practices to form virtual ACOs that would facilitate participation in MSSP ACOs and APMs.

Resolution:
802

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RE: Due Diligence for Physicians and Practices Joining an ACO wi

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Insurance Coverage for Additional Screening Recommended in States with Laws Requiring Notification of “Dense Breasts” on Mammogr

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Fri, 09/28/2018 - 11:28 #1

Carla Frenzel

Insurance Coverage for Additional Screening Recommended in States with Laws Requiring Notification of “Dense Breasts” on Mammogr

PDF version

RESOLVED, That our American Medical Association support insurance coverage for supplemental screening recommended for patients with “dense breast” tissue following a conversation between the patient and their physician; and be it further

RESOLVED, That our AMA advocate for insurance coverage for and adequate access to supplemental screening recommended for patients with “dense breast” tissue following a conversation between the patient and their physician.

Resolution:
803

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Tue, 10/30/2018 - 18:20

DAVID WELSH

RE: Insurance Coverage for Additional Screening Recommended in S

support.

Opinion Type: My post is my personal opinion

Top

Sun, 11/04/2018 - 21:18

Sheila Rege

RE: Insurance Coverage for Additional Screening Recommended in S

This is Sheila Rege MD speaking on behalf of the Women Physicians Section in strong support of this issue. As a radiation oncologist, I often have difficult conversations with patients when the report comes back as "dense breast tissue" and additional screening is not paid for by insurance or have significant high co-pay amounts. I believe that this resolution is consistent with value based insurance design (VBID) whereby insurance coverage will ensure adherence to

guidelines recommended additional screenings as well as increase compliance and early detection.

Opinion Type: My post reflects the opinion of my delegation or section

Signature Name: Sheila Rege

Delegation section or society: Women Physicians Section

Top

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Your name Courtney Perlino

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RE: Insurance Coverage for Additional Screening Recommended in S

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Arbitrary Documentation Requirements for Outpatient Services

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Tue, 10/02/2018 - 13:06 #1

Carla Frenzel

Arbitrary Documentation Requirements for Outpatient Services

PDF version

RESOLVED, That our American Medical Association agree that documentation for outpatient physician services should be completed in a timely manner; and be it further

RESOLVED, That for circumstances in which more specific definitions of timeliness are required, AMA policy is that documentation for outpatient services should be completed, when possible, within 14 days of a provided service; and be it further

RESOLVED, That our AMA work with government health plans and private insurers to help them better understand the unintended consequences of imposing documentation rules with unrealistically short timeframes, and that our AMA oppose the use of such rules or

regulations in determining whether submitted claims are valid and payable.

Resolution:
804

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RE: Arbitrary Documentation Requirements for Outpatient Services

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Prompt Pay

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Tue, 10/02/2018 - 13:07 **#1**

Carla Frenzel

Prompt Pay

PDF version

RESOLVED, That American Medical Association policy H-190.959 be amended as follows:

Physician Reimbursement by Health Insurance and Managed Care Companies

1. Our AMA shall make it a top priority to seek regulatory and legislative relief to ensure that all health insurance and managed care companies pay for clean claims submitted electronically within fourteen three days.
2. When electronic claims are deemed to be lacking information to make the claim complete, the health insurance and managed care companies will be required to notify the health care provider within five one business days to allow prompt resubmission of a clean claim.

3. Our AMA shall advocate for heavy penalties to be imposed on health insurance and managed care companies, including their employees, that do not comply with laws and regulations establishing guidelines for claims payment.

Resolution:
805

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Wed, 10/10/2018 - 13:28 (new)

Andrea Preisler

RE: Prompt Pay

Staff has identified the following policies that are relevant to this resolution:

D-385.984 ERISA Preemption and State Prompt Pay Laws

(1) Our AMA continue to actively work with constituent societies to advocate for strong prompt payment laws, as well as full enforcement and implementation of those laws. [...]

H-185.938 Health Insurance Exchange and 90-Day Grace Period

1. Our AMA opposes the preemption of state law by federal laws relating to the federal grace period for subsidized health benefit exchange enrollees, and will seek appropriate changes to federal law and regulations to protect state and prompt payment laws. [...]

5. Our AMA will vigorously support state societies in their legal attempts to enforce prompt pay statutes and rules during grace periods.

