

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2019 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-19)

Report of Reference Committee J

Ravi Goel, MD, Chair

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Your Reference Committee recommends the following consent calendar for acceptance:

**RECOMMENDED FOR ADOPTION**

1. Resolution 811 – Require Payers to Share Prior Authorization Cost Burden
2. Resolution 812 – Autopsy Standards as Condition of Participation
3. Resolution 813 – Public Reporting of PBM Rebates

**RECOMMENDED FOR ADOPTION WITH CHANGE IN TITLE**

4. Resolution 820 – E-Cigarette and Vaping Associated Illness

**RECOMMENDED FOR ADOPTION AS AMENDED**

5. Council on Medical Service Report 1 – Established Patient Relationships and Telemedicine
6. Council on Medical Service Report 2 – Addressing Financial Incentives to Shop for Lower-Cost Health Care
7. Council on Medical Service Report 3 – Improving Risk Adjustment in Alternative Payment Models
8. Resolution 806 – Support for Housing Modification Policies
9. Resolution 808 – Protecting Patient Access to Seat Elevation and Standing Features in Power Wheelchairs
10. Resolution 810 – Hospital Medical Staff Policy
11. Resolution 815 – Step Therapy
12. Resolution 817 – Transparency of Costs to Patients for Their Prescription Medications Under Medicare Part D and Medicare Advantage Plans

**RECOMMENDED FOR ADOPTION IN LIEU OF**

13. Council on Medical Service Report 4 – Mechanisms to Address High and Escalating Pharmaceutical Prices in lieu of Resolution 802 – Ensuring Fair Pricing of Drugs Developed with the United States Government

- 1 Resolution 805 – Fair Medication Pricing for Patients in United States: Advocating for
- 2 a Global Pricing Standard
- 3 14. Resolution 801 – Reimbursement for Post-Exposure Protocol for Needlestick Injuries
- 4 15. Resolution 807 – Addressing the Need for Low Vision Aid Devices
- 5 16. Resolution 816 – Definition of New Patient
- 6 17. Resolution 819 – Hospital Website Voluntary Physician Inclusion

#### 7 **RECOMMENDED FOR REFERRAL**

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- 9 18. Resolution 809 – AMA Principles of Medicaid Reform
- 10 19. Resolution 814 – PBM Value-Based Framework for Formulary Design
- 11 20. Resolution 818 – Medical Center Auto Accept Policies

The following resolutions were handled via the reaffirmation consent calendar:

- Resolution 803 – Encourage Federal Efforts to Expand Access to Scheduled Dialysis for Undocumented People
- Resolution 804 – Protecting Seniors from Medicare Advantage Plans

**RECOMMENDED FOR ADOPTION**

- (1) RESOLUTION 811 – REQUIRE PAYERS TO SHARE PRIOR AUTHORIZATION COST BURDEN

**RECOMMENDATION:**

Resolution 811 be adopted.

HOD ACTION: Resolution 811 adopted as amended.

**RESOLVED, The AMA petition the Centers for Medicare and Medicaid Services to require the precertification process to include a one-time standard record of identifying information for the patient and insurance company representative to include their name, medical degree and NPI number.**

RESOLVED, That our American Medical Association reaffirm policies H-320.939, "Prior Authorization and Utilization Management Reform," and H-385.951, "Remuneration for Physician Services." (Reaffirm HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 811. An amendment was offered to petition the Centers for Medicare and Medicaid Services to require a one-time standard record of identifying information for the patient and insurance company representatives. However, your Reference Committee believes that the amendment is outside the scope of Resolution 811. Accordingly, your Reference Committee recommends that Resolution 811 be adopted.

- (2) RESOLUTION 812 – AUTOPSY STANDARDS AS CONDITION OF PARTICIPATION

**RECOMMENDATION:**

Resolution 812 be adopted.

HOD ACTION: Resolution 812 adopted.

RESOLVED, That our American Medical Association call upon the Centers for Medicare and Medicaid Services to reinstate the Autopsy Standard as a Medicare Condition of Participation. (Directive to Take Action)

Testimony was very supportive of Resolution 812. Speakers testified to the importance of the practice of autopsy and the usefulness of autopsy data. Other testimony spoke to the importance of autopsy as an educational tool. Accordingly, your Reference Committee recommends that Resolution 812 be adopted.

- (3) RESOLUTION 813 – PUBLIC REPORTING OF PBM REBATES

1           **RECOMMENDATION:**

2

3           **Resolution 813 be adopted.**

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5           **HOD ACTION: Resolution 813 adopted.**

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7 RESOLVED, That our American Medical Association advocate for Pharmacy Benefit  
8 Managers (PBMs) and state regulatory bodies to make rebate and discount reports and  
9 disclosures available to the public (Directive to Take Action); and be it further

10

11 RESOLVED, That our AMA advocate for the inclusion of required public reporting of rebates  
12 and discounts by PBMs in federal and state PBM legislation. (Directive to Take Action)

13 Your Reference Committee heard supportive testimony on Resolution 813. Your Reference  
14 Committee notes that Resolution 813 is consistent with ongoing AMA advocacy efforts on the  
15 federal and state levels in support of disclosing PBM rebates and discounts. As such, your  
16 Reference Committee recommends that Resolution 813 be adopted.

**RECOMMENDED FOR ADOPTION WITH CHANGE IN TITLE**

- (4) RESOLUTION 820 – E-CIGARETTE AND VAPING  
ASSOCIATED ILLNESS

**RECOMMENDATION A:**

Resolution 820 be adopted.

**RECOMMENDATION B:**

Title of Resolution 820 be changed to read as follows:

**DIAGNOSTIC CODES FOR E-CIGARETTE AND VAPING  
ASSOCIATED ILLNESS**

**HOD ACTION: Resolution 820 adopted with change in title.**

RESOLVED, That our AMA advocate for diagnostic coding systems including ICD codes to have a mechanism to release emergency codes for emergent diseases; and be it further

RESOLVED, That our AMA advocate for creation and release of ICD codes to include appropriate diagnosis codes for both the use of and toxicity related to e-cigarettes and vaping, including pulmonary toxicity.

Your Reference Committee heard supportive testimony on Resolution 820. Your Reference Committee believes that Resolution 820 builds upon existing AMA policy and advocacy on the issue of e-cigarettes and vaping, and recommends its adoption.

**RECOMMENDED FOR ADOPTION AS AMENDED**

- (5) COUNCIL ON MEDICAL SERVICE REPORT 1 –  
ESTABLISHED PATIENT RELATIONSHIPS AND  
TELEMEDICINE

**RECOMMENDATION A:**

Council on Medical Service Report 1 be amended by addition of a new Recommendation to read as follows:

4. That our AMA advocate to the Interstate Medical Licensure Compact Commission and Federation of State Medical Boards for reduced application fees and secondary state licensure(s) fees processed through the Interstate Medical Licensure Compact. (Directive to Take Action)

**RECOMMENDATION B:**

Council on Medical Service Report 1 be amended by addition of a new Recommendation to read as follows:

5. That our AMA work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services, in accordance with AMA Policy H-480.946, Coverage of and Payment for Telemedicine. (New HOD Policy)

**RECOMMENDATION C:**

Recommendations in Council on Medical Service Report 1 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 1 adopted as amended and the remainder of the Report filed.

