DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2018 Interim Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-18)

Report of Reference Committee J

Steven Chen, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Medical Service Report 2 - Air Ambulance Regulations and Payments
2. Council on Medical Service Report 3 - Sustain Patient-Centered Medical Home Practices
3. Joint Report of the Council on Medical Service and the Council on Science and Public Health - Aligning Clinical and Financial Incentives for High-Value Care
4. Resolution 801 - Encourage Final Evaluation Reports of Section 1115 Demonstrations at the End of the Demonstration Cycle
5. Resolution 804 - Arbitrary Documentation Requirements for Outpatient Services
6. Resolution 810 - Medicare Advantage Step Therapy

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

7. Board of Trustees Report 9 - Hospital Closures and Physician Credentialing
8. Council on Medical Service Report 1 - Prescription Drug Importation for Personal Use
9. Council on Medical Service Report 4 - The Site-of-Service Differential
10. Resolution 802 - Due Diligence for Physicians and Practices Joining an ACO with Risk Based Models (Up Side and Down Side Risk)
11. Resolution 803 - Insurance Coverage for Additional Screening Recommended in States with Laws Requiring Notification of “Dense Breasts” on Mammogram
12. Resolution 805 - Prompt Pay
13. Resolution 806 - Telemedicine Models and Access to Care in Post-Acute and Long-Term Care
14. Resolution 808 - The Improper Use of Beers or Similar Criteria and Third-Party Payer Compliance Activities (H-185.940)
15. Resolution 812 - ICD Code for Patients Harm From Payer Interference
16. Resolution 814 - Prior Authorization Relief in Medicare Advantage Plans
17. Resolution 820 - Ensuring Quality Health Care for Our Veterans

RECOMMENDED FOR REFERRAL

18. Resolution 826 - Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients

RECOMMENDED FOR NOT ADOPTION

19. Resolution 822 - Bone Density Reimbursement

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

20. Resolution 807 - Emergency Department Copayments for Medicaid Beneficiaries
21. Resolution 818 - Drug Pricing Transparency
22. Resolution 823 - Medicare Cuts to Radiology Imaging

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

- Resolution 809 - Medicaid Clinical Trials Coverage
- Resolution 813 - Direct Primary Care Health Savings Account Clarification
- Resolution 815 - Uncompensated Physician Labor
- Resolution 816 - Medicare Advantage Plan Inadequacies
- Resolution 817 - Increase Reimbursement for Psychiatric Services
- Resolution 819 - Medicare Reimbursement Formula for Oncologists Administering Drugs
- Resolution 821 - Direct Primary Care and Concierge Medicine Based Practices

The following resolution was withdrawn by the sponsor:

- Resolution 811 - Infertility Benefits for Active-Duty Military Personnel

The following resolutions were recommended against consideration:

- Resolution 824 – Impact on the Medical Staff of the Success or Failure in Generating Savings of Hospital Integrated System ACOs
- Resolution 825 – Preservation of the Patient-Physician Relationship

(1) COUNCIL ON MEDICAL SERVICE REPORT 2 - AIR AMBULANCE REGULATIONS AND PAYMENTS

RECOMMENDATION:

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

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

Council on Medical Service Report 2 recommends that our AMA amend Policy, H-130.954 by addition to support the education of first responders about the costs associated with inappropriate use of emergency patient transportation systems; support increased data collection and data transparency of air ambulance providers and services to the appropriate state and federal agencies, particularly increased price transparency; work with relevant stakeholders to evaluate the Airline Deregulation Act as it applies to air ambulances; support stakeholders sharing air ambulance best practices across regions; and rescind Policy D-130.964.

Testimony on Council on Medical Service Report 2 was unanimously supportive. A member of the Council on Medical Service introduced the report noting that there is little reliable data on the costs and charges of air ambulance services. Additionally, the Council explained that it declined to call for increased consumer education on the costs of air ambulance services out of concern that it would result in patients declining potentially life-saving transportation and care. The Council further stated that the profound lack of data on air ambulances precludes it from proposing amendment to the Airline Deregulation Act. Importantly, the Council highlighted that the recent Federal Aviation Administration Reauthorization called for the establishment of a consumer hotline for consumer complaints, and an advisory committee to look into surprise billing and create industry best practices.

Numerous speakers highlighted that air ambulances often fly across state lines and stated that this ability must be preserved, as conserved in the Council report. An amendment was offered by an individual representing the air ambulance industry calling for increased payment of air ambulance services from Medicare and Medicaid. However, your Reference Committee declines to accept this amendment and believes that increased data transparency and availability is critical before calling for such a request. Another speaker noted that individuals often can pay a monthly fee to air ambulance companies that protect them from high bills for utilizing the company's services. However, additional testimony stated that this suggestion amounts to additional patient burden and expense, and your Reference Committee believes that this practice may be problematic in areas where there are multiple air ambulance providers or if an accident necessitating air ambulance care occurs outside of that provider's service area. Accordingly, your Reference Committee recommends that the recommendations in Council on Medical Service Report 2 be adopted and the remainder of the report be filed.

(2) COUNCIL ON MEDICAL SERVICE REPORT 3 - SUSTAIN PATIENT-CENTERED MEDICAL HOME PRACTICES

RECOMMENDATION:

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

HOD ACTION: Recommendations of Council on Medical Service Report 3 adopted and the remainder of the report filed.

Council on Medical Service Report 3 recommends that our AMA reaffirm Policies H-160.919 and H-385.908; amend Policy H-160.918 to also urge CMS to assist physician practices seeking to sustain medical home status with financial and other resources, and delete [d] which states that our AMA "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;" 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; and 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.

Testimony on Council on Medical Service Report 3 was unanimously supportive. Testimony thanked the Council for its thoughtful report. A member of the Council on Medical Service introduced the report noting that the Council believes that primary care and the PCMH are bedrocks of high-quality, patient-centered care. However, in order to make the transition to and sustain a PCMH, practices of all sizes and settings must have the support to confront the challenges of practice transformation from the Centers for Medicare and Medicaid Services, third-party insurers, and other stakeholders. Accordingly, your Reference Committee recommends that the recommendations in Council on Medical Service Report 3 be adopted and the remainder of the report be filed.