Opinion Type: My post is my personal opinion

Top

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Your name Courtney Perlino

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RE: Prompt Pay

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Telemedicine Models and Access to Care in Post-Acute and Long-Term Care

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Tue, 10/16/2018 - 15:14 #1

Carla Frenzel

Telemedicine Models and Access to Care in Post-Acute and Long-Term Care

PDF version

RESOLVED, That our American Medical Association advocate for removal of arbitrary limits on telemedicine visits by medical practitioners in nursing facilities and instead base them purely on medical necessity, and collaborate with AMDA – The Society for Post-Acute and Long-Term Care Medicine to effect a change in Medicare's policy regarding this matter under the provisions of Physician Fee Schedule (PFS) and Quality Payment Program (QPP) (New HOD Policy); and be it further

RESOLVED, That our AMA work with AMDA-The Society for Post-Acute and Long-Term Care Medicine and other stakeholders to influence Congress to broaden the scope of telemedicine care models in post-

acute and long-term care and authorize payment mechanisms for models that are evidence based, relevant to post-acute and long-term care and continue to engage primary care physicians and practitioners in the care of their patients. (Directive to Take Action)

Resolution:
806

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Tue, 10/23/2018 - 11:45

Courtney Perlino

RE: Telemedicine Models and Access to Care in Post-Acute and Lon

Staff has identified the following policy that is relevant to this resolution:

H-480.946 Coverage of and Payment for Telemedicine
1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles: a) A valid patient-physician relationship must be established before the provision of telemedicine services, through: - A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or - A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or - Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on

telemedicine developed by major medical specialty societies, such as those of radiology and pathology. Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services. b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services. c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board. d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services. e) The delivery of telemedicine services must be consistent with state scope of practice laws. f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit. g) The standards and scope of telemedicine services should be consistent with related in-person services. h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes. i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine. j) The patient's medical history must be collected as part of the provision of any telemedicine service. k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient. l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record. m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.

2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information. 3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine. 4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine. 5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models. 6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service. 7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines.

Reference Committee J Staff

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RE: Telemedicine Models and Access to Care in Post-Acute and Lon

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Emergency Department Copayments for Medicaid Beneficiaries

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Tue, 10/16/2018 - 15:17 #1

Carla Frenzel

Emergency Department Copayments for Medicaid Beneficiaries

PDF version

RESOLVED, That our American Medical Association oppose imposition of copays for Medicaid beneficiaries seeking care in the emergency department. (New HOD Policy)

Resolution:
807

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RE: Emergency Department Copayments for Medicaid Beneficiaries

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The Improper Use of Beers or Similar Criteria and Third-Party Payer Compliance Activities (H-185.940)

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Tue, 10/16/2018 - 15:18 #1

Carla Frenzel

The Improper Use of Beers or Similar Criteria and Third-Party Payer Compliance Activities (H-185.940)

PDF version

RESOLVED, That our American Medical Association identify and establish a workgroup with insurers that are inappropriately applying Beers or similar criteria to quality rating programs and work with the insurers to resolve internal policies that financially penalize physicians (Directive to Take Action); and be it further

RESOLVED, That our AMA study and report back to the House of Delegates the 2019 Interim Meeting, the potential inappropriate use of Beers Criteria by insurance companies looking at which companies

are involved and the effect of the use of these criteria on physicians' practices (Directive to Take Action); and be it further

RESOLVED, That our AMA provide a mechanism for members to report possible abuses of Beers Criteria by insurance companies. (Directive to Take Action)

Resolution:
808

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Medicaid Clinical Trials Coverage

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Tue, 10/16/2018 - 15:18 **#1**

Carla Frenzel

Medicaid Clinical Trials Coverage

PDF version

RESOLVED, That our American Medical Association actively lobby for and support federal legislation that guarantees coverage of routine patient care costs for Medicaid enrollees who participate in clinical trials. (Directive to Take Action)

Resolution:
809

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Wed, 10/17/2018 - 13:37 (new)

Jane Ascroft

RE: Medicaid Clinical Trials Coverage

In addition to policy provided by the sponsor, staff has identified the following policy that is relevant to this resolution:

H-460.965 Viability of Clinical Research Coverages and Reimbursement
Our AMA believes that:
(1) legislation and regulatory reform should be pursued to mandate third party payer coverage of patient care costs (including co-pays/co-insurance/deductibles) of nationally approved (e.g., NIH, VA, ADAMHA, FDA), scientifically based research protocols or those scientifically based protocols approved by nationally recognized peer review mechanisms;
(2) third party payers should formally integrate the concept of risk/benefit analysis and the criterion of availability of effective alternative therapies into their decision making processes;
(3) third party payers should be particularly sensitive to the difficulty and complexity of treatment decisions regarding the seriously ill and provide flexible, informed and expeditious case management when indicated;
(4) its efforts to identify and evaluate promising new technologies and potentially obsolete technologies should be enhanced;
(5) its current efforts to identify unproven or fraudulent technologies should be enhanced;
(6) sponsors (e.g., NIH, pharmaceutical firms) of clinical research should finance fully the incremental costs added by research activities (e.g., data collection, investigators' salaries, data analysis) associated with the clinical trial. Investigators should help to identify such incremental costs of research;
(7) supports monitoring present studies and demonstration projects, particularly as they relate to the magnitude (if any) of the differential