That our AMA reaffirm Policy D-480.969, which supports coverage for telemedicine-provided services comparable to coverage for in-person services.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 215-A-18, and the remainder of the report be filed:

1. That our American Medical Association (AMA) work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact to consider

1 joining the Compact as a means of enhancing patient access to and proper regulation of  
2 telemedicine services. (Directive to Take Action)

3  
4 2. That our AMA reaffirm Policy H-480.946, which delineates standards and safeguards that  
5 should be met for the coverage and payment of telemedicine, including that physicians  
6 and other health practitioners delivering telemedicine services must be licensed in the  
7 state where the patient receives services. (Reaffirm HOD Policy)

8  
9 3. That our AMA reaffirm Policy H-480.969, which maintains that state medical boards should  
10 require a full and unrestricted license in that state for the practice of telemedicine, with no  
11 differentiation by specialty, unless there are other appropriate state-based licensing  
12 methods, and with exemptions for emergent or urgent circumstances and “curbside  
13 consultations.” (Reaffirm HOD Policy)

14  
15 Your Reference Committee heard supportive testimony on Council on Medical Service Report  
16 1. In introducing the report, a member of the Council on Medical Service testified that the  
17 Council found that the Interstate Medical Licensure Compact (the Compact) is the most viable  
18 approach to facilitating multistate licensure without undermining state jurisdiction over medical  
19 practice, noting that the Compact has been adopted in more than half of states within two  
20 years of its launch. A member of the Council on Legislation testified in support of the report’s  
21 approach, reiterating that the Compact is the first-line defense against proposals to create a  
22 federal telemedicine license.

23  
24 A representative of the AMA Integrated Physician Practice Section (IPPS) testified to the cost  
25 burden of obtaining licenses in multiple states through the Compact and suggested a new  
26 recommendation asking the AMA to advocate to the Interstate Medical Licensure Compact  
27 Commission and Federation of State Medical Boards for reduced application fees and  
28 secondary state licensure(s) fees processed through the Compact. Testimony was supportive  
29 of this amendment. An additional amendment was offered asking the AMA to work with state  
30 medical associations to encourage state legislation that enhances patient access to and  
31 proper regulation of telemedicine services. Your Reference Committee supports this  
32 amendment and believes another amendment offered on payment for telemedicine is beyond  
33 the scope of this report. Accordingly, your Reference Committee recommends that Council  
34 on Medical Service Report 1 be adopted as amended, and the remainder of the report be  
35 filed.

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37 (6) COUNCIL ON MEDICAL SERVICE 2 – ADDRESSING  
38 FINANCIAL INCENTIVES TO SHOP FOR LOWER-COST  
39 HEALTH CARE

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41 **RECOMMENDATION A:**

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43 **Recommendation 2 in Council on Medical Service Report 2**  
44 **be amended by addition and deletion to read as follows:**

45  
46 **2. That our AMA support the following quality and cost**  
47 **principles for any FIP:**  
48 **a) Remind patients that they can receive care from the**  
49 **physician or facility of their choice consistent with their**  
50 **health plan benefits.**

b) Provide publicly available information regarding the metrics used to identify, and quality scores associated with, lower and higher-cost health care items, services, physicians and facilities.

c) Provide patients and physicians with the quality scores associated with both lower and higher-cost physicians and facilities, as well as information regarding the methods used to determine quality scores. Differences in cost due to specialty or sub-specialty focus should be explicitly stated and clearly explained if data is made public.

d) Respond within a reasonable timeframe to inquiries of whether the physician is among the preferred lower-cost physicians; the physician's quality scores and those of lower-cost physicians; and directions for how to appeal exclusion from lists of preferred lower-cost physicians.

e) Provide a process through which patients and physicians can publicly report unsatisfactory care experiences when with referred to lower-cost physicians or facilities. The reporting process should be easily accessible by patients and physicians participating in the program.

f) Provide meaningful transparency of prices and vendors.

g) Inform patients of the health plan cost-sharing and any financial incentives associated with receiving care from FIP-preferred, other in-network, and out-of-network physicians and facilities.

h) Inform patients that pursuing lower-cost and/or incentivized care, including FIP incentives, may require them to undertake some burden, such as traveling to a lower-cost site of service or complying with a more complex dosing regimen for lower-cost prescription drugs.

i) Methods of cost attribution to a physician or facility must be transparent, and the assumptions underlying cost attributions must be publicly available if cost is a factor used to stratify physicians or facilities. (New HOD Policy)

#### **RECOMMENDATION B:**

**Recommendations in Council on Medical Service Report 2 be adopted as amended and the remainder of the report be filed.**

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

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

1. That our American Medical Association (AMA) support the following continuity of care principles for any financial incentive program (FIP):



- a) Collaborate with the physician community in the development and implementation of patient incentives.
  - b) Collaborate with the physician community to identify high-value referral options based on both quality and cost of care.
  - c) Provide treating physicians with access to patients' FIP benefits information in real-time during patient consultations, allowing patients and physicians to work together to select appropriate referral options.
  - d) Inform referring and/or primary care physicians when their patients have selected an FIP service prior to the provision of that service.
  - e) Provide referring and/or primary care physicians with the full record of the service encounter.
  - f) Never interfere with a patient-physician relationship (eg, by proactively suggesting health care items or services that may or may not become part of a future care plan).
  - g) Inform patients that only treating physicians can determine whether a lower-cost care option is medically appropriate in their case and encourage patients to consult with their physicians prior to making changes to established care plans. (New HOD Policy)
2. That our AMA support the following quality and cost principles for any FIP:
- a) Remind patients that they can receive care from the physician or facility of their choice consistent with their health plan benefits.
  - b) Provide publicly available information regarding the metrics used to identify, and quality scores associated with, lower and higher-cost health care items, services, physicians and facilities.
  - c) Provide patients and physicians with the quality scores associated with both lower and higher-cost physicians and facilities, as well as information regarding the methods used to determine quality scores.
  - d) Respond within a reasonable timeframe to inquiries of whether the physician is among the preferred lower-cost physicians; the physician's quality scores and those of lower-cost physicians; and directions for how to appeal exclusion from lists of preferred lower-cost physicians.
  - e) Provide a process through which patients and physicians can publicly report unsatisfactory care experiences with referred lower-cost physicians or facilities.
  - f) Provide meaningful transparency of prices and vendors.
  - g) Inform patients of the health plan cost-sharing and any financial incentives associated with receiving care from FIP-preferred, other in-network, and out-of-network physicians and facilities.
  - h) Inform patients that pursuing lower-cost and/or incentivized care, including FIP incentives, may require them to undertake some burden, such as traveling to a lower-cost site of service or complying with a more complex dosing regimen for lower-cost prescription drugs. (New HOD Policy)
3. That our AMA support requiring health insurers to indemnify patients for any additional medical expenses resulting from needed services following inadequate FIP-recommended services. (New HOD Policy)
4. That our AMA oppose FIPs that effectively limit patient choice by making alternatives other than the FIP-preferred choice so expensive, onerous and inconvenient that patients effectively must choose the FIP choice. (New HOD Policy)

5. That our AMA encourage state medical associations and national medical specialty societies to apply these principles in seeking opportunities to collaborate in the design and implementation of FIPs, with the goal of empowering physicians and patients to make high-value referral choices. (New HOD Policy)
6. That our AMA encourage objective studies of the impact of FIPs that include data collection on dimensions such as:
  - a) Patient outcomes/the quality of care provided with shopped services;
  - b) Patient utilization of shopped services;
  - c) Patient satisfaction with care for shopped services;
  - d) Patient choice of health care provider;
  - e) Impact on physician administrative burden; and
  - f) Overall/systemic impact on health care costs and care fragmentation. (New HOD Policy)

Testimony on Council on Medical Service Report 2 was supportive. A member of the Council on Medical Service introduced the report stating that the Council's report was intended to address potential consequences with financial incentive programs including patient choice, continuity of care, and the physician-patient relationship. Amendments were offered to improve transparency and remove differences in cost due to specialty and sub-specialty. Your Reference Committee agrees with these amendments and offers language to ensure that transparency is given to patients and physicians.

