DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its November 2020 Special 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 (November 2020 Meeting)

Report of Reference Committee A

Hilary E. Fairbrother, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Medical Service Report 3 – Medicare Prescription Drug and Vaccine Coverage and Payment
2. Council on Medical Service Report 5 – Medicaid Reform
3. Council on Medical Service Report 6 – Value-Based Management of Drug Formularies

RECOMMENDED FOR ADOPTION AS AMENDED

4. Council on Medical Service Report 1 – Options to Maximize Coverage under the AMA Proposal for Reform
5. Council on Medical Service Report 7 – Health Plan Initiatives Addressing Social Determinants of Health
6. Resolution 114 – Establishing a Professional Services Claims-Based Payment Enhancement for Activities Associated with the COVID-19 Pandemic

RECOMMENDED FOR ADOPTION IN LIEU OF

7. Resolution 105 – Access to Medication

RECOMMENDED FOR REFERRAL

8. Resolution 101 – End of Life Care Payment

RECOMMENDED FOR ADOPTION

(1) COUNCIL ON MEDICAL SERVICE REPORT 3 – MEDICARE PRESCRIPTION DRUG AND VACCINE COVERAGE AND PAYMENT

RECOMMENDATION:

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

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

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 203-A-19, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) continue to solicit input from national medical specialty societies and state medical associations for their recommendations to ensure adequate Medicare Part B drug reimbursement. (Directive to Take Action)

2. That our AMA work with interested national medical specialty societies on alternative methods to reimburse physicians and hospitals for the cost of Part B drugs. (Directive to Take Action)

3. That our AMA continue working with interested stakeholders to improve the utilization rates of adult vaccines by individuals enrolled in Medicare. (Directive to Take Action)

4. That our AMA reaffirm Policy H-440.860, which supports easing federally imposed immunization burdens by, for example, covering all vaccines in Medicare under Part B and simplifying the reimbursement process to eliminate payment-related barriers to immunization; and urges the Centers for Medicare & Medicaid Services (CMS) to raise vaccine administration fees annually, synchronous with the increasing cost of providing vaccinations. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy D-440.981, which supports adequate reimbursement for vaccines and their administration from all public and private payers; encourages health plans to recognize that physicians incur costs associated with the procurement, storage and administration of vaccines that may be beyond the average wholesale price of any one particular vaccine; and advocates that a physician's office can bill Medicare for all vaccines administered to Medicare beneficiaries and that the patient shall only pay the applicable copay to prevent fragmentation of care. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-440.875, which states that our AMA will aggressively petition CMS to include coverage and payment for any vaccinations administered to Medicare patients that are recommended by the Advisory Committee on Immunization

Practices, the US Preventive Services Task Force, or based on prevailing preventive clinical health guidelines. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy D-330.954, which supports the use of Medicare drug price negotiation. (Reaffirm HOD Policy)

8. That our AMA reaffirm Policy H-110.980, which outlines safeguards to ensure that international drug price averages are used as a part of drug price negotiations in a way that upholds market-based principles and preserve patient access to necessary medications. (Reaffirm HOD Policy)

Testimony on Council on Medical Service Report 3 was limited yet supportive. In introducing the report, a member of the Council on Medical Service emphasized that the prices and coverage of, and payment for, prescription drugs and vaccines under Medicare Parts B and D not only impact patients' ability to access the drugs and vaccines they need, but also impact physicians' ability to cover their costs associated with acquiring, storing and administering Part B drugs, and Part B and Part D vaccines. The Council member further stressed that the time is now for organized medicine to move forward with building consensus on which alternative methods would be preferred to reimburse physicians for the cost of Part B drugs. A proposed amendment to Recommendation 2 of the report called for the deletion of the term "hospitals" from the recommendation. However, the majority of testimony supported the report as written, as prescription drugs administered in physicians' offices and hospital outpatient clinics fall under Medicare Part B coverage of physician services.