costs of patient care associated with clinical trials and with general practice;
(8) results of all trials should be communicated as soon as possible to the practicing medical community maintaining the peer reviewed process of publication in recognized medical journals as the preferred means of evaluation and communication of research results;
(9) funding of biomedical research by the federal government should reflect the present opportunities and the proven benefits of such research to the health and economic well being of the American people;
(10) the practicing medical community, the clinical research community, patient advocacy groups and third party payers should continue their ongoing dialogue regarding issues in payment for technologies that benefit seriously ill patients and evaluative efforts that will enhance the effectiveness and efficiency of our nation's health care system; and
(11) legislation and regulatory reform should be supported that establish program integrity/fraud and abuse safe harbors that permit sponsors to cover co-pays/coinsurance/ deductibles and otherwise not covered clinical care in the context of nationally approved clinical trials. (CSA Rep. F, I-89 Reaffirmed: Joint CMS/CSA Rep., I-92 Reaffirmed: BOT Rep.40, I-93 Reaffirmed: CSA Rep. 13, I-99 Reaffirmation A-00 Reaffirmed: CMS Rep. 4, A-02 Reaffirmed: CMS Rep. 4, A-12 BOT Action in response to referred for decision: Res. 813, I-15 BOT Action in response to referred for decision: Res. 823, I-15)

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RE: Medicaid Clinical Trials Coverage

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Medicare Advantage Step Therapy

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Tue, 10/16/2018 - 15:19 **#1**

Carla Frenzel

Medicare Advantage Step Therapy

PDF version

RESOLVED, That our American Medical Association continue strong advocacy for the rejection of step therapy in Medicare Advantage plans and impede the implementation of the practice before it takes effect on January 1, 2019. (Directive to Take Action)

Resolution:
810

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Mon, 10/22/2018 - 11:26

Courtney Perlino

RE: Medicare Advantage Step Therapy

In addition to policy provided by the sponsor, staff has identified the following policies that are relevant to this resolution:

D-330.904 Opposition to the CMS Medicare Part B Drug Payment Model
1. Our AMA will request that the Centers for Medicare & Medicaid Services (CMS) withdraw the proposed Part B Drug Payment Model. 2. Our AMA will support and actively work to advance Congressional action to block the proposed Part B Drug Payment Model if CMS proceeds with the proposal. 3. Our AMA will advocate against policies that are likely to undermine access to the best course of treatment for individual patients and oppose demonstration programs that could lead to lower quality of care and do not contain mechanisms for safeguarding patients. 4. Our AMA will advocate for ensuring that CMS solicits and takes into consideration feedback from patients, physicians, advocates, or other stakeholders in a way that allows for meaningful input on any Medicare coverage or reimbursement policy that impacts patient access to medical therapies, including policies on coverage and reimbursement.

H-320.949 Clinical Practice Guidelines and Clinical Quality Improvement Activities
Our AMA adopts the following principles for the development and application of utilization management guidelines: (1) The criteria or guidelines used for utilization management shall be based upon sound clinical evidence and consider, among other factors, the safety and effectiveness of diagnosis or treatment, and must be age appropriate. (2) These utilization management guidelines and the criteria for their application shall be developed with the participation

of practicing physicians. (3) Appropriate data, clinical evidence, and review criteria shall be available on request. (4) When used by health plans or health care organizations, such criteria must allow variation and take into account individual patient differences and the resources available in the particular health care system or setting to provide recommended care. The guidelines should also include a statement of their limitations and restrictions. (5) Patients and physicians shall be able to appeal decisions based on the application of utilization management guidelines. (6) The competence of non-physician reviewers and the availability of same-specialty peer review must be delineated and assured. (7) Maintaining the best interests of the patient uppermost, the final decision to discharge a patient, or any other patient management decision, remains the prerogative of the physician.

Reference Committee J Staff

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Your name Courtney Perlino

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RE: Medicare Advantage Step Therapy

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ICD Code for Patients Harm From Payer Interference

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Tue, 10/16/2018 - 15:21 #1

Carla Frenzel

ICD Code for Patients Harm From Payer Interference

PDF version

RESOLVED, That our American Medical Association support the creation and implementation of an ICD code(s) to identify administrator or payer influence that affects treatment and leads to or contributes to, directly or indirectly, patient harm. (New HOD Policy)

Resolution:
812

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RE: ICD Code for Patients Harm From Payer Interference

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Direct Primary Care Health Savings Account Clarification

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Tue, 10/16/2018 - 15:23 #1

Carla Frenzel

Direct Primary Care Health Savings Account Clarification

PDF version

RESOLVED, That our American Medical Association seek federal changes to the Internal Revenue Code allowing health savings accounts to be used with direct primary care. (Directive to Take Action)

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813

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Wed, 10/17/2018 - 14:31

Courtney Perlino

RE: Direct Primary Care Health Savings Account Clarification

Staff has identified the following policies that are relevant to this resolution:

H-385.912 Direct Primary Care
Our AMA supports: (1) inclusion of Direct Primary Care as a qualified medical expense by the Internal Revenue Service; and (2) efforts to ensure that patients in Direct Primary Care practices have access to specialty care, including efforts to oppose payer policies that prevent referrals to in-network specialists.

