Reference Committee J (Advocacy related to medical service, medical practice, insurance and related topics)		
Item of Business	**Recommendation(s)/Resolve Clause(s)**	**Consensus Position**
CMS Report 1: Established Patient Relationships and Telemedicine	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 joining the Compact as a means of enhancing patient access to and proper regulation of telemedicine services. (Directive to Take Action) 2.That our AMA reaffirm Policy H-480.946, which delineates standards and safeguards that should be met for the coverage and payment of telemedicine, including that physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services. (Reaffirm HOD Policy) 3.That our AMA reaffirm Policy H-480.969, which maintains that state medical boards should require a full and unrestricted license in that state for the practice of telemedicine, with no differentiation by specialty, unless there are other appropriate state-based licensing methods, and with exemptions for emergent or urgent circumstances and “curbside consultations.” (Reaffirm HOD Policy) Fiscal Note: Less than $500.	Support

CMS Report 2: Addressing Financial Incentives to Shop for Lower-Cost Health Care	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.	Support

	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) Fiscal Note: Less than $500.	

CMS Report 3: Improving Risk Adjustment in Alternative Payment Models	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)	Support

	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) Fiscal Note: Less than $500	

CMS Report 4: Mechanisms to Address High and Escalating Pharmaceutical Prices	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)	Support

	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) Fiscal Note: Less than $500	
Resolution 801: Reimbursement for Post-Exposure Protocol for Needlestick Injuries MSS	RESOLVED, That our American Medical Association encourage medical schools to ensure medical students can be reimbursed for the costs associated with post-exposure protocol for blood or body substance exposure sustained during clinical rotations either by their insurance provider or the state's workers' compensation fund, where applicable (Directive to Take Action); and be it further RESOLVED, That our AMA encourage state societies to work with their respective workers' compensation fund to include medical students as recipients of medical benefits in the event of blood or body substance exposure during clinical rotations. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000	Support

Resolution 802: Ensuring Fair Pricing of Drugs Developed with the United States Government MSS	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.	Monitor

	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) Fiscal Note: Minimal - less than $1,000	

Resolution 803: Encourage Federal Efforts to Expand Access to Scheduled Dialysis for Undocumented People MSS	RESOLVED, That our American Medical Association support expanded access to scheduled dialysis for undocumented persons with end-stage renal disease. (New HOD Policy) Fiscal Note: Minimal - less than $1,000	Support
Resolution 804: Protecting Seniors from Medicare Advantage Plans Indiana	RESOLVED, That our American Medical Association encourage AARP, insurance companies and other vested parties to develop simplified tools and guidelines for comparing and contrasting Medicare Advantage plans. (New HOD Policy) Fiscal Note: Modest - between $1,000 - $5,000	Support
Resolution 805: Fair Medication Pricing for Patients in United States: Advocating for a Global Pricing Standard IMGS	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) Fiscal Note: Modest - between $1,000 - $5,000	Monitor
Resolution 806: Support for Housing Modification Policies MSS	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) Fiscal Note: Minimal - less than $1,000	Monitor
Resolution 807: Addressing the Need for Low Vision Aid Devices New England	RESOLVED, That our American Medical Association support legislative and regulatory actions promoting insurance coverage and adequate funding for low vision aids for patients with visual disabilities. (Directive to Take Action) Fiscal Note: Minimal - less than $1,000	Support

Resolution 808: Protecting Patient Access to Seat Elevation and Standing Features in Power Wheelchairs AAPM&R	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 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) Fiscal Note: Modest - between $1,000 - $5,000	Support

Resolution 809: AMA Principles of Medicaid Reform Utah	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.	Monitor

	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 RESOLVED, That our AMA pursue action to improve the federal requirements for Medicaid programs based on the AMA's principles of Medicaid reform (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000	
Resolution 810: Hospital Medical Staff Policy Utah	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) Fiscal Note: Minimal - less than $1,000	Monitor

Resolution 811: Require Payers to Share Prior Authorization Cost Burden Michigan	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) Fiscal Note: Minimal - less than $1,000	Support
*Resolution 812: Autopsy Standards as Condition of Participation	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) Fiscal Note: Modest - between $1,000 - $5,000	Monitor
*Resolution 813: Public Reporting of PBM Rebates	RESOLVED, That our American Medical Association advocate for Pharmacy Benefit Managers (PBMs) and state regulatory bodies to make rebate and discount reports and disclosures available to the public (Directive to Take Action); and be it further RESOLVED, That our AMA advocate for the inclusion of required public reporting of rebates and discounts by PBMs in federal and state PBM legislation. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000	Support
*Resolution 814: PBM Value-Based Framework for Formulary Design	RESOLVED, That our American Medical Association emphasize the importance of physicians’ choice of the most appropriate pharmaceutical treatment for their patients in its advocacy; (Directive to Take Action) and be it further RESOLVED, That our AMA advocate for pharmacy benefit managers (PBMs) and health plans to use a value-based decision-making framework that is transparent and includes applicable specialty clinical oversight when determining which specialty drugs to give preference on their formularies. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000	Support

*Resolution 815: Step Therapy	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) Fiscal Note: Modest - between $1,000 - $5,000	Support
**Resolution 816: Definition of New Patient Georgia	RESOLVED, That our American Medical Association advocate for the definition of a “new patient” to represent the multitude of factors and time needed to appropriately evaluate a patient’s health condition and in accordance with relevant payer guidelines. (Directive to Take Action) Fiscal Note: Not yet determined	Monitor
**Resolution 817: Transparency of Costs to Patients for Their Prescription Medications Under Medicare Part D and Medicare Advantage Plans Georgia	RESOLVED, That our American Medical Association advocate for transparent patient educational resources on their personal costs for their medications under Medicare Part D and Medicare Advantage plans--both printed and online video--which health care systems could provide to patients and which consumers could access directly (Directive to Take Action); and be it further RESOLVED, That our AMA advocate for increased resources for federal and state programs like GeorgiaCares and educate physicians, hospitals, and patients about the availability of these programs. (Directive to Take Action) Fiscal Note: Not yet determined	Monitor

* - Handbook Addendum
** - Sunday Tote