Further testimony raised concerns with financial incentive programs and their potential to fragment care, and the Council noted that it too shares those concerns. The Council stated that this report is not advocating for the existence of these programs but rather advocating for safeguards within the programs. The Reference Committee agrees and highlights that this report is not an endorsement of any financial incentive program. Therefore, your Reference Committee recommends that Council on Medical Service Report 2 be adopted as amended and the remainder of the report be filed.

(7) COUNCIL ON MEDICAL SERVICE REPORT 3 – IMPROVING  
RISK ADJUSTMENT IN ALTERNATIVE PAYMENT MODELS

**RECOMMENDATION A:**

**Council on Medical Service Report 3 be amended by addition of a new Recommendation to read as follows:**

**8. That our AMA support risk adjustment mechanisms that allow for flexibility to account for changes in science and practice as to not discourage or punish early adopters of effective therapy. (New HOD Policy)**

**RECOMMENDATION B:**

**Recommendations in Council on Medical Service Report 3 be adopted as amended and the remainder of the Report be filed.**

**HOD ACTION: Recommendations in Council on Medical Service Report 3 adopted as amended and the remainder of the Report filed.**

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

1. That our American Medical Association (AMA) reaffirm Policy H-385.908 stating that the AMA will work with the Centers for Medicare & Medicaid Services and interested organizations to design systems that identify data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient's health and success of treatment, such as disease stage and socio-demographic factors; account for differences in patient needs, such as functional limitations, changes in medical conditions, and ability to access health care services; and explore an approach in which the physician managing a patient's care can contribute additional information, such as disease severity, that may not be available in existing risk adjustment methods to more accurately determine the appropriate risk stratification. (Reaffirm HOD Policy)
2. That our AMA reaffirm Policy D-478.995 advocating for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records so that capturing patient characteristics and risk adjustment measures do not add to physician and practice administrative burden. (Reaffirm HOD Policy)
3. That our AMA support risk stratification systems that use fair and accurate payments based on patient characteristics, including socioeconomic factors, and the treatment that would be expected to result in the need for more services or increase the risk of complications. (New HOD Policy)
4. That our AMA support risk adjustment systems that use fair and accurate outlier payments if spending on an individual patient exceeds a pre-defined threshold or individual stop loss insurance at the insurer's cost. (New HOD Policy)
5. That our AMA support risk adjustment systems that use risk corridors that use fair and accurate payment if spending on all patients exceeds a pre-defined percentage above the payments or support aggregate stop loss insurance at the insurer's cost. (New HOD Policy)
6. That our AMA support risk adjustment systems that use fair and accurate payments for external price changes beyond the physician's control. (New HOD Policy)
7. That our AMA support accountability measures that exclude from risk adjustment methodologies any services that the physician does not deliver, order, or otherwise have the ability to influence. (New HOD Policy)

Testimony on Council on Medical Service Report 3 was unanimously supportive. A member of the Council on Medical Service introduced the report outlining the importance of the Council's recommendations to enable physicians to care for vulnerable populations. An amendment was offered to add a recommendation to ensure the recommendations apply to early adopters of novel therapies. The Council on Medical Service appreciated and agreed with the new recommendation to ensure our AMA is supporting all physicians. Therefore, your Reference Committee agrees with this addition. A concern was raised that the report does not

adequately address hierarchical condition category (HCC) coding. The Council on Medical Service subsequently addressed this concern stating that the report is intentionally broad to include not only HCCs but also all risk adjustment methods. Your Reference Committee agrees. Accordingly, your Reference Committee recommends that Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

(8) RESOLUTION 806 – SUPPORT FOR HOUSING  
MODIFICATION POLICIES

**RECOMMENDATION A:**

Resolution 806 be amended by addition and deletion to read as follows:

**RESOLVED**, That our American Medical Association support improved access to legislation for health insurance coverage of housing modification benefits for: ~~(a) the elderly; (b) other populations that require these modifications in order to mitigate preventable health conditions, including but not limited to the elderly, the disabled or soon to be disabled;~~ and ~~(c) other persons with physical and/or mental disabilities.~~ (New HOD Policy)

**RECOMMENDATION B:**

Resolution 806 be adopted as amended.

**HOD ACTION:** Resolution 806 adopted as amended.

RESOLVED, That our American Medical Association support legislation for health insurance coverage of housing modification benefits for: (a) the elderly; (b) other populations that require these modifications in order to mitigate preventable health conditions, including but not limited to the disabled or soon to be disabled; and (c) other persons with physical and/or mental disabilities. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 806. There was unanimous support for the intent of Resolution 806; however, numerous speakers raised concerns that this resolution requests a new, expensive benefit mandate in a budget neutral health insurance environment. A member of the Council on Medical Service commended the authors for bringing forth Resolution 806 and stated that the Council agrees with the intent of the resolution. However, the Council recommended amended language to broaden and simplify the resolution. The Council stated that it does not believe that the legislation called for in Resolution 806 is required to improve access to housing modifications for certain populations nor does it believe that it is necessary to link to Medicare or any insurance to support improved access to housing modifications. Additionally, the Council noted that the Physician-Focused Payment Model Technical Advisory Committee (PTAC) recently reviewed an alternative payment model (APM) proposal for modification services and that a simple policy statement on the issue could be used to support such proposals moving forward. Your Reference Committee believes that the amended language addresses the concerns raised. Therefore, your Reference Committee recommends that Resolution 806 be adopted as amended.

(9) RESOLUTION 808 – PROTECTING PATIENT ACCESS TO  
SEAT ELEVATION AND STANDING FEATURES IN POWER  
WHEELCHAIRS

**RECOMMENDATION A:**

The second, third, and fourth Resolves of Resolution 808  
be deleted.

~~RESOLVED, That our AMA urge CMS to require the DME  
Medicare Administrative Contractors (MACs) to determine  
an appropriate coverage policy for Medicare beneficiaries  
in need of the seat elevation and standing features in their  
power wheelchairs on an individual basis according to the  
National Coverage Determination (NCD) for mobility  
assistance equipment (MAE), activate the existing  
Healthcare Common Procedure Coding System (HCPCS)  
codes for seat elevation and standing feature in power  
wheelchairs, and determine appropriate reimbursement  
levels for these codes in order to facilitate access to these  
important benefits for Medicare beneficiaries with mobility  
impairments (Directive to Take Action); and be it further~~

~~RESOLVED, That if CMS is not able or willing to provide  
access to seat elevation and standing feature through its  
administrative authority, our AMA advocate before  
Congress to support legislation that will clarify the DME  
benefit to include coverage, coding and reasonable  
reimbursement of standing feature and seat elevation in  
power wheelchairs for appropriate Medicare beneficiaries  
with mobility impairments (Directive to Take Action); and  
be it further~~

~~RESOLVED, That our AMA encourage all health insurance  
carriers to cover standing feature and seat elevation in  
power wheelchairs for appropriate beneficiaries with  
mobility impairments. (Directive to Take Action)~~

**RECOMMENDATION B:**

Resolution 808 be adopted as amended.