(3) JOINT REPORT OF THE COUNCIL ON MEDICAL SERVICE AND THE COUNCIL ON SCIENCE AND PUBLIC HEALTH - ALIGNING CLINICAL AND FINANCIAL INCENTIVES FOR HIGH-VALUE CARE

RECOMMENDATION:

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

HOD ACTION: Recommendations of Joint Report of the Council on Medical Service and the Council on Science and Public Health adopted and the remainder of the report filed.

The Joint Report of the Council on Medical Service and the Council on Science and Public Health recommends that our AMA reaffirm Policies H-155.960, H-185.939 and H-165.856; 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; 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; 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; 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; 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; continue to support implementing innovative VBID programs in Medicare Advantage plans; 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; and 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.

Testimony on the Joint Report of the Council on Medical Service and the Council on Science and Public Health was generally supportive. A member of the Council on Medical Service introduced the report and underscored that the recommendations of the report expand the AMA's leadership on coverage for high-value care and build on AMA policy regarding value-based insurance design (VBID). A member of the Council on Science and Public Health testified that the recommendations of the report recognize that health insurance must provide ongoing access to care for patients with chronic disease. Your Reference Committee believes that the Joint Report of the Council on Medical Service and the Council on Science and Public Health addresses challenges associated with the preventive services benefit of the Affordable Care Act and opportunities to better align incentives around high-value care, including through application of VBID. Accordingly, your Reference Committee recommends that the recommendations of the Joint Report of the Council on Medical Service and the Council on Science and Public Health be adopted and the remainder of the report be filed.

(4) RESOLUTION 801 - ENCOURAGE FINAL EVALUATION REPORTS OF SECTION 1115 DEMONSTRATIONS AT THE END OF THE DEMONSTRATION CYCLE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 801 be adopted.

HOD ACTION: Resolution 801 adopted.

Resolution 801 asks that our AMA 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.

Your Reference Committee heard supportive testimony on Resolution 801. Your Reference Committee believes Resolution 801 is consistent with existing AMA policy regarding the evaluation of demonstration programs, and recommends its adoption.

(5) RESOLUTION 804 - ARBITRARY DOCUMENTATION REQUIREMENTS FOR OUTPATIENT SERVICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 804 be adopted.

HOD ACTION: Resolution 804 adopted.

The revised Resolution 804 asks that our AMA agree that documentation for outpatient physician services should be completed in a timely manner; and 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.

Testimony on Resolution 804 was unanimously supportive. Testimony stated that our AMA should help prevent public and private payers from implementing onerous documentation requirements on physicians, and your Reference Committee agrees. Accordingly, your Reference Committee recommends that Resolution 804 be adopted.

(6) RESOLUTION 810 - MEDICARE ADVANTAGE STEP THERAPY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 810 be adopted.

HOD ACTION: Resolution 810 adopted.

Resolution 810 asks that our AMA 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.

Your Reference Committee heard highly supportive testimony on Resolution 810. Your Reference Committee notes that our AMA and 93 state medical associations and national medical specialty societies raised extensive concerns with CMS in a sign-on letter regarding its new policy allowing Medicare Advantage plans, starting in 2019, to utilize step-therapy protocols for physician-administered drugs covered under Medicare Part B. Your Reference Committee believes that Resolution 810 is highly consistent not only with AMA advocacy efforts to date, but also with existing policy that opposes regulations and demonstration programs that are likely to undermine access to the best course of treatment for individual patients. As such, your Reference Committee recommends that Resolution 810 be adopted.

(7) BOARD OF TRUSTEES REPORT 9 - HOSPITAL CLOSURES AND PHYSICIAN CREDENTIALING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 3 in Board of Trustees Report 9 be amended by addition and deletion as follows:

3. That our AMA: (a) continue to monitor the development and implementation of physician credentialing repository databases that track hospital affiliations, including tracking hospital closures, as well as how and where these closed hospitals are storing physician credentialing information; 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)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 9 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations of Board of Trustees Report 9 adopted as amended and the remainder of the report filed.

Board of Trustees Report 9 recommends that our AMA reaffirm Policy H-230.956; 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; continue to monitor the development and implementation of physician credentialing repository databases that track hospital affiliations; and 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.

Testimony was supportive of Board of Trustees Report 9. A member of the Board of Trustees introduced the report highlighting that the AMA should encourage emulation of appropriate existing laws and regulations by developing model state legislation that supports timely access to credentialing files following the closure of a hospital. An amendment was offered to include tracking hospital closures, and your Reference Committee accepts this amendment. An additional amendment was offered to limit the

credentialing information available on the clearinghouse to undergraduate and graduate medical education training. However, your Reference Committee believes that it is likely that the Board of Trustees intended to have additional information available in the clearinghouse besides education, and your Reference Committee proposes an amendment to allow for leeway in what information can and should be made available in the forthcoming clearinghouse. Accordingly, your Reference Committee recommends that the recommendations in Board of Trustees Report 9 be adopted as amended and the remainder of the report be filed.

(8) COUNCIL ON MEDICAL SERVICE REPORT 1 - PRESCRIPTION DRUG IMPORTATION FOR PERSONAL USE

RECOMMENDATION A:

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

1. That our American Medical Association (AMA) support the in-person purchase and importation of Health Canada-approved 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)

RECOMMENDATION B:

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

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Council on Medical Service Report 1 be changed to read as follows:

CANADIAN PRESCRIPTION DRUG IMPORTATION FOR PERSONAL USE

HOD ACTION: Recommendations of Council on Medical Service Report 1 be adopted as amended and the remainder of the report be filed with a change in title.

Council on Medical Service Report 1 recommends that our 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; 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; and reaffirm Policies D-100.983 and D-100.985.

Your Reference Committee heard predominantly supportive testimony on Council on Medical Service Report 1, with testimony also in support of broadening the focus of its recommendations. In introducing the report, a member of the Council on Medical Service underscored that the recommendations of the report aim to provide patients with an option to lower their out-of-pocket costs for prescription drugs while ensuring that the prescription drugs that are imported in-person from a licensed, "brick-and-mortar" Canadian pharmacy are of the same quality and chemical makeup as those currently distributed in the US. The Council member also noted that the FDA has voiced its confidence in Health Canada in providing effective oversight of drugs approved for use by Canadian patients. A member of the Council on Legislation testified in support of the report, noting that the recommendations of the report are consistent with our AMA's existing policy on prescription drug importation, which the Council on Legislation has used to guide its assessment of legislation introduced to date.