Your Reference Committee believes that Council on Medical Service Report 3 strongly responds to concerns raised at past House of Delegates meetings concerning the payment for and coverage of prescription drugs and vaccines under Medicare Parts B and D. As such, your Reference Committee believes that the recommendations of Council on Medical Service Report 3 should be adopted.

(2) COUNCIL ON MEDICAL SERVICE REPORT 5 – MEDICAID REFORM

RECOMMENDATION:

Recommendations in Council on Medical Service Report 5 be <u>adopted</u> and the remainder of the Report be <u>filed</u>.

HOD ACTION: Recommendations in Council on Medical Service Report 5 <u>adopted</u> and the remainder of the Report <u>filed</u>.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 809-I-19, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support increases in states' Federal Medical Assistance Percentages or other funding during significant economic downturns

to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment. (New HOD Policy)

2. That our AMA reaffirm Policy H-290.986, which supports the Medicaid program's role as a safety net for the nation's most vulnerable populations. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy D-290.979, which states that our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133 percent [(138 percent federal poverty level (FPL) including the income disregard)] as authorized by the ACA. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-290.965, which supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016 and maintaining federal funding for Medicaid expansion populations at 90 percent beyond 2020. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-290.966, which supports state Medicaid waivers, provided they promote improving access to quality medical care; are properly funded; have sufficient provider payment levels; and do not coerce physicians into participating. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-290.963, which opposes caps on federal Medicaid funding. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy H-290.976, which affirms the AMA's commitment to advocating that Medicaid should pay physicians at minimum 100 percent of Medicare rates. (Reaffirm HOD Policy)

Testimony was supportive of Council on Medical Service Report 5. A member of the Council on Medical Service introduced the report and stated that the Council agreed with the intent of the principles proposed in the referred resolution and found them to be largely addressed by existing AMA policies. Additional testimony focused on the need to help safeguard Medicaid funding as millions of newly unemployed Americans turn to the program for health coverage. A representative of the AMA Women Physicians Section testified that Medicaid is a crucial safety net for low-income women and families, and that buttressing the program in times of economic difficulties via increased federal funding, as addressed by Recommendation 1, is critical to facilitating access to care.

A proposed amendment to Recommendation 1 of the report specified support for legislation that triggers automatic increases in states' Federal Medical Assistance Percentages (FMAPs) based on national and state unemployment data. However, the testimony supported the report as written. Your Reference Committee believes that the proposed amendment could be construed as too prescriptive and could hinder AMA support of proposals to increase states' FMAPs outside of an automatic trigger. Therefore, your Reference Committee believes that the recommendations of Council on Medical Service 5 should be adopted as written.

(3) COUNCIL ON MEDICAL SERVICE REPORT 6 – VALUE-BASED MANAGEMENT OF DRUG FORMULARIES

RECOMMENDATION:

Recommendations in Council on Medical Service Report 6 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 6 adopted and the remainder of the Report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 814-I-19, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policy H-120.988, upholding the ability of patients to access treatments prescribed by their physicians. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-285.965, which states that pharmacy and therapeutics (P&T) committee members should include independent physician representatives, and that mechanisms should be established for ongoing peer review of formulary policy as well as for appealing formulary exclusions. (Reaffirm HOD Policy)

3. That our AMA advocate that pharmacy benefit managers (PBMs) and health plans use a transparent process in formulary development and administration, and include practicing network physicians from the appropriate medical specialty when making determinations regarding formulary inclusion or placement for a particular drug class. (New HOD Policy)

4. That our AMA reaffirm Policy D-110.987, which supports improved transparency of PBM operations, including disclosing rebate and discount information as well as P&T committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy; and formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-110.986, which outlines principles guiding AMA's support for value-based pricing programs, initiatives and mechanisms for pharmaceuticals. (Reaffirm HOD Policy)