**HOD ACTION: Resolution 808 adopted as amended.**

RESOLVED, That our American Medical Association request that the Centers for Medicare and Medicaid Services (CMS) render a benefit category determination (BCD) that establishes that the seat elevation and standing features of power wheelchairs are primarily medical in nature and qualify under the definition of durable medical equipment (DME) when used in a power wheelchair (Directive to Take Action); and be it further

1 RESOLVED, That our AMA urge CMS to require the DME Medicare Administrative  
2 Contractors (MACs) to determine an appropriate coverage policy for Medicare beneficiaries  
3 in need of the seat elevation and standing features in their power wheelchairs on an individual  
4 basis according to the National Coverage Determination (NCD) for mobility assistance  
5 equipment (MAE), activate the existing Healthcare Common Procedure Coding System  
6 (HCPCS) codes for seat elevation and standing feature in power wheelchairs, and determine  
7 appropriate reimbursement levels for these codes in order to facilitate access to these  
8 important benefits for Medicare beneficiaries with mobility impairments (Directive to Take  
9 Action); and be it further

10  
11 RESOLVED, That if CMS is not able or willing to provide access to seat elevation and standing  
12 feature through its administrative authority, our AMA advocate before Congress to support  
13 legislation that will clarify the DME benefit to include coverage, coding and reasonable  
14 reimbursement of standing feature and seat elevation in power wheelchairs for appropriate  
15 Medicare beneficiaries with mobility impairments (Directive to Take Action); and be it further

16  
17 RESOLVED, That our AMA encourage all health insurance carriers to cover standing feature  
18 and seat elevation in power wheelchairs for appropriate beneficiaries with mobility  
19 impairments. (Directive to Take Action)

20  
21 Your Reference Committee heard supportive testimony on Resolution 808. A member of the  
22 Council on Medical Service stated that, though the Council agrees with the intent of Resolution  
23 808, the Council believes the resolution is overly prescriptive and instead called for adoption  
24 of the first resolve and deleting the second, third, and fourth resolve clauses. The Council  
25 testified that the specific requests in the resolve clauses are unnecessary and that policy does  
26 not need to dictate alternative courses of action to achieve coverage of standing features of  
27 power wheelchairs. Finally, the Council testified that Resolution 808 may detract from other  
28 advocacy priorities. Subsequent testimony supported this amendment. Moreover, a member  
29 of the Council on Legislation echoed the concerns of the Council on Medical Service and  
30 joined them in calling for adoption of the first resolve and deleting the remaining resolves.  
31 Your Reference Committee agrees and believes that adoption of the first resolve clause  
32 satisfies the intent of Resolution 808. Accordingly, your Reference Committee recommends  
33 that Resolution 808 be adopted as amended.

34  
35 (10) RESOLUTION 810 – HOSPITAL MEDICAL STAFF POLICY

36  
37 **RECOMMENDATION A:**

38  
39 **The second Resolve of Resolution 810 be deleted.**

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41 ~~**RESOLVED, That our AMA support and advocate that the**~~  
42 ~~**decisions made by hospital medical staffs focus on quality**~~  
43 ~~**patient care., medical staff standards and the operation of**~~  
44 ~~**the hospital, and that those decisions not engage the**~~  
45 ~~**medical staff in external political matters (e.g., advanced**~~  
46 ~~**practice clinician scope of practice expansion, etc.)**~~  
47 ~~**(Directive to Take Action); and be it further**~~

48  
49 **RECOMMENDATION B:**

50  
51 **The third Resolve of Resolution 810 be deleted.**

**~~RESOLVED, That AMA Policy H-225.993, “Medical Staff Policy Determination,” be rescinded. (Rescind HOD Policy)~~**

**RECOMMENDATION C:**

**Resolution 810 be adopted as amended.**

**HOD ACTION: Resolution 810 adopted as amended**

RESOLVED, That our American Medical Association support and advocate that hospital medical staff leadership should be fully licensed physicians and that if others are included, they should be non-voting or advisory to the hospital medical staff members (Directive to Take Action); and be it further

RESOLVED, That our AMA support and advocate that the decisions made by hospital medical staffs focus on quality patient care, medical staff standards and the operation of the hospital, and that those decisions not engage the medical staff in external political matters (e.g., advanced practice clinician scope of practice expansion, etc.) (Directive to Take Action); and be it further

RESOLVED, That AMA Policy H-225.993, “Medical Staff Policy Determination,” be rescinded. (Rescind HOD Policy)

Testimony on Resolution 810 was mixed. Most speakers asked that the first Resolve clause be adopted and that the second and third Resolve clauses be deleted. Substantial testimony highlighted the scope of practice issues inherent in the second Resolve clause and noted that it is well within the purview of physicians to advocate for their patients and themselves. Speakers were supportive of existing AMA policy on organized medical staffs, including Policy H-225.993 that the third Resolve clause rescinds. Accordingly, your Reference Committee recommends that Resolution 810 be adopted as amended.

**(11) RESOLUTION 815 – STEP THERAPY**

**RECOMMENDATION A:**

**That the first Resolve of Resolution 815 be amended by addition and deletion to read as follows:**

**RESOLVED, That our American Medical Association amend Policy D-320.981, “Medicare Advantage Step Therapy,” by addition and deletion to read as follows:**

**MEDICARE ADVANTAGE STEP THERAPY D-320.981**

**1. Our AMA believes that step therapy programs create barriers to patient care and encourage health plans to instead focus utilization management protocol on review of statistical outliers.**

**2. Our AMA will advocate that health plan ~~the Medicare Advantage~~ step therapy protocols, if not repealed, should feature the following patient protections:**

- a. Enable the treating physician, rather than another entity such as the insurance company, to determine if a patient “fails” a treatment;
- b. Exempt patients from the step therapy protocol when the physician believes the required step therapy treatments would be ineffective, harmful, or otherwise against the patients’ best interests;
- c. Permit a physician to override the step therapy process when patients are stable on a prescribed medication;
- d. Permit a physician to override the step therapy if the physician expects the treatment to be ineffective based on the known relevant medical characteristics of the patient and the known characteristics of the drug regimen; if patient comorbidities will cause, or will likely cause, an adverse reaction or physical harm to the patient; or is not in the best interest of the patient, based on medical necessity;
- e. Include an exemption from step therapy for emergency care;
- f. Require health insurance plans to process step therapy approval and override request processes electronically;
- g. Not require a person changing health insurance plans to repeat step therapy that was completed under a prior plan; and
- h. Consider a patient with recurrence of the same systematic disease or condition to be considered an established patient and therefore not subject to duplicative step therapy policies for that disease or condition (Modify HOD Policy); and be it further