H-380.984 The Role of Cash Payments in All Physician Practices
GUIDING PRINCIPLES FOR OPERATING A CASH-BASED PRACTICE
1. Prior to transitioning to or opening a cash-based practice, physicians should develop a business plan that includes the following: (a) An analysis of the target patient mix, and, if transitioning from a traditional practice, an analysis of how the target compares to the current patient population with respect to demographics such as age, income and health status. (b) A description of the type(s) of care that will be offered by the practice. (c) An evaluation of practice expenses to determine revenue requirements. (d) A description of how the marketing, billing and collection needs of the practice will be met. (e) Consideration of the legal, regulatory and contractual implications of opening or transitioning to a cash-based practice. 2. Cash-based practices should develop and maintain an appropriate and transparent fee schedule that is understandable and easily accessible to patients. 3. Cash-based practices should have clearly defined payment policies that help patients understand their payment responsibilities. These policies should include guidance about how patients can coordinate health insurance benefits with cash-based

physician services. 4. Cash-based practices should encourage patients to maintain health insurance coverage for more complex or catastrophic health care events.

Reference Committee J Staff

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Your name Courtney Perlino

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RE: Direct Primary Care Health Savings Account Clarification

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Prior Authorization Relief in Medicare Advantage Plans

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4 posts / 0 new

Tue, 10/16/2018 - 15:24 #1

Carla Frenzel

Prior Authorization Relief in Medicare Advantage Plans

PDF version

RESOLVED, That our American Medical Association support legislation that would apply the following legislative processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans:

- Listing services that require a PA on a website.

- Notifying providers of any changes at least 45 days prior to change.

- Standardizing a PA request form.

- Not denying payment for PA that has been approved unless fraudulently obtained or ineligible at time of service.

- Defining a consistent process for appeals and grievances, including to Medicaid and Medicaid managed care plans (New HOD Policy); and be it further

RESOLVED, That our AMA apply these same legislative processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans, to include:

- Medications already working when a patient changes health plans cannot be changed by the plan without discussion and approval of the ordering physician.

- Minimizing PA requirements as much as possible within each plan.

- Making an easily accessible and reasonably responsive direct communication tool available to resolve disagreements between plan and ordering provider. (New HOD Policy)

Resolution:
814

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Mon, 10/22/2018 - 15:46

Jane Ascroft

RE: Prior Authorization Relief in Medicare Advantage Plans

In addition to policy provided by the sponsor, staff has identified the following policies that are relevant to this resolution:

H-320.961 Preauthorization for Payment of Services
Our AMA supports legislation and/or regulations that would prevent the retrospective denial of payment for any claim for services for which a physician had previously obtained authorization, unless fraud was committed or incorrect information provided at the time such prior approval was obtained. (Res. 701, I-92 Reaffirmed by Res. 723, A-95 Modified by Sub. Res. 704, I-96 Reaffirmed: CMS Rep. 5, I-00 Reaffirmation I-04 Reaffirmed: CMS Rep. 1, A-14 Reaffirmed: CMS Rep. 07, A-16 Reaffirmed: CMS Rep. 08, A-17)

H-320.968 Approaches to Increase Payer Accountability
Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.
(1) Disclosure Requirements. Our AMA supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on (a) coverage provisions, benefits, and exclusions; (b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient; (d) medical expense ratios; and (e) cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)
(2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review; (c) Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a

physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.

(3) Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above. (BOT Rep. M, I-90 Reaffirmed by Res. 716, A-95 Reaffirmed by CMS Rep. 4, A-95 Reaffirmation I-96 Reaffirmed: Rules and Cred. Cmt., I-97 Reaffirmed: CMS Rep. 13 , I-98 Reaffirmation I-98 Reaffirmation A-99 Reaffirmation I-99 Reaffirmation A-00 Reaffirmed in lieu of Res. 839, I-08 Reaffirmation A-09 Reaffirmed: Sub. Res. 728, A-10 Modified: CMS Rep. 4, I-10 Reaffirmation A-11 Reaffirmed in lieu of Res. 108, A-12 Reaffirmed: Res. 709, A-12 Reaffirmed: CMS Rep. 07, A-16 Reaffirmed in lieu of: Res. 242, A-17 Reaffirmed in lieu of: Res. 106, A-17 Reaffirmation: A-17 Reaffirmation: I-17 Reaffirmation: A-18)

H-285.965 Managed Care Cost Containment Involving Prescription Drugs

(1) Physicians who participate in managed care plans should maintain awareness of plan decisions about drug selection by staying informed about pharmacy and therapeutics (P&T) committee actions and by ongoing personal review of formulary composition. P&T committee members should include independent physician representatives. Mechanisms should be established for ongoing peer review of formulary policy. Physicians who perceive inappropriate influence on formulary development from pharmaceutical industry consolidation should notify the proper regulatory authorities.