Some speakers were in support of our AMA also advocating for personal importation of prescription drugs using mail-order and online pharmacies. Your Reference Committee notes that existing Policy D-100.983 listed on the first page of the report, and recommended for reaffirmation, already guides AMA policy with respect to personal importation of prescription drugs via the Internet and mail-order. Namely, the policy predicates AMA support for such importation on ensuring the authenticity and integrity of prescription drugs that are imported. Members of the Council on Medical Service and the Council on Legislation noted that the mechanism outlined in the policy of our AMA to ensure product integrity is the implementation and utilization of "track-and-trace" technology. Testimony underscored that track-and-trace remains an important mechanism to ensure medication efficacy, and that the priority of our AMA with respect to personal importation of prescription drugs needs to be on our patients – that they are able to import prescription drugs for personal use that are of the same potency and purity as they otherwise would have access to in the US.

Your Reference Committee recognizes the potential for an increased risk to patients of receiving counterfeit or substandard drugs when such drugs are not purchased and imported in-person. In fact, a study by the Food and Drug Administration (FDA) revealed that although nearly half of imported drugs in the study were reported to be Canadian or from Canadian pharmacies, 85 percent of those drugs originated elsewhere and were fraudulently misrepresented as Canadian. Domestically, steps are being taken to implement track-and-trace technology. Namely, the FDA is working towards fully implementing the Drug Supply Chain Security Act by 2023, which outlines steps to build an electronic, interoperable system to identify and trace certain prescription drugs as they are distributed in the US.

There was also an amendment offered to study and report back regarding the in-person importation of prescription drugs obtained directly from a properly licensed non-US pharmacy beyond Canada, including in Mexico. Your Reference Committee notes that referred Resolution 226-I-17 to which this report responded solely addressed the in-

person purchase and importation of prescription drugs from Canada, not other countries. A member of the Council on Medical Service raised concerns with the regulatory and safety standards of Mexico pertaining to prescription drugs and pharmacies. In addition, the member noted that the FDA's enforcement discretion pertaining to prescription drugs imported in-person from other countries would remain, and as such questioned whether such a study would be warranted and be a prudent use of AMA resources.

Your Reference Committee is offering an amendment to the first recommendation of the report to include a requirement that prescription drugs purchased and imported in-person must be approved by Health Canada. The inclusion of Health Canada in the first recommendation continues our AMA's prioritization of patient safety in prescription drug importation as the agency is the equivalent to the FDA in Canada. As such, your Reference Committee recommends that the recommendations of Council on Medical Service Report 1 be adopted as amended and the remainder of the report be filed.

(9) COUNCIL ON MEDICAL SERVICE REPORT 4 - THE SITE-OF-SERVICE DIFFERENTIAL

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 5 in Council on Medical Service Report 4 be amended by addition to read as follows:

5. That our AMA support Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments. ~~Site-neutral payments should be based on the actual costs of providing those services and not defined as equal payments or reducing all payments to the lowest amount paid in any setting.~~ (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendation 6 in Council on Medical Service Report 4 be amended by addition and deletion to read as follows:

6. 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~~ actual costs of providing the service in each setting. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 4 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations of Council on Medical Service Report 4 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 4 recommends that our AMA reaffirm Policies H-240.993, D-330.997, H-400.957 and H-400.966; support Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments; 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; 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; 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; and 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.

Your Reference Committee heard supportive testimony on Council on Medical Service Report 4. In introducing the report, a member of the Council on Medical Service outlined amendments to the fifth and sixth recommendations of the report, after having spoken to members of the Integrated Physician Practice Section (IPPS). Your Reference Committee accepts the amendments and applauds the efforts done to unify the house of medicine behind the recommendations of Council on Medical Service Report 4. Your Reference Committee appreciates amendments that were offered to correct for underpayments made to physicians through the potential use of Medicare Part A savings, but agrees with the member of Council on Medical Service who stated that the ninth recommendation of the report needs to be implemented before such an amendment could be considered. The ninth recommendation of the report calls for our AMA to collect data and conduct research both: a) to document the role 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 care delivery. Your Reference Committee believes that the recommendations of Council on Medical Service Report 4 recognize the high priority placed on the issue of the site-of-service differential by the members of our AMA, and recommends that the recommendations of Council on Medical Service Report 4 be adopted as amended and the remainder of the report be filed.

(10) RESOLUTION 802 - DUE DILIGENCE FOR PHYSICIANS AND PRACTICES JOINING AN ACO WITH RISK BASED MODELS (UP SIDE AND DOWN SIDE RISK)

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 802 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA develop educational resources and business tools ~~analytics~~ to help physicians complete due diligence in evaluating the performance of physician-led and 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 (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 802 be amended by deletion as follows:

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. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 802 be adopted as amended.

HOD ACTION: Resolution 802 adopted as amended.

Resolution 802 asks that our AMA 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; 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 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.

Testimony on Resolution 802 was unanimously supportive. Your Reference Committee notes that Resolution 802 coincides with ongoing AMA advocacy efforts seeking to better define ACO accountability to match its capabilities to withstand risk. Specifically, in our AMA's recent comment letter on the ACO proposed rule, our AMA urged the Centers for Medicare and Medicaid Services to retain the Track 1 model instead of forcing all ACOs into two-sided risk models and provided evidence that ACOs can achieve savings for Medicare without downside risk. An amendment was offered suggesting that our AMA develop educational information and a webinar directed towards small physician practices to encourage their participation in these payment model activities. However, your Reference Committee believes that the request to develop educational resources in the second resolve clause satisfies this ask. Additionally, your Reference Committee suggests several minor amendments to be inclusive of all practice sizes and notes that definitions of a "smaller practice" are variable. Moreover, your Reference Committee suggests calling for business tools believing that this language is broader than the call for analytics and will provide the AMA with more leeway in the business resources it makes available to physicians. Therefore, your Reference Committee recommends that Resolution 802 be adopted as amended.