~~RESOLVED, That our American Medical Association extend its advocacy for the patient protections against step therapy protocols outlined in D-320.981, “Medicare Advantage Step Therapy,” to all health plans (Directive to Take Action); and be it further~~

#### **RECOMMENDATION B:**

**Resolution 815 be adopted as amended.**

**HOD ACTION: Resolution 815 adopted as amended.**

RESOLVED, That our American Medical Association extend its advocacy for the patient protections against step therapy protocols outlined in D-320.981, “Medicare Advantage Step Therapy,” to all health plans (Directive to Take Action); and be it further

RESOLVED, That our AMA actively support state and federal legislation that would allow timely clinician-initiated exceptions to, and place reasonable limits on, step therapy protocols imposed by health care plans. (Directive to Take Action)



1 Testimony on Resolution 815 was unanimously supportive. An amendment was offered to  
2 ensure that the intent of the first Resolve of Resolution 815 would be included in the content  
3 and text of Policy D-320.981, "Medicare Advantage Step Therapy." Your Reference  
4 Committee believes that Resolution 815 is consistent with ongoing AMA advocacy efforts on  
5 the state and federal levels, and with commercial plans, focused on step therapy reforms and  
6 protections. As such, your Reference Committee recommends that Resolution 815 be  
7 adopted as amended.

8 (12) RESOLUTION 817 – TRANSPARENCY OF COSTS TO  
9 PATIENTS FOR THEIR PRESCRIPTION MEDICATIONS  
10 UNDER MEDICARE PART D AND MEDICARE ADVANTAGE  
11 PLANS

12  
13 **RECOMMENDATION A:**

14  
15 **The first Resolve in Resolution 817 be amended by deletion**  
16 **to read as follows:**

17  
18 **RESOLVED, That our American Medical Association**  
19 **advocate for transparent patient educational resources on**  
20 **their personal costs for their medications under Medicare**  
21 **Part D and Medicare Advantage plans--both printed and**  
22 **online video--which health care systems could provide to**  
23 **patients and which consumers could access directly**  
24 **(Directive to Take Action); and be it further**

25  
26 **RECOMMENDATION B:**

27  
28 **The second Resolve in Resolution 817 be amended by**  
29 **addition and deletion to read as follows:**

30  
31 **RESOLVED, That our AMA ~~advocate for~~ support increased**  
32 **~~resources~~ funding for federal and state health insurance**  
33 **assistance programs like ~~GeorgiaCares~~ and educate**  
34 **physicians, hospitals, and patients about the availability of**  
35 **these programs. (Directive to Take Action)**

36  
37 **RECOMMENDATION C:**

38  
39 **Resolution 817 be adopted as amended.**

40  
41 **HOD ACTION: Resolution 817 adopted as amended.**

42  
43 **RESOLVED, That our American Medical Association advocate for transparent patient**  
44 **educational resources on their personal costs for their medications under Medicare Part D**  
45 **and Medicare Advantage plans--both printed and online video--which health care systems**  
46 **could provide to patients and which consumers could access directly (Directive to Take**  
47 **Action); and be it further**  
48

1 RESOLVED, That our AMA advocate for increased resources for federal and state programs  
2 like GeorgiaCares and educate physicians, hospitals, and patients about the availability of  
3 these programs. (Directive to Take Action)

4  
5 Your Reference Committee heard generally supportive testimony on Resolution 817. In  
6 response to testimony raising the need for the first Resolve to also include costs to patients  
7 under traditional Medicare, your Reference Committee offers an amendment to the first  
8 Resolve to enable the AMA to advocate for transparent patient educational resources on their  
9 personal costs for their medications under Medicare Parts A, B and D. In addition, your  
10 Reference Committee offers an amendment to the second Resolve of Resolution 817 to clarify  
11 its intent of supporting increased funding for federal and state health insurance assistance  
12 programs, while removing reference to a specific state program. Your Reference Committee  
13 recommends that Resolution 817 be adopted as amended.

**RECOMMENDED FOR ADOPTION IN LIEU OF**

- (13) COUNCIL ON MEDICAL SERVICE REPORT 4 –  
MECHANISMS TO ADDRESS HIGH AND ESCALATING  
PHARMACEUTICAL PRICES  
RESOLUTION 802 – ENSURING FAIR PRICING OF DRUGS  
DEVELOPED WITH THE UNITED STATES GOVERNMENT  
RESOLUTION 805 – FAIR MEDICATION PRICING FOR  
PATIENTS IN UNITED STATES: ADVOCATING FOR A  
GLOBAL PRICING STANDARD

**RECOMMENDATION A:**

Recommendation 1(e) in Council on Medical Service  
Report 4 be amended by deletion to read as follows:

e. The arbitration process should include the submission  
of a value-based price ~~benchmark~~ for the drug in question  
to inform the arbitrator's decision;

**RECOMMENDATION B:**

Recommendation 1(f) in Council on Medical Service Report  
4 be amended by deletion to read as follows:

f. The arbitrator should be required to choose either the bid  
of the pharmaceutical manufacturer or the bid of the  
payer/~~government entity~~;

**RECOMMENDATION C:**

Recommendation 1 in Council on Medical Service Report 4  
be amended by addition of a new standard 1(i) to read as  
follows:

i. The arbitration process should include a mechanism to  
revisit the arbitrator's decision due to new evidence or  
data.

**RECOMMENDATION D:**

Recommendation 2 in Council on Medical Service Report 4  
be amended by addition of a new principle 2(e) to read as  
follows:

e. Any data used to determine an international price index  
or average to guide prescription drug pricing should be  
updated regularly.

**RECOMMENDATION E:**

**Recommendations in Council on Medical Service Report 4 be adopted as amended in lieu of Resolutions 802 and 805 and the remainder of the Report be filed.**

**HOD ACTION: Recommendations in Council on Medical Service Report 4 adopted as amended in lieu of Resolutions 802 and 805 and the remainder of the Report filed.**

**Title changed to: ADDITIONAL MECHANISMS TO ADDRESS HIGH AND ESCALATING PHARMACEUTICAL PRICES**

**CMS Report 4**

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

1. That our American Medical Association (AMA) advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
  - a. The arbitration process should be overseen by objective, independent entities;
  - b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel;
  - c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process;
  - d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question;
  - e. The arbitration process should include the submission of a value-based price benchmark for the drug in question to inform the arbitrator's decision;
  - f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer/government entity;
  - g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases; and
  - h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision. (New HOD Policy)
2. That our AMA advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
  - a. Any international drug price index or average should exclude countries that have single-payer health systems and use price controls;
  - b. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;
  - c. The use of any international drug price index or average should preserve patient access to necessary medications; and
  - d. The use of any international drug price index or average should limit burdens on physician practices. (New HOD Policy)

3. That our AMA support the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction. (New HOD Policy)
4. That our AMA reaffirm Policy H-110.983, which advocates that any revised Medicare Part B Competitive Acquisition Program meet certain outlined standards to improve the value of the program by lowering the cost of drugs without undermining quality of care. (Reaffirm HOD Policy)
5. That our AMA reaffirm Policy H-110.986, which outlines principles for value-based pricing programs, initiatives and mechanisms for pharmaceuticals, and supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research. (Reaffirm HOD Policy)
6. That our AMA reaffirm Policy H-460.909, which outlines principles for creating a centralized comparative effectiveness research entity. (Reaffirm HOD Policy)
7. That our AMA reaffirm Policy D-330.954, which states that our AMA will work toward eliminating Medicare prohibition on drug price negotiation. (Reaffirm HOD Policy)