(2) Physicians should be particularly vigilant to ensure that formulary decisions adequately reflect the needs of individual patients and that individual needs are not unfairly sacrificed by decisions based on the needs of the average patient. Physicians are ethically required to advocate for additions to the formulary when they think patients would benefit materially and for exceptions to the formulary on a case-by-case basis when justified by the health care needs of particular patients. Mechanisms to appeal formulary exclusions should be established. Other cost-containment mechanisms, including prescription caps and prior authorization, should not unduly burden physicians or patients in accessing optimal drug therapy.

(3) Limits should be placed on the extent to which managed care plans use incentives or pressures to lower prescription drug costs. Financial incentives are permissible when they promote cost-effectiveness, not when they require withholding medically necessary care. Physicians must not be made to feel that they jeopardize their compensation or participation in a managed care plan if they prescribe drugs that are necessary for their patients but that may also be costly. There should be limits on the magnitude of financial incentives, incentives should be calculated according to the practices of a sizable group of physicians rather than on an individual basis, and incentives based on quality of care rather than cost of care should be used. Physician penalties for non-compliance with a managed care formulary in the form of deductions from withholds or direct charges are inappropriate and unduly coercive. Prescriptions should not be changed without physicians having a change to discuss the change with the patient.

(4) Managed care plans should develop and implement educational

programs on cost-effective prescribing practices. Such initiatives are preferable to financial incentives or pressures by HMOs or hospitals, which can be ethically problematic.

(5) Patients must fully understand the methods used by their managed care plans to limit prescription drug costs. During enrollment, the plan must disclose the existence of formularies, the provisions for cases in which the physician prescribes a drug that is not included in the formulary and the incentives or other mechanisms used to encourage physicians to consider costs when prescribing drugs. In addition, plans should disclose any relationships with pharmaceutical benefit management companies or pharmaceutical companies that could influence the composition of the formulary. If physicians exhaust all avenues to secure a formulary exception for a significantly advantageous drug, they are still obligated to disclose the option of the more beneficial, more costly drug to the patient, so that the patient can decide whether to pay out-of-pocket.

(6) Research should be conducted to assess the impact of formulary constraints and other approaches to containing prescription drug costs on patient welfare.

(7) Our AMA urges pharmacists to contact the prescribing physician if a prescription written by the physician violates the managed care drug formulary under which the patient is covered, so that the physician has an opportunity to prescribe an alternative drug, which may be on the formulary.

(8) When pharmacists, insurance companies, or pharmaceutical benefit management companies communicate directly with physicians or patients regarding prescriptions, the reason for the intervention should be clearly identified as being either educational or economic in nature.

(9) Our AMA will develop model legislation which prohibits managed care entities, and other insurers, from retaliating against a physician by disciplining, or withholding otherwise allowable payment because they have prescribed drugs to patients which are not on the insurer's formulary, or have appealed a plan's denial of coverage for the prescribed drug.

(10) Our AMA urges health plans including managed care organizations to provide physicians and patients with their medication formularies through multiple media, including Internet posting.

(11) In the case where Internet posting of the formulary is not

available and the formulary is changed, coverage should be maintained until a new formulary is distributed.
(12) For physicians who do not have electronic access, hard copies must be available. (CEJA Rep. 2, A-95 Res. 734, A-97 Appended by Res. 524 and Sub. Res.714, A-98 Reaffimed: Res. 511, A-99 Modified: Res. 501, Reaffirmed: Res. 123 and 524, A-00 Modified: Res. 509, I-00 Reaffirmed: CMS Rep. 6, A-03 Reaffirmation I-04 Reaffirmed: Sub. Res. 529, A-05 Reaffirmation A-08 Reaffirmation A-10 Reaffirmed in lieu of Res. 822, I-11 Reaffirmation A-14)

D-190.974 Administrative Simplification in the Physician Practice
1. Our AMA strongly encourages vendors to increase the functionality of their practice management systems to allow physicians to send and receive electronic standard transactions directly to payers and completely automate their claims management revenue cycle and will continue to strongly encourage payers and their vendors to work with the AMA and the Federation to streamline the prior authorization process.
2. Our AMA will continue its strong leadership role in automating, standardizing and simplifying all administrative actions required for transactions between payers and providers.
3. Our AMA will continue its strong leadership role in automating, standardizing, and simplifying the claims revenue cycle for physicians in all specialties and modes of practice with all their trading partners, including, but not limited to, public and private payers, vendors, and clearinghouses.
4. Our AMA will prioritize efforts to automate, standardize and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care.
5. Our AMA will continue to use its strong leadership role to support state and specialty societiy initiatives to simplify administrative functions.
6. Our AMA will expand its Heal the Claims process(TM) campaign as necessary to ensure that physicians are aware of the value of automating their claims cycle. (CMS Rep. 8, I-11 Appended: Res. 811, I-12 Reaffirmation A-14 Reaffirmation: A-17 Reaffirmed: BOT Action in response to referred for decision: Res. 805, I-16 Reaffirmation: I-17)