(11) RESOLUTION 803 - INSURANCE COVERAGE FOR ADDITIONAL SCREENING RECOMMENDED IN STATES WITH LAWS REQUIRING NOTIFICATION OF "DENSE BREASTS" ON MAMMOGRAM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be <u>adopted in lieu of Resolution 803</u>:

HOD ACTION: The alternate resolution <u>adopted in lieu of Resolution 803</u>:

RESOLVED, That our American Medical Association (AMA) reaffirm Policy H-525.993, which supports insurance coverage for screening mammography (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA reaffirm Policy H-525.977, which opposes state requirements for mandatory notification of breast tissue density to patients (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA encourage research on the benefits and harms of adjunctive screening for breast cancer for women identified to have dense breasts on an otherwise negative screening mammogram, in order to guide appropriate and evidence-based insurance care and coverage of the service (New HOD Policy); and be it further

RESOLVED, That our AMA support insurance coverage for and adequate access to supplemental screening recommended for patients with "dense breast" tissue following a discussion between the patient and their physician which integrates secondary risk characteristics. (New HOD Policy)

Resolution 803 asks that our AMA support insurance coverage for supplemental screening recommended for patients with "dense breast" tissue following a conversation between the patient and their physician; and 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.

Your Reference Committee heard mixed testimony on Resolution 803. Amendments were offered in support of insurance coverage for and adequate access to supplemental screening recommended for patients with dense breast tissue, which your Reference Committee incorporated in the alternate resolution. Based on testimony addressing the evidence behind screening mammography and concerns regarding state requirements for mandatory notification of breast tissue density to patients, your Reference Committee is recommending the reaffirmation of applicable AMA policy. Finally, several speakers stressed that AMA policy should not get ahead of the science on this issue, and as such your Reference Committee is including a recommendation to encourage research on the benefits and harms of adjunctive screening for breast cancer for women identified to have dense breasts on an otherwise negative screening mammogram. Accordingly, your Reference Committee recommends that the alternate resolution offered be adopted in lieu of Resolution 803.

H-525.993 Screening Mammography
Our AMA: a. recognizes the mortality reduction benefit of screening mammography and supports its use as a tool to detect breast cancer. b. recognizes that as with all medical screening procedures there are small, but not inconsequential associated risks including false positive and false negative results and overdiagnosis. c. favors participation in and support of the efforts of professional, voluntary, and government organizations to educate physicians and the public regarding the value of screening mammography in reducing breast cancer mortality, as well as its limitations. d. advocates remaining alert to new epidemiological findings regarding screening mammography and encourages the periodic reconsideration of these recommendations as more epidemiological data become available. e. believes that beginning at the age of 40 years, all women should be eligible for screening mammography. f. encourages physicians to regularly discuss with their individual patients the benefits and risks of screening

mammography, and whether screening is appropriate for each clinical situation given that the balance of benefits and risks will be viewed differently by each patient. g. encourages physicians to inquire about and update each patient's family history to detect red flags for hereditary cancer and to consider other risk factors for breast cancer, so that recommendations for screening will be appropriate. h. supports insurance coverage for screening mammography. i. supports seeking common recommendations with other organizations, informed and respectful dialogue as guideline-making groups address the similarities and differences among their respective recommendations, and adherence to standards that ensure guidelines are unbiased, valid and trustworthy. j. reiterates its longstanding position that all medical care decisions should occur only after thoughtful deliberation between patients and physicians. (CSA Rep. F, A-88; Reaffirmed: Res. 506, A-94; Amended: CSA Rep. 16, A-99; Appended: Res. 120, A-02; Modified: CSAPH Rep. 6, A-12)

H-525.977 Breast Density Notification
Our AMA supports the inclusion of breast tissue density information in the mammography report when appropriate and education of patients about the clinical relevance of such information, but opposes state requirements for mandatory notification of breast tissue density to patients. (Res. 502, A-14)

(12) RESOLUTION 805 - PROMPT PAY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be adopted in lieu of Resolution 805:

HOD ACTION: The alternate resolution adopted in lieu of Resolution 805.

RESOLVED, That our American Medical Association continue to encourage regulators to enforce existing prompt pay requirements. (Directive to Take Action)

Resolution 805 asks that Policy H-190.959 be amended by addition and deletion to seek regulatory and legislative relief to ensure that all health insurance and managed care companies pay for clean claims submitted electronically within three days instead of fourteen days; and 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 one day instead of five business days to allow prompt resubmission of a clean claim.

Testimony on Resolution 805 was supportive. A member of the Council on Medical Service testified that existing AMA policy addresses the intent of Resolution 805 and that the Council is unsure why our AMA would request to shorten the payment timeline when we are still struggling to achieve conformance with our 14-day policy. Additionally, the member expressed concern that asking this of payers may result in payers requesting

faster claims submission of providers. Recognizing the importance of Resolution 805 and the concerns expressed in testimony, your Reference Committee suggests an alternate resolution for our AMA to continue to work with regulators to enforce existing prompt pay requirements. Your Reference Committee believes that the issue lies not with the exact number of days in which payment must be made but rather with the lack of enforcement of current prompt pay regulations. Accordingly, your Reference Committee recommends that the alternate resolution be adopted in lieu of Resolution 805.

(13) RESOLUTION 806 - TELEMEDICINE MODELS AND ACCESS TO CARE IN POST-ACUTE AND LONG-TERM CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 806 be amended by addition and deletion to read as follows:

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 relevant national medical specialty societies ~~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

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 806 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work with relevant national medical specialty societies ~~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.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 806 be adopted as amended.

HOD ACTION: Resolution 806 adopted as amended.

Resolution 806 asks that our AMA 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); and 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.

Your Reference Committee heard limited yet supportive testimony on Resolution 806. Your Reference Committee is offering amendments to the resolution to ensure that our AMA is able to work with all relevant national medical specialty societies to achieve the objectives of the resolution. Accordingly, your Reference Committee recommends that Resolution 806 be adopted as amended.