#### Resolution 802

RESOLVED, That our American Medical Association amend Policy H-110.987 by addition to read as follows:

##### **Pharmaceutical Costs, H-110.987**

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.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
14. Our AMA will support trial programs using international reference pricing for pharmaceuticals as an alternative drug reimbursement model for Medicare, Medicaid, and/or any other federally-funded health insurance programs, either as in individual solution or in conjunction with other approaches. (Modify Current HOD Policy)

#### Resolution 805

RESOLVED, That our American Medical Association advocate for legislation to create an International Pricing Index that would track global medication prices for all prescription medications and keep U.S. medication costs aligned with prices paid in other countries to help control costs and reduce unreasonable patient financial barriers to treatment (Directive to Take Action); and be it

RESOLVED, That our AMA advocate for legislation that would ensure that patients are charged fairly for prescription medications based on the International Pricing Index and that additional costs will not be arbitrarily assigned or passed onto patients. (Directive to Take Action)

Your Reference Committee heard predominantly supportive testimony on Council on Medical Service Report 4. In introducing the report, a member of the Council on Medical Service emphasized that lack of competition for some drugs has weakened the bargaining power of payers. In addition, the Council member underscored that there is often limited recourse following an unjustifiable price hike of a prescription medication, leaving patients wondering whether they will be able to continue to afford their medication. As such, the report

1 recommends policies to promote reasonable pricing behavior in the pharmaceutical  
2 marketplace, as an alternative to price controls.

3  
4 Testimony on Resolutions 802 and 805 was mixed. Your Reference Committee underscores  
5 that adopting the resolutions would have unintended consequences, as neither includes any  
6 safeguards guiding the use of international price indices in determining prescription drug  
7 prices. Concerning Resolution 802, even allowing trial programs using international reference  
8 pricing for pharmaceuticals, without safeguards, could have negative consequences to  
9 physician practices and patients. Importantly, a member of the Council on Medical Service  
10 noted that Council on Medical Service Report 4 addresses the intent of Resolutions 802 and  
11 805, and should be adopted in lieu of the resolutions.

12  
13 A member of the Council on Legislation testified in strong support of the recommendations of  
14 the report, noting that the report is incredibly timely as the U.S. House of Representatives and  
15 Senate are moving forward with drug pricing proposals, and the Administration has taken an  
16 interest in this issue as well. Pertinent to H.R. 3, the Elijah E. Cummings Lower Drug Costs  
17 Now Act of 2019, the member of the Council on Legislation noted that Council on Medical  
18 Service Report 4 recommends a key safeguard that ensures that any international drug price  
19 index or average exclude countries that have single-payer health systems and use price  
20 controls. The Council member highlighted that previously, the Administration has floated the  
21 idea of utilizing an international pricing index model for Part B drugs. Finally, the member of  
22 the Council on Legislation stated that report recommendations pertaining to the use of  
23 arbitration and contingent exclusivity periods to guide pharmaceutical pricing will be welcome  
24 policy additions as the Council on Legislation reviews relevant legislation addressing drug  
25 pricing in the future.

26  
27 Amendments were offered to ensure that the advocacy of our AMA pertaining to the use of  
28 arbitration in drug pricing is consistent with our advocacy related to surprise billing. In addition,  
29 amendments were offered to ensure that prices that are the result of arbitration or the use of  
30 international price averages are able to be revisited as new data and evidence are released.  
31 A speaker stressed the need for the report to also include the practices of pharmacy benefit  
32 managers (PBMs), but a member of the Council on Medical Service highlighted that the  
33 Council just presented a report at the 2019 Annual Meeting on PBMs that addresses concerns  
34 raised in testimony. In addition, a member of the Council on Medical Service stressed that the  
35 second recommendation of Council on Medical Service Report 4 does not endorse the use of  
36 international price indices and averages in determining drug prices, but rather establishes  
37 broad guiding principles and safeguards to ensure that our AMA has more nuanced policy to  
38 respond to relevant legislative and regulatory proposals. Your Reference Committee also  
39 heard testimony which highlighted other factors contributing to high drug prices, including off-  
40 shoring drug production as well as monopolies in drug production, but notes that these issues  
41 are outside of the scope of Council on Medical Service Report 4, and instead fall under the  
42 auspices of Reference Committee K.

43  
44 Your Reference Committee thanks the Council on Medical Service for a comprehensive  
45 report. Your Reference Committee believes that Council on Medical Service Report 4 strongly  
46 responds to concerns raised at past House of Delegates meetings that more needs to be done  
47 to improve the affordability of prescription drugs for our patients. Your Reference Committee  
48 underscores that the recommendations of Council on Medical Service Report 4 add to the  
49 already large body of AMA policies that address the high cost of prescription medications,  
50 which guide AMA advocacy efforts to improve patient access to medication while reducing  
51 their costs and balancing the need for appropriate innovation incentives. Pursuant to these

1 policies, the AMA supports: (1) requiring manufacturer and pharmaceutical supply chain  
2 transparency; (2) increasing competition and curtailing anti-competitive practices; (3) ensuring  
3 prescribers have accurate point-of-care coverage and patient cost-sharing information as part  
4 of their workflow including in the electronic health record; and (4) streamlining and  
5 modernizing the utilization control methods used by health insurers in response to higher  
6 prescription drug costs. As such, your Reference Committee recommends that the  
7 recommendations of Council on Medical Service Report 4 be adopted as amended in lieu of  
8 Resolutions 802 and 805, and the remainder of the report be filed.

9  
10 (14) RESOLUTION 801 – REIMBURSEMENT FOR POST-  
11 EXPOSURE PROTOCOL FOR NEEDLESTICK INJURIES

12  
13 **RECOMMENDATION:**

14  
15 **Alternate Resolution 801 be adopted in lieu of Resolution**  
16 **801.**

17  
18 **RESOLVED, That our American Medical Association**  
19 **encourage medical schools to have policies in place**  
20 **addressing diagnosis, treatment, and follow-up at no cost**  
21 **to medical students when a medical student is exposed to**  
22 **an infectious or environmental hazard in the course of their**  
23 **medical student duties, including procedures defining**  
24 **financial responsibility that would cover the costs**  
25 **associated with medical student exposures.**

26  
27 **HOD ACTION: Alternate Resolution 801 adopted as amended**  
28 **in lieu of Resolution 801.**

29  
30 RESOLVED, That our American Medical Association encourage medical schools to ensure  
31 medical students can be reimbursed for the costs associated with post-exposure protocol for  
32 blood or body substance exposure sustained during clinical rotations either by their insurance  
33 provider or the state's workers' compensation fund, where applicable (Directive to Take  
34 Action); and be it further

35  
36 RESOLVED, That our AMA encourage state societies to work with their respective workers'  
37 compensation fund to include medical students as recipients of medical benefits in the event  
38 of blood or body substance exposure during clinical rotations. (Directive to Take Action)

39  
40 Your Reference Committee heard testimony that was supportive of the intent of Resolution  
41 801. A representative of the AMA Medical Student Section highlighted the need to ensure that  
42 medical schools have policies addressing needlestick injuries and offer medical students  
43 adequate coverage of associated diagnostic testing and therapies. Noting that medical  
44 schools have policies in place regarding procedures for care following student exposures per  
45 Liaison Committee on Medical Education (LCME) standards, a member of the Council on  
46 Medical Service proposed alternate language that meets the sponsor's goal of covering  
47 medical students' out-of-pocket expenses associated with post-exposure treatment without  
48 trying to change workers' compensation laws and regulations in all 50 states. Additional  
49 alternate language was offered that would encourage coverage of testing and indicated  
50 medications associated with needlestick injuries for all physicians. There was significant  
51 testimony regarding the incidence of exposures and the associated cost burden for students.