H-320.952 External Grievance Review Procedures
Our AMA establishes an External Grievance procedure for all health plans including those under the Affordable Care Act (ACA) with the following basic components:
(1) It should apply to all health carriers and Accountable Care Organizations;
(2) Grievances involving adverse determinations may be submitted by the policyholder, their representative, or their attending physician;
(3) Issues eligible for external grievance review should include, at a minimum, denials for (a) medical necessity determinations; and (b) determinations by carrier that such care was not covered because it was experimental or investigational;
(4) Internal grievance procedures should generally be exhausted before requesting external review;
(5) An expedited review mechanism should be created for urgent medical conditions;
(6) Independent reviewers practicing in the same state should be used whenever possible;
(7) Patient cost sharing requirements should not preclude the ability of a policyholder to access such external review;
(8) The overall results of external review should be available for public scrutiny with procedures established to safeguard the confidentiality of individual medical information;
(9) External grievance reviewers shall obtain input from physicians involved in the area of practice being reviewed. If the review involves specialty or sub-specialty issues the input shall, whenever possible, be obtained from specialists or sub-specialists in that area of medicine.
(Res. 701, I-98 Reaffirmation I-99 Reaffirmation A-00 Reaffirmed: CMS Rep. 6, A-10 Reaffirmed: Res. 709, A-12 Modified: Res. 712, A-13 Reaffirmed in lieu of: Res. 242, A-17 Reaffirmation: I-17)

Reference Committee J Staff

Opinion Type: My post is my personal opinion

Top

Sat, 10/27/2018 - 18:37

DAVID WELSH

	RE: Prior Authorization Relief in Medicare Advantage Plans
	More has to be done to correct this growing problem. Support. **Opinion Type:** My post is my personal opinion

Top

Sun, 11/04/2018 - 21:43

Sheila Rege	**RE: Prior Authorization Relief in Medicare Advantage Plans**
	Our AMA has data showing that physicians spend an average of 14.5 hours on prior authorization - that's time taken away from our busy schedule when we could be seeing patients instead. If a patient is on a medication that is already working, and changes health plans then we as physicians now have to once again obtain pre-approval. And sometimes these medications are changed by the new health plan without their physician being informed. This is unacceptable. Agree with Dr. Welsh - more needs to be done on this. Strongly support. **Opinion Type:** My post is my personal opinion

Top

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Your name Courtney Perlino

Subject

RE: Prior Authorization Relief in Medicare Advantage Plans

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Uncompensated Physician Labor

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Tue, 10/16/2018 - 15:35 **#1**

Carla Frenzel

Uncompensated Physician Labor

PDF version

RESOLVED, That our American Medical Association adopt policy that physicians should be compensated for reviewing and responding to new after-hour patient messages. (New HOD Policy)

Resolution:
815

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Wed, 10/17/2018 - 14:33

Courtney Perlino

RE: Uncompensated Physician Labor

In addition to policy provided by the sponsor, staff has identified the following policies that are relevant to this resolution:

H-390.859 Reimbursement for Telephonic and Electronic Communications
(1) The policy of our AMA is that physicians should uniformly be compensated for their professional services, at a fair fee of their choosing, for established patients with whom the physician has had previous face-to-face professional contact, whether the current consultation service is rendered by telephone, fax, electronic mail or other forms of communication. (2) Our AMA presses CMS and other payers to separately recognize and adequately pay for non-face-to-face electronic visits.

H-385.919 Payment for Electronic Communication
Our AMA will: (1) advocate that pilot projects of innovative payment models be structured to include incentive payments for the use of electronic communications such as Web portals, remote patient monitoring, real-time virtual office visits, and email and telephone communications; (2) continue to update its guidance on communication and information technology to help physicians meet the needs of their patients and practices; and (3) educate physicians on how to effectively and fairly bill for electronic communications between patients and their physicians.