(14) RESOLUTION 808 - THE IMPROPER USE OF BEERS OR SIMILAR CRITERIA AND THIRD-PARTY PAYER COMPLIANCE ACTIVITIES (H-185.940)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be adopted in lieu of Resolution 808:

HOD ACTION: The alternate resolution adopted in lieu of Resolution 808.

THE IMPROPER USE OF BEERS OR SIMILAR CRITERIA

RESOLVED, That our American Medical Association (AMA) reaffirm Policy H-185.940 (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA educate and urge health insurers, benefit managers, and other payers not to inappropriately apply the Beers or similar criteria to quality ratings programs in a way that may financially penalize physicians. (New HOD Policy)

Resolution 808 asks that our AMA 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; 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; and provide a mechanism for members to report possible abuses of Beers criteria by insurance companies.

There was mixed testimony on Resolution 808. A member of the Council on Medical Service called for reaffirmation of Policy H-185.940 stating that the Council believes existing AMA policy satisfies Resolution 808. Moreover, the member questioned the necessity of a workgroup and a report back because the American Geriatric Society (AGS) and our AMA state that the criteria should not be used in a punitive manner and the criteria is no longer used as part of the Medicare star ratings system. Your Reference Committee notes that, effective in 2017, it is simply a "display measure." Moreover, while the American Geriatric Society states that the criteria be used as both an educational tool and quality measure, it further states that the intent is not to apply the criteria in a punitive manner (*see* https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2017-Star-Ratings-Request-for-Comments.pdf). A member of the Beers Panel and the AGS testified against adoption stating that AGS published an article in 2015 about how to use the Beers Criteria and stated that that the workgroup called for in the resolution is an ineffective use of AMA resources and that instead our AMA should continue its work on the Beers Criteria and Prior Authorization. Testimony further stated that our AMA does and should continue to take advantage of comment periods relating to the Beers Criteria and that the next comment period will begin in early 2019.

With respect to the underlying intent of the third resolve of the original resolution, your Reference Committee notes that there already are a variety of forums in which members of the Federation can seek AMA assistance, such as through the Specialty and Service Society and the work of the Advocacy Resource Center. In addition, the AMA Advocacy Group engages health insurers directly on systemic issues that involve national insurers or cut across multiple health insurance markets, such as the AMA's current broad-based efforts to reduce the patient and practice burdens associated with prior authorization.

Based on testimony, your Reference Committee believes that the problem may not be the Beers Criteria itself but rather how payers are using clinical guidelines to financially penalize physicians. This belief was echoed by the author who stated that they simply wanted our AMA to assist in ensuring that insurers are not using the Beers Criteria in a punitive manner and was open to amendment of Resolution 808. Accordingly, your Reference Committee recommends adopting an alternate resolution that reaffirms Policy H-185.940. Your Reference Committee believes that the alternate resolution achieves the request of the authors and targets the source of the issue.

> H-185.940 Beers or Similar Criteria and Third Party Payer Compliances Activities
> Our AMA adopts policy: (1) discouraging health insurers, benefit managers, and other payers from using the Beers Criteria and other similar lists to definitively determine coverage and/or reimbursement, and inform health insurers and other payers of this policy; and (2) clarifying that while it is appropriate for

the Beers Criteria to be incorporated in quality measures, such measures should not be applied in a punitive or onerous manner to physicians and must recognize the multitude of circumstances where deviation from the quality measure may be appropriate, and inform health insurers and other payers of this policy. (BOT Rep. 14, A-12)

(15) RESOLUTION 812 - ICD CODE FOR PATIENTS HARM FROM PAYER INTERFERENCE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be adopted in lieu of Resolution 812:

HOD ACTION: The alternate resolution adopted in lieu of Resolution 812.

PRIOR AUTHORIZATION AND PATIENT HARM

RESOLVED, That our American Medical Association support efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm. (New HOD Policy)

Resolution 812 asks that our AMA 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.

Testimony was supportive of the intent of Resolution 812 and the importance of supporting efforts to track the harm to patients caused by payer interference via prior authorization requirements. A member of the Council on Medical Service proposed substitute language and testified that the ICD-10 code requested by Resolution 812 would require physicians to clearly document the correlation between payer policies and adverse clinical outcomes, which raises concerns about the appropriateness of documenting this information in the clinical record, timing of when the code would be reported during the patient's treatment, and potential repercussions to the physician for what he/she did for the patient to prevent the harm. Additionally, the Council member stated that this documentation burden would likely lead to underutilization of the code and that there may be more suitable ways to obtain this data. Your Reference Committee suggests that the Prior Authorization Physician Survey may be one way to obtain this data. In last year's survey, 92 percent of physicians reported that prior authorization can have a negative impact on patient clinical outcomes. And this year's version of the survey, which will be conducted in December, includes more questions addressing this point. Our AMA will have new data to report early next year. Taking into account these considerations and believing that an ICD-10 code is not the appropriate

mechanism to address the issue, your Reference Committee recommends that the alternate resolution be adopted in lieu of Resolution 812.

(16) RESOLUTION 814 - PRIOR AUTHORIZATION RELIEF IN MEDICARE ADVANTAGE PLANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolve of Resolution 814 be amended by addition and deletion as follows:

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

a. ~~Listing~~ List services and prescription medications that require a PA on a website and ~~Ensuring~~ ensure that patient informational materials include full disclosure of any PA requirements.
b. ~~Notifying~~ Notify providers of any changes to PA requirements at least 45 days prior to change.
c. ~~Improving~~ Improve transparency by requiring plans to report on the scope of PA practices, including the list of services and prescription medications subject to PA and corresponding denial, delay, and approval rates.
d. ~~Standardizing~~ Standardize a PA request form.
e. ~~Minimizing~~ Minimize PA requirements as much as possible within each plan and ~~eliminating~~ eliminate the application of PA to services and prescription medications that are routinely approved.
f. ~~Not denying payment~~ Pay for services and prescription medications for which PA ~~that~~ has been approved unless fraudulently obtained ~~or ineligible at time of service~~.
g. Allow continuation of ~~Medications~~ medications already being administered or prescribed when a patient changes health plans, and only change such medications with the ~~cannot be changed by the health plan without discussion and~~ approval of the ordering physician.
h. ~~Making~~ Make an easily accessible and responsive direct communication tool available to resolve disagreements between health plan and ordering provider.
i. ~~Defining~~ Define a consistent process for appeals and grievances, including to Medicaid and Medicaid managed care plans. (New HOD Policy) ~~; and be it further~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 814 be amended by deletion as follows:

~~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:~~

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

~~b. Minimizing PA requirements as much as possible within each plan.~~

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

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 814 be adopted as amended.