1 Your Reference Committee believes that physicians generally have access to disability  
2 insurance or workers' compensation programs and that broadening the resolution to  
3 physicians is beyond the scope of Resolution 801. Accordingly, your Reference Committee  
4 recommends adoption of Alternate Resolution 801 in lieu of Resolution 801.

5  
6 (15) RESOLUTION 807 – ADDRESSING THE NEED FOR LOW  
7 VISION AID DEVICES

8  
9 **RECOMMENDATION:**

10  
11 **Alternate Resolution 807 be adopted in lieu of Resolution**  
12 **807.**

13  
14 **RESOLVED, That our American Medical Association work**  
15 **with interested national medical specialty societies and**  
16 **state medical associations to support insurance coverage**  
17 **for and increased access to low vision aids for patients**  
18 **with visual disabilities. (New HOD Policy)**

19  
20 **HOD ACTION: Alternate Resolution 807 adopted as amended**  
21 **in lieu of Resolution 807.**

22  
23 RESOLVED, That our American Medical Association support legislative and regulatory  
24 actions promoting insurance coverage and adequate funding for low vision aids for patients  
25 with visual disabilities. (Directive to Take Action)

26  
27 Testimony on Resolution 807 was mixed, with some speakers supportive of insurance  
28 coverage of low vision aids, because these devices can positively impact quality of life and  
29 independence, and other speakers opposed a new benefit mandate, in accordance with AMA  
30 Policies H-185.964 and H-165.856. A member of the Council on Medical Service proposed  
31 alternate language that supports patient access to low vision aids without calling for a new  
32 benefit mandate. Your Reference Committee believes this alternate language gives the AMA  
33 sufficient flexibility to promote patient access to low vision aids. Accordingly, your Reference  
34 Committee recommends that Alternate Resolution 807 be adopted in lieu of Resolution 807.

35  
36 (16) RESOLUTION 816 – DEFINITION OF NEW PATIENT

37  
38 **RECOMMENDATION:**

39  
40 **Policies H-70.919 and H-70.921 be reaffirmed in lieu of**  
41 **Resolution 816.**

42  
43 **HOD ACTION: Policies H-70.919 and H-70.921 reaffirmed in**  
44 **lieu of Resolution 816.**

45  
46 RESOLVED, That our American Medical Association advocate for the definition of a "new  
47 patient" to represent the multitude of factors and time needed to appropriately evaluate a  
48 patient's health condition and in accordance with relevant payer guidelines. (Directive to Take  
49 Action)

Substantial testimony supported reaffirmation of existing AMA policy regarding the CPT Editorial Panel process in lieu of Resolution 816. The Chairman of the CPT Editorial Panel spoke to the independent nature of the CPT editorial process and the recent work of the panel on office visits. While limited testimony called for referral for decision, other speakers emphasized that the proper forum for discussing the concerns raised in Resolution 816 is the CPT Editorial Panel. Therefore, your Reference Committee recommends that Policies H-70.919 and H-70.921 be reaffirmed in lieu of Resolution 816.

#### H-70.919 Use of CPT Editorial Panel Process

Our AMA reinforces that the CPT Editorial Panel is the proper forum for addressing CPT code set maintenance issues and all interested stakeholders should avail themselves of the well-established and documented CPT Editorial Panel process for the development of new and revised CPT codes, descriptors, guidelines, parenthetical statements and modifiers. (BOT Rep. 4, A-06; Reaffirmation A-07; Reaffirmation I-08; Reaffirmation A-09; Reaffirmation A-10; Reaffirmation A-11; Reaffirmation I-14; Reaffirmed: CMS Rep. 4, I-15; Reaffirmation A-16; Reaffirmed in lieu of: Res. 117, A-16; Reaffirmed in lieu of: Res. 121, A-17; Reaffirmation: A-18 Reaffirmation: I-18)

#### H-70.921 Update on Revision of CPT E&M Codes and Development of Clinical Examples

Our AMA policy is that future efforts to substantially revise Evaluation and Management (E&M) codes should only occur under the auspices of the CPT Editorial Panel and then through a broadly inclusive process that provides for significant and meaningful input from state medical associations, medical specialty societies and public and private payers. (BOT Rep. 26, I-04; Reaffirmed: CMS Rep. 1, A-14)

### (17) RESOLUTION 819 – HOSPITAL WEBSITE VOLUNTARY PHYSICIAN INCLUSION

#### RECOMMENDATION:

**Alternate Resolution 819 be adopted in lieu of Resolution 819.**

**RESOLVED, That our American Medical Association support the inclusion of all credentialed physicians in hospital and other health care facility websites and physician directories. (New HOD Policy)**

**HOD ACTION: Alternate Resolution 819 and Amendment J9 referred.**

**RESOLVED, That our American Medical Association advocate for regulation and/or legislation requiring that all credentialed physicians (employed and voluntary) of a hospital and/or other healthcare facility be equally included on the websites and physician search engines, such as Find a Doctor sites (Directive to Take Action); and be it further**

1       **RESOLVED, That our American Medical Association study**  
2       **the effect on independent practices of the omission of**  
3       **credentialed physicians from hospital and other healthcare**  
4       **facilities' websites and physician directories. (Directive to**  
5       **Take Action)**  
6

7  
8       RESOLVED, That our American Medical Association advocate for regulation and/or  
9       legislation requiring that all credentialed physicians (employed and voluntary) of a hospital  
10      and/or other healthcare facility be equally included on the websites and physician search  
11      engines, such as Find a Doctor sites (Directive to Take Action); and be it further  
12

13      RESOLVED, That our American Medical Association study a requirement that all credentialed  
14      physicians (employed and voluntary) of a hospital and/or other healthcare facility be equally  
15      included on the websites and physician search engines, such as Find a Doctor sites with a  
16      report back at the 2020 Annual Meeting. (Directive to Take Action)  
17

18      Your Reference Committee heard testimony supportive of having all credentialed physicians  
19      included in hospital and other health care facility websites. Speakers shared stories of  
20      hospitals only advertising employed physicians, and suggested that this practice may be  
21      intended to encourage independent physicians to consolidate with these hospitals. Testimony  
22      noted that the practice of hospitals and other health care facilities omitting non-employed  
23      physicians from their websites is not transparent and can lead patients to be unable to find  
24      these physicians. The sponsors testified that the original Resolution 819 was confusing and  
25      they were open to alternate language. Your Reference Committee crafted alternate language  
26      that is reflective of the testimony, and recommends that Alternate Resolution 819 be adopted  
27      in lieu of Resolution 819.