Reference Committee J Staff

Opinion Type: My post is my personal opinion

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Your name Courtney Perlino

Subject

RE: Uncompensated Physician Labor

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Medicare Advantage Plan Inadequacies

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Tue, 10/16/2018 - 15:36 **#1**

Carla Frenzel

Medicare Advantage Plan Inadequacies

PDF version

RESOLVED, That our American Medical Association investigate the deficiencies of Medicare Advantage plans, with the goal of improving nursing home, rehab and physical therapy benefits. Full transparency about the cost and coverage of the plan, as well as communication about plan limitations, should be required (Directive to Take Action); and be it further

RESOLVED, That our AMA issue an opinion on whether Medicare Advantage plans should be limited to healthier seniors with both a short problem list and short medication list, and whether there should be a cap on administrative costs for these plans. (Directive to Take Action)

Resolution:

816

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Your name Courtney Perlino

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RE: Medicare Advantage Plan Inadequacies

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Increase Reimbursement for Psychiatric Services

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Tue, 10/16/2018 - 15:36 **#1**

Carla Frenzel

Increase Reimbursement for Psychiatric Services

PDF version

RESOLVED, That our American Medical Association support increasing reimbursement for psychiatric services through direct funding adjustments or the CPT Editorial Panel process.

Resolution:
817

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Your name [Courtney Perlino]

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RE: Increase Reimbursement for Psychiatric Services

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Drug Pricing Transparency

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Tue, 10/16/2018 - 15:38 **#1**

Carla Frenzel

Drug Pricing Transparency

PDF version

RESOLVED, That our American Medical Association advocate to the U.S. Surgeon General for federal legislation that investigates all drug pricing.

Resolution:
818

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Wed, 10/17/2018 - 14:37

Courtney Perlino

RE: Drug Pricing Transparency

Staff has identified the following policies that are relevant to this resolution:

H-110.987 Pharmaceutical Costs
... 5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies. ... 10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment. 11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase. 12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.

H-110.984 Insulin Affordability
Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate; and (2) support initiatives, including those by national medical specialty

societies, that provide physician education regarding the cost-effectiveness of insulin therapies.

H-110.988 Controlling the Skyrocketing Costs of Generic Prescription Drugs
1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs. 2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients. 3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs. 4. Our AMA supports measures that increase price transparency for generic prescription drugs.

H-110.991 Price of Medicine
Our AMA: (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications; (2) will pursue legislation requiring pharmacies to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication; (3) opposes provisions in pharmacies' contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient's co-pay is higher than the drug's cash price; (4) will disseminate model state legislation to promote increased drug price and cost transparency and to prohibit "clawbacks" and standard gag clauses in contracts between pharmacies and pharmacy benefit managers (PBMs) that bar pharmacists from telling consumers about less-expensive options for purchasing their medication; and (5) supports physician education regarding drug price and cost transparency and challenges patients may encounter at the pharmacy point-of-sale.

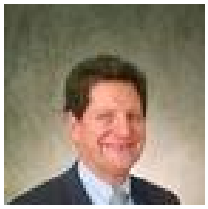
Reference Committee J Staff

Opinion Type: My post is my personal opinion

Top

Mon, 10/22/2018 - 20:24

Stephen Rockower



RE: Drug Pricing Transparency

We are fully ion support of this. Maryland passsed legislation to require transparency and limitations of proce gouging. This is still in the courts, however, and our Attorney General has recently submitted it to the Supreme Court.

Opinion Type: My post reflects the opinion of my delegation or section

Signature Name: Stephen Rockower

Delegation section or society: Maryland

Top

Sat, 10/27/2018 - 18:35

DAVID WELSH

RE: Drug Pricing Transparency

Support.

Opinion Type: My post is my personal opinion

Top

Sun, 11/04/2018 - 21:52

Sheila Rege

RE: Drug Pricing Transparency

We should advocate for transparency of drug pricing and need legislative help for our patients.

Opinion Type: My post is my personal opinion

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Your name [Courtney Perlino]

Subject

RE: Drug Pricing Transparency

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Medicare Reimbursement Formula for Oncologists Administering Drugs

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Tue, 10/16/2018 - 15:39 #1

Carla Frenzel

Medicare Reimbursement Formula for Oncologists Administering Drugs

PDF version

RESOLVED, That our American Medical Association amend policy H-55.994 by addition to read as follows:

Coverage of Chemotherapy in Physicians' Offices H-55.994

The AMA: (1) supports adequate reimbursement for outpatient oncology office visits that recognizes the complexity of the patient's care management; and (2) advocates that physicians who bill any third party payer for administering chemotherapy should ensure that the services billed for are described adequately and fully on the appropriate claim form and that the chemotherapy descriptors and

code numbers provided by CPT are utilized (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA advocate for a change to the Medicare reimbursement formula such that the costs of chemotherapeutic agents are covered, plus an unrelated flat fee to cover the cost of the infusion or injection of said agents.

Resolution:
819

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Fri, 10/19/2018 - 15:42 (new)

Jane Ascroft

RE: Medicare Reimbursement Formula for Oncologists Administering

In addition to policy provided by the sponsor, staff has identified the following policies that are relevant to this resolution:

D-330.960 Cuts in Medicare Outpatient Infusion Services
1. Our AMA will actively support efforts to seek legislation to ensure that Medicare payments for drugs fully cover the physician's acquisition, inventory and carrying cost and that Medicare payments for drug administration and related services are adequate to ensure continued patient access to outpatient infusion services. 2. Our AMA will continue strong advocacy efforts working with relevant national medical specialty societies to ensure adequate physician payment for Part B drugs and patient access to biologic and pharmacologic agents.