HOD ACTION: Resolution 814 adopted as amended.

Resolution 814 asks that our AMA 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: 1) Listing services that require a PA on a website, 2) Notifying providers of any changes at least 45 days prior to change, 3) Standardizing a PA request form, 4) Not denying payment for PA that has been approved unless fraudulently obtained or ineligible at time of service and 5) Defining a consistent process for appeals and grievances, including to Medicaid and Medicaid managed care plans; and apply these same legislative processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans, to include: 1) Medications already working when a patient changes health plans cannot be changed by the plan without discussion and approval of the ordering physician, 2) Minimizing PA requirements as much as possible within each plan and 3) Making an easily accessible and reasonably responsive direct communication tool available to resolve disagreements between plan and ordering provider.

A member of the Council on Medical Service testified that, at the 2017 Annual Meeting, the Council presented a comprehensive report on prior authorization and utilization management reform that recommended that our AMA continue its widespread prior authorization advocacy and outreach, including promotion of the Prior Authorization and Utilization Management Reform Principles, model state legislation, the Prior Authorization Physician Survey, and our AMA Prior Authorization toolkit. The Council believes that these tools, coupled with existing AMA prior authorization policy, address the points outlined in Resolution 814. Policy H-320.939 supports prior authorization advocacy and outreach, including promotion/adoption of the Prior Authorization and Utilization Management Reform Principles and AMA model legislation aimed at reducing PA burdens and improving access to care. Policy H-320.961 supports legislation or regulations that prevent the retrospective denial of payment for services for which a physician had previously received authorization. Additional testimony echoed that the

points raised in the resolution are addressed by numerous additional policies—including Policies H-320.968, H-320.952, H-285.965, and D-190.974—as well as the aforementioned Principles, the Consensus Statement on Improving the Prior Authorization Process, and AMA model state legislation.

Amendments were offered to ensure that our AMA took action on PA both in the legislative and regulatory spheres and to take out wording that PA be approved unless ineligible at the time of service to reduce physician burden and inappropriate PA determinations. Your Reference Committee accepts these amendments. Overall, although your Reference Committee agrees with testimony stating that Resolution 814 is largely addressed by current policy, it believes portions of Resolution 814 are consistent and additive to current policy. Moreover, your Reference Committee understands the burdens imposed on physicians by PA and wants to ensure that our AMA continues to do all it can to reduce PA and its negative impacts on patients and physicians. Accordingly, your Reference Committee recommends that Resolution 814 be adopted as amended.

(17) RESOLUTION 820 - ENSURING QUALITY HEALTH CARE FOR OUR VETERANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 820 be <u>amended by addition and deletion</u> to read as follows:

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 <u>Safe and Quality</u> 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 align its practices with external best practices assure they are similar to those of hospitals, state medical boards, and insurance companies~~.
(Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 820 be adopted as amended.

HOD ACTION: Resolution 820 adopted as amended.

Resolution 820 asks that our AMA amend Policy H-510.986 by addition to state that 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; and 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.

Your Reference Committee heard mixed testimony on Resolution 820. An amendment was offered to remove language in Part 5 of the proposed policy addition because it is potentially inflammatory, and your Reference Committee agrees. Moreover, though your Reference Committee understands that while the VA is highly regulated on the federal side, such regulations and practices may diverge from those of local hospitals and states. Therefore, your Reference Committee believes that a dialogue with the VHA is appropriate to explore these differences to ensure the continued quality care of our veterans. Accordingly, your Reference Committee recommends that Resolution 820 be adopted as amended.

(18) RESOLUTION 826 - DEVELOPING SUSTAINABLE SOLUTIONS TO DISCHARGE OF CHRONICALLY-HOMELESS PATIENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 826 be referred.

HOD ACTION: Resolution 826 referred with report back at the 2019 Annual Meeting.

Resolution 826 work with relevant stakeholders in developing sustainable plans for the appropriate discharge of chronically-homeless patients from hospitals, and reaffirm Policies H-270.962 and H-130.940.

Your Reference Committee heard mixed testimony on Resolution 826. Speakers stressed that the resolution could have unintended consequences and amount to an unfunded mandate. Your Reference Committee agrees and recommends referral of Resolution 826.

(19) RESOLUTION 822 - BONE DENSITY REIMBURSEMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 822 not be adopted.

HOD ACTION: Resolution 822 not adopted.

Resolution 822 asks that our AMA advocate for the correction of the underpayment by Medicare, Medicaid, and third-party payers to medical practices for office-based DXA tests.

There was mixed testimony on Resolution 822. Several speakers were supportive of the resolution and stated that inadequate reimbursement often results in access to care issues. A member of the Council on Medical Service called for not adoption of Resolution 822 explaining that current payment rates for bone density are largely based off of Resource-Based Relative Value Scale Update Committee (RUC) recommendations. Moreover, the DXA is a covered service when provided once every two years as part of the Annual Wellness Visit, in addition to being part of the Welcome to Medicare exam, and beneficiaries no longer have to pay copayments for this preventive benefit. Additionally, an AMA representative to the RUC stated that the AMA supports resource-based payment, and that, if payment is inadequate, it should be nominated for a misvalued service and should go through the RUC process to be remedied. The representative also urged the authors to work with colleagues in radiology and other specialties for the best possible outcome. Numerous speakers echoed this sentiment that the best and most appropriate course of action is to go through the RUC process. Your Reference Committee strongly agrees and therefore recommends that Resolution 822 be not adopted.

(20) RESOLUTION 807 - EMERGENCY DEPARTMENT COPAYMENTS FOR MEDICAID BENEFICIARIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-290.965, H-130.970, H-385.921, and D-290.977 be reaffirmed in lieu of Resolution 807.