**RECOMMENDED FOR REFERRAL****(18) RESOLUTION 809 – AMA PRINCIPLES OF MEDICAID REFORM****RECOMMENDATION:****Resolution 809 be referred.****HOD ACTION: Resolution 809 referred.**

RESOLVED, That our American Medical Association support the following principles of Medicaid reform:

1. Provide appropriate access to care that is the most cost effective and efficient to our citizens.
2. Encourage individuals to be enrolled in private insurance supported by Medicaid funding, if possible.
3. Create the best coverage at the lowest possible cost.
4. Incentivize Medicaid patient behavior to improve lifestyle, health, and compliance with appropriate avenues of care and utilization of services.
5. Establish a set of specialty specific high-quality metrics with appropriate remuneration and incentives for clinicians to provide high quality care.
6. Seek to establish improved access for Medicaid patients to primary care providers and referrals to specialists for appropriate care.
7. Assure appropriate payment and positive incentives to encourage but not require clinician participation in Medicaid for both face-to-face and non-face-to-face encounters, under appropriate establishment of clinician-patient relationship.
8. Include payment incentives to clinicians for after-hours primary care to assist patients with an inability to access care during normal business hours.
9. Avoid tactics and processes that inhibit access to care, delay interventions and prevent ongoing maintenance of health.
10. Eliminate current disincentives (e.g., Medicaid spend-down in order to qualify) to patients improving their lives while on Medicaid, to increase successful transition into the private insurance market.
11. Cease any tax, or attempt to tax, any health care profession for the purpose of supporting the cost of Medicaid.
12. Develop a physician directed clinician oversight board at the state level to insure the proper access, quality and cost of care under the Medicaid program throughout all geographically diverse areas of the states.
13. Allow clinicians to see patients for more than one procedure in a visit so that patients do not have to return for another service at an extra cost to the Medicaid program and extra time and effort to the Medicaid patient (e.g., if patient comes because they are sick, allow them to have a diabetes check-up at the same time).
14. Strategically plan to reduce administrative costs and burdens to clinicians, and of the Medicaid program itself, by reducing at least, but not limited to, burdensome documentation requirements, administrative obstacles, and regulatory impediments. (New HOD Policy) and be it further

1 RESOLVED, That our AMA pursue action to improve the federal requirements for Medicaid  
2 programs based on the AMA's principles of Medicaid reform (Directive to Take Action)

3 Your Reference Committee heard mixed testimony on Resolution 809. There were multiple  
4 calls for referral, as well as for not adoption. The sponsor of the resolution was also open to  
5 referral. A member of the Council on Medical Service called for referral, and testified that while  
6 some principles outlined in Resolution 809 are consistent with AMA policy, others are not, and  
7 would have unintended consequences if adopted. A member of the Council on Legislation  
8 also called for referral, stressing that there is no mention in Resolution 809 of foundational  
9 AMA policies that have guided our advocacy pertaining to Medicaid on the federal and state  
10 levels to date. As such, the member of the Council on Legislation stated that referral would  
11 enable a study to be carried out which compares the principles of Medicaid reform outlined in  
12 Resolution 809 with existing policy, and advocacy efforts to date, and determines what  
13 additional policy on the issue, if any, is needed, to guide AMA advocacy moving forward. Your  
14 Reference Committee agrees with the significant concerns regarding Resolution 809 raised  
15 in testimony, and recommends that it be referred.

16  
17 (19) RESOLUTION 814 – PBM VALUE-BASED FRAMEWORK  
18 FOR FORMULARY DESIGN

19  
20 **RECOMMENDATION:**

21  
22 **Resolution 814 be referred.**

23  
24 **HOD ACTION: Resolution 814 referred.**

25  
26 RESOLVED, That our American Medical Association emphasize the importance of  
27 physicians' choice of the most appropriate pharmaceutical treatment for their patients in its  
28 advocacy; (Directive to Take Action) and be it further

29  
30 RESOLVED, That our AMA advocate for pharmacy benefit managers (PBMs) and health  
31 plans to use a value-based decision-making framework that is transparent and includes  
32 applicable specialty clinical oversight when determining which specialty drugs to give  
33 preference on their formularies. (Directive to Take Action)

34  
35 Your Reference Committee heard mixed testimony on Resolution 814. A member of the  
36 Council on Medical Service testified that the second resolve of Resolution 814 could have  
37 severe unintended consequences if adopted. The Council member underscored that more  
38 parameters and definitions are needed to guide the use of such value-based decision-making  
39 frameworks by PBMs and health plans. Significantly, the member of the Council on Medical  
40 Service stressed that adopting such general language pertaining to the use of value-based  
41 decision-making frameworks by PBMs in formulary preference decisions could lead the  
42 resulting AMA policy to be interpreted in several different ways, some of which may not be the  
43 intent of the resolution sponsor and could be problematic for physicians in placing our patients  
44 on the most appropriate treatment regimen. The term "value-based" is defined differently by  
45 physicians, pharmaceutical companies, health plans and PBMs. Your Reference Committee  
46 agrees, and recommends that Resolution 814 be referred.

47  
48 (20) RESOLUTION 818 – MEDICAL CENTER AUTO ACCEPT  
49 POLICIES

50

**RECOMMENDATION:**

**Resolution 818 be referred.**

**HOD ACTION: Resolution 818 referred.**

RESOLVED, That our American Medical Association study the impact of “auto accept” policies (i.e. unconditional acceptance for the care of a patient) on public health, as well as their compliance with the Emergency Medical Treatment and Labor Act (EMTALA) in order to protect the safety of our patients, with report back at the 2020 Annual Meeting (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that if a medical center adopts an “auto accept” i.e. unconditional acceptance for the care of a patient) policy, it must have been ratified, as well as overseen and/or crafted, by the independent medical staff (New HOD Policy)

Testimony on Resolution 818 was supportive. However, your Reference Committee notes that simultaneously calling for a study and adoption of policy runs counter to the policymaking process, which is predicated on studying the body of evidence on a particular issue before adopting policy on that issue. Importantly, your Reference Committee highlights that the issue of “auto accept” policies is significantly more nuanced than the resolution implies. The phrase “auto accept” policy is not a policy at hospitals but rather a practice. Moreover, “auto accept” practices may have The Joint Commission or medical staff bylaw implications. Therefore, the accountability may lie in current guidelines instead of the creation of new guidelines. Further, your Reference Committee notes that our AMA has significant policy on patient safety (Ethics Opinion 8.6; Ethics Opinion 9.5.1; Ethics Opinion 9.4.2; Policy H-335.965) and believes that this policy permits AMA advocacy on this issue if needed while the requested study is performed. Accordingly, your Reference Committee recommends that Resolution 818 be referred.

1 Mister Speaker, this concludes the report of Reference Committee J. I would like to  
2 thank Peter R. Fenwick, MD, Christopher Garofalo, MD, Halea K. Meese, Josephine  
3 Nguyen, MD, Erin Shriver, MD, E. Linda Villarreal, MD, and all those who testified  
4 before the Committee. I would also like to thank AMA staff: Courtney Perlino, MPP,  
5 Jane Ascroft, MPA, and Andrea Preisler, JD.

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