(Res. 926, I-03 Reaffirmed and Modified: CMS Rep. 3, I-08 Reaffirmation A-15 Reaffirmed: CMS Rep. 10, A-16)

H-330.884 Access to In-Office Administered Drugs
1. Our American Medical Association will advocate that physician access to in-office administered drugs, including drugs dispensed by pharmacies, be preserved. 2. Our AMA will work with the Center for Medicare & Medicaid Services, The Joint Commission, America's Health Insurance Plans, Federation of State Medical Boards, National Association of Boards of Pharmacy, and other involved stakeholders to improve and support patient access to in-office administered drugs. 3. Our AMA will advocate for coverage for in-office administered drugs and related delivery services for patients who are physically unable to self-administer the drug. (Res. 702, A-15 Reaffirmed: CMS Rep. 10, A-16 Reaffirmation: A-18)

H-55.995 Medicare Coverage of Outpatient Chemotherapy Drugs
Carriers should recognize and encourage the administration of chemotherapy in physicians' offices, wherever practical and medically acceptable, as being more cost-effective than administration in many other settings. (CMS Rep. J, A-82 Amended: CLRPD Rep. A, I-92 Reaffirmed: CMS Rep. 10, A-03 Reaffirmed: CMS Rep. 4, A-13)

H-330.888 Exempt Physician-Administered Drugs from Medicare Sequestration
Our AMA supports passage of federal legislation 1) exempting payments for biologics and other drugs provided under Medicare Part B from sequestration cuts, and 2) reimbursing providers for reductions in payments for biologics and other drugs furnished under Medicare Part B on or after April 1, 2013. (Res. 235, A-13 Reaffirmation A-15)

Reference Committee J Staff

Opinion Type: My post is my personal opinion

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Your name [Courtney Perlino]

Subject

RE: Medicare Reimbursement Formula for Oncologists Administering

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Press Center **AMA Insurance**

Ensuring Quality Health Care for Our Veterans

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Tue, 10/16/2018 - 15:39 **#1**

Carla Frenzel

Ensuring Quality Health Care for Our Veterans

PDF version

RESOLVED, That our American Medical Association amend policy H-510.986, "Ensuring Access to Care for our Veterans," by addition to read as follows:

Ensuring Access to Safe and Quality 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.

5. Our AMA will strongly advocate that the Veterans Health Administration and Congress develop and implement necessary resources, protocols, and accountability to ensure the Veterans Health Administration recruits, hires and retains first-rate, competent, and ethical physicians and other health care professionals to deliver the safe, effective and high-quality care that our veterans have been promised and are owed.

6. Our AMA will engage the Veterans Health Administration in dialogue on accreditation practices by the Veterans Health Administration to assure they are similar to those of hospitals, state medical boards, and insurance companies.

Resolution:
820

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Your name Courtney Perlino

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RE: Ensuring Quality Health Care for Our Veterans

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AMA Insurance

Direct Primary Care and Concierge Medicine Based Practices

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Tue, 10/16/2018 - 15:40 #1

Carla Frenzel

Direct Primary Care and Concierge Medicine Based Practices

PDF version

RESOLVED, That our American Medical Association actively lobby for revision to the U.S. tax code to allow funds from health savings accounts to be used for concierge medicine and direct primary care without incurring a tax penalty.

Resolution:
821

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Wed, 10/17/2018 - 14:39

Courtney Perlino

RE: Direct Primary Care and Concierge Medicine Based Practices

In addition to policy provided by the sponsor, staff has identified the following policy that is relevant to this resolution:

H-380.984 The Role of Cash Payments in All Physician Practices
GUIDING PRINCIPLES FOR OPERATING A CASH-BASED PRACTICE
1. Prior to transitioning to or opening a cash-based practice, physicians should develop a business plan that includes the following: (a) An analysis of the target patient mix, and, if transitioning from a traditional practice, an analysis of how the target compares to the current patient population with respect to demographics such as age, income and health status. (b) A description of the type(s) of care that will be offered by the practice. (c) An evaluation of practice expenses to determine revenue requirements. (d) A description of how the marketing, billing and collection needs of the practice will be met. (e) Consideration of the legal, regulatory and contractual implications of opening or transitioning to a cash-based practice. 2. Cash-based practices should develop and maintain an appropriate and transparent fee schedule that is understandable and easily accessible to patients. 3. Cash-based practices should have clearly defined payment policies that help patients understand their payment responsibilities. These policies should include guidance about how patients can coordinate health insurance benefits with cash-based physician services. 4. Cash-based practices should encourage patients to maintain health insurance coverage for more complex or catastrophic health care events.

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