HOD ACTION: Policies H-290.965, H-130.970, H-385.921, and D-290.977 reaffirmed in lieu of Resolution 807.

Resolution 807 asks that our AMA oppose imposition of copays for Medicaid beneficiaries seeking care in the emergency department. ESI triage level versus prudent layperson standards – 1115 waivers for increasing amounts and to use for emergent services.

There was mixed testimony on Resolution 807. Testimony indicated that the imposition of Medicaid copayments for "nonemergent" emergency room care does not appear to affect Medicaid beneficiary use of hospital emergency departments. Speakers stressed the need to promote the use of preventive care and encourage appropriate treatment settings by Medicaid beneficiaries. Some testimony also raised concerns that requiring Medicaid copayments for emergency care could place hospitals at risk of EMTALA violations.

The implied goal of imposing copays for Medicare beneficiaries seeking care in the emergency department is to promote more appropriate utilization of the emergency department by this segment of the population. Your Reference Committee believes that Policy H-290.965 addresses the goal that imposing ED copayments is attempting to achieve, while recognizing that other best practices may be more successful in impacting avoidable ED visits among Medicaid beneficiaries. Policy H-130.970 responds to testimony that raised concerns with state Medicaid policies that violate the "prudent layperson" standard of determining when to seek emergency care. Finally, several speakers stressed that steps need to be taken to ensure that Medicaid beneficiaries are better able to access primary care services, and as such is recommending the reaffirmation of Policies H-385.921, and D-290.977. To achieve the goal of ensuring Medicaid beneficiary access to care while promoting appropriate ED utilization, your Reference Committee recommends that Policies H-290.965, H-130.970, H-385.921, and D-290.977 be reaffirmed in lieu of Resolution 807.

H-290.965 Affordable Care Act Medicaid Expansion
1. Our AMA encourages state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access. 2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models. 3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries. 4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty

care for all Medicaid beneficiaries, including children and adolescents.5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care. 6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs. 7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care. **8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.** 9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS. 10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016. 11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists. 12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches. **13. Our AMA supports the use of emergency department (ED) best practices that are evidence-based to reduce avoidable ED visits.** (CMS Rep. 02, A-16; Reaffirmation: A-17)

H-130.970 Access to Emergency Services
1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services: (A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part. (B) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96) (C) All health plans should be prohibited from requiring prior authorization for emergency services. (D) Health plans may require patients, when able, to notify the plan or primary physician at the time of presentation for emergency services, as long as such notification does not delay the initiation of appropriate assessment and medical treatment. (E) All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize an "emergency medical condition" as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer. (F) Failure to obtain prior authorization for emergency services should never constitute a basis for denial of payment by any health plan or third party payer whether it is retrospectively determined that an

emergency existed or not. (G) States should be encouraged to enact legislation holding health plans and third party payers liable for patient harm resulting from unreasonable application of prior authorization requirements or any restrictions on the provision of emergency services. H) Health plans should educate enrollees regarding the appropriate use of emergency facilities and the availability of community-wide 911 and other emergency access systems that can be utilized when for any reason plan resources are not readily available. (I) In instances in which no private or public third party coverage is applicable, the individual who seeks emergency services is responsible for payment for such services. **2. Our AMA will work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the "prudent layperson" standard of determining when to seek emergency care**. (CMS Rep. A, A-89; Modified by CMS Rep. 6, I-95; Reaffirmation A-97; Reaffirmed by Sub. Res. 707, A-98; Reaffirmed: Res. 705, A-99; Reaffirmed: CMS Rep. 3, I-99; Reaffirmation A-00; Reaffirmed: Sub. Res. 706, I-00; Amended: Res. 229, A-01; Reaffirmation and Reaffirmed: Res. 708, A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 07, A-16; Appended: Res. 128, A-17; Reaffirmation: A-18)

H-385.921 Health Care Access for Medicaid Patients
It is AMA policy that to increase and maintain access to health care for all, payment for physician providers for Medicaid, TRICARE, and any other publicly funded insurance plan must be at minimum 100% of the RBRVS Medicare allowable. (Res. 103, A-07; Reaffirmed: CMS Rep. 2, I-08; Reaffirmation A-12; Reaffirmed: Res 132, A-14; Reaffirmed in lieu of Res. 808, I-14; Reaffirmation A-15)

D-290.977 Medicaid Primary Care Payment Increases
Our AMA: (1) advocates that the Affordable Care Act's Medicaid primary care payment increases for Evaluation and Management codes and vaccine administration codes include obstetricians and gynecologists as qualifying specialists, and support flexibility to achieve the best possible outcome; and (2) advocates for the Affordable Care Act's Medicaid primary care payment increases to continue past 2014 in a manner that does not negatively impact payment for any other physicians. (CMS Rep. 7, I-14)

(21) RESOLUTION 818 - DRUG PRICING TRANSPARENCY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-110.987, H-110.984, H-110.986 and H-125.980 be reaffirmed in lieu of Resolution 818.

HOD ACTION: Resolution 818 not adopted.

Resolution 818 asks that our AMA advocate to the U.S. Surgeon General for federal legislation that investigates all drug pricing.

Your Reference Committee heard mixed testimony on Resolution 818. In introducing the resolution, the sponsor offered an amendment to advocate for federal legislation to promote drug pricing transparency for essential medications. Members of the Council on Medical Service and Council on Legislation testified that even with the amendment, existing policy and advocacy efforts already address the intent of the resolution. First, a member of the Council on Medical Service stated that Policy H-110.987 already supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug by 10% or more each year or per course of treatment and provide justification for the price increase; and (b) legislation that authorizes the Attorney General and/or the FTC to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients.

A member of the Council on Legislation stated that through its legislative and regulatory efforts on the federal level, development and dissemination of model state legislation and working with interested state medical societies, our AMA is supporting requiring pharmaceutical supply chain transparency – among pharmaceutical manufacturers, pharmacy benefit managers and health plans. In particular, the AMA submitted a letter to Secretary Azar regarding the Trump Administration's drug pricing blueprint, which highlighted our policy priorities addressing drug price transparency and promoting and ensuring fair competition in the pharmaceutical marketplace. Also, our AMA has been active in testifying before Congress on the issue. Finally, our AMA also submitted letters of support of relevant federal legislation and amendments, including H.R. 6733, Know the Cost Act of 2018; S. 2554, The Patients Right to Know Drug Prices Act of 2018; and a bipartisan amendment to require pharmaceutical manufacturers to provide an appropriate disclosure of pricing information for their product in direct-to-consumer (DTC) advertisements.

Another amendment was offered that was more focused on addressing insulin pricing. A member of the Council on Medical Service testified that the Council just presented a report at the 2018 Annual Meeting on insulin pricing, which established Policy H-110.984 that states that our AMA will encourage the FTC and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate. Relevant to encouraging the use of value-based contracts, Policy H-110.986 outlines principles to guide the support of our AMA for value-based pricing programs, initiatives and mechanisms for pharmaceuticals. Addressing anticompetitive patent reforms, Policy H-110.987 states that our AMA will continue to support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system. The policy also states that our AMA encourages FTC actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives. Policy H-125.980 supports an abbreviated pathway for biosimilar approval.

Your Reference Committee believes that our AMA must continue to place a high priority on promoting prescription drug price transparency. However, your Reference Committee believes that Resolution 818 and all amendments offered are already addressed by existing AMA policy and ongoing advocacy efforts. As such, your Reference Committee

recommends that Policies H-110.987, H-110.984, H-110.986 and H-125.980 be reaffirmed in lieu of Resolution 818.

H-110.987 Pharmaceutical Costs
1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives. 2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition. 3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry. 4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system. 5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies. 6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation. 7. Our AMA supports legislation to shorten the exclusivity period for biologics. 8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens. 9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients. 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. (CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18)

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. (CMS Rep. 07, A-18)

H-110.986 Incorporating Value into Pharmaceutical Pricing
1. Our AMA supports value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by the following principles: (a) value-based prices of pharmaceuticals should be determined by objective, independent entities; (b) value-based prices of pharmaceuticals should be evidence-based and be the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes; (c) processes to determine value-based prices of pharmaceuticals must be transparent, easily accessible to physicians and patients, and provide practicing physicians and researchers a central and significant role; (d) processes to determine value-based prices of pharmaceuticals should limit administrative burdens on physicians and patients; (e) processes to determine value-based prices of pharmaceuticals should incorporate affordability criteria to help assure patient affordability as well as limit system-wide budgetary impact; and (f) value-based pricing of pharmaceuticals should allow for patient variation and physician discretion. 2. Our AMA supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research. 3. Our AMA supports direct purchasing of pharmaceuticals used to treat or cure diseases that pose unique public health threats, including hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size. (CMS Rep. 05, I-16; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: CMS-CSAPH Rep. 01, A-17; Reaffirmed: CMS Rep. 07, A-18)

H-125.980 Abbreviated Pathway for Biosimilar Approval
Our AMA supports FDA implementation of the Biologics Price Competition and Innovation Act of 2009 in a manner that 1) places appropriate emphasis on promoting patient access, protecting patient safety, and preserving market competition and innovation; 2) includes planning by the FDA and the allocation of sufficient resources to ensure that physicians understand the distinctions between biosimilar products that are considered highly similar, and those that are deemed interchangeable. Focused educational activities must precede and accompany the entry of biosimilars into the U.S. market, both for physicians and patients; and 3) includes compiling and maintaining an official compendium of biosimilar products, biologic reference products, and their related interchangeable biosimilars as they are developed and approved for marketing by the FDA. (Res. 220, A-09; Reaffirmation A-11; Modified: CSAPH Rep. 1, I-11; Modified: CSAPH Rep. 4, A-14)

(22) RESOLUTION 823 - MEDICARE CUTS TO RADIOLOGY IMAGING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy D-390.969 be reaffirmed in lieu of Resolution 823.

HOD ACTION: Policy D-390.969 reaffirmed in lieu of Resolution 823.

Resolution 823 asks that our AMA advocate for elimination of the Medicare differential imaging payments for small practices versus facility payments, and for elimination of the Medicare computed radiography (CR) payment reductions.

Your Reference Committee heard mixed testimony on Resolution 823. While testimony was generally supportive of the first Resolve of the resolution, several speakers stressed that existing policy, as well as Council on Medical Service Report 4 being considered at this meeting, addresses its intent. Several speakers raised concerns with the second Resolve of Resolution 823. Namely, a member of the Council on Medical Service underscored that the time to weigh in on Medicare computed radiography payment reductions has passed, since these reductions were set in statute two years ago (Consolidated Appropriations Act of 2016). Also, testimony raised concerns that the second Resolve has the potential to adversely affect other specialties, because if the payment reductions to Medicare computed radiography were overturned, it would require a pay-for, which would likely be a reduction to all physician services via the Medicare conversion factor.

Your Reference Committee believes that both Resolves of Resolution 823 are already addressed by existing policy, as well as Council on Medical Service Report 4 being considered at this meeting. As such, your Reference Committee recommends the reaffirmation of Policy D-390.969 in lieu of Resolution 823.

D-390.969 Parity in Medicare Reimbursement
Our AMA will continue its comprehensive advocacy campaign to: (1) repeal the reductions in Medicare payment for imaging services furnished in physicians' offices, as mandated by the Deficit Reduction Act of 2005; (2) pass legislation allowing physicians to share in Medicare Part A savings that are achieved when physicians provide medical care that results in fewer in-patient complications, shorter lengths-of-stays, and fewer hospital readmissions; and (3) advocate for other mechanisms to ensure adequate payments to physicians, such as balance billing and gainsharing. (BOT Action in response to referred for decision Res. 236, A-06; Reaffirmation I-08; Modified: BOT Rep. 09, A-18)

Madam Speaker, this concludes the report of Reference Committee J. I would like to thank Timothy Beittel, MD, Nitin Damle, MD, Florence Jameson, MD, Steve Lee, MD, Adam Panzer, Susan Strate, MD, and all those who testified before the Committee. I would also like to thank AMA staff: Courtney Perlino, MPP, Andrea Preisler, JD, and Jane Ascroft, MPA.

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