6. That our AMA advocate that any refunds or rebates received by a health plan or PBM from a pharmaceutical manufacturer under an outcomes-based contract be shared with impacted patients. (New HOD Policy)

7. That our AMA oppose indication-based formularies in order to protect the ability of patients to access and afford the prescription drugs they need, and physicians to make the best prescribing decisions for their patients. (New HOD Policy)

There was supportive testimony on Council on Medical Service Report 6. In introducing the report, a member of the Council on Medical Service underscored that the recommendations of Council on Medical Service Report 6 highlight a key AMA position: When the prescription of a drug represents safe and effective therapy, third-party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, and should fulfill their obligation to their beneficiaries by covering such therapy. In addition, the Council member noted that the report recommends policies that are timely and in the best interest of patients.

An amendment was offered to one of these policies, Recommendation 6 of the report, to change the wording so that refunds and rebates under an outcomes-based contract would be shared with patients directly if not being applied to reduce premiums and/or increase benefits in the subsequent year. However, your Reference Committee believes that the amendment is too prescriptive.

In addition, there was a proposed amendment to add language clarifying that transparency should also include all rebates paid to any party. However, your Reference Committee notes that the amendment is already addressed in existing Policy D-110.987, recommended for reaffirmation in Council on Medical Service Report 6. Your Reference Committee believes that the recommendations of Council on Medical Service Report 6 augment the policy of our AMA pertaining to the value-based management of drug formularies, and recommends their adoption.

RECOMMENDED FOR ADOPTION AS AMENDED

(4) COUNCIL ON MEDICAL SERVICE REPORT 1 – OPTIONS TO MAXIMIZE COVERAGE UNDER THE AMA PROPOSAL FOR REFORM

1. That our American Medical Association (AMA) ~~support~~ advocate that any public option to expand health insurance coverage must meet the following standards:

RECOMMENDATION A:

Recommendation 1(b) in Council on Medical Service Report 1 be amended by addition to read as follows:

1(b) Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.

RECOMMENDATION B:

Recommendation 1(c) in Council on Medical Service Report 1 be amended by addition and deletion to read as follows:

1(c) Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice ~~not be tied to Medicare and/or Medicaid rates~~.

RECOMMENDATION C:

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

The public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.

RECOMMENDATION D:

Recommendation 2(c) in Council on Medical Service Report 1 be amended by addition and deletion to read as follows:

2(c) Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled ~~enrolling in health insurance coverage~~.

RECOMMENDATION E:

Recommendation 2(e) in Council on Medical Service Report 1 be amended by deletion to read as follows:

2(e) Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium ~~bronze~~ plans with the highest actuarial values.

RECOMMENDATION F:

Recommendation 2(f) in Council on Medical Service Report 1 be amended by addition to read as follows:

2(f) Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.

RECOMMENDATION G:

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.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 113-A-19, Resolution 114-A-19, the alternate resolution proposed by Reference Committee A, and the amendment offered during the House of Delegates' consideration of item 9 of the report of Reference Committee A, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support that a public option to expand health insurance coverage must meet the following standards:

a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.

b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage.
c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must not be tied to Medicare and/or Medicaid rates.
d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
e. The public option is financially self-sustaining and has uniform solvency requirements.
f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans. (New HOD Policy)

2. That our AMA support states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:

a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage.
c. Individuals should have the opportunity to opt out from enrolling in health insurance coverage.
d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium bronze plans with the highest actuarial values.
f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze plans, to maximize the value of zero-premium plans to plan enrollees.
g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period. (New HOD Policy)

3. That our AMA reaffirm Policy H-165.825, which states that the largest two Federal Employees Health Benefits Program (FEHBP) insurers in counties that lack a marketplace plan should be required to offer at least one silver-level marketplace plan as a condition of FEHBP participation. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-165.828, which encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account partially funded by an amount determined to be equivalent to the cost-sharing subsidy. (Reaffirm HOD Policy)

Your Reference Committee appreciates all of the testimony provided on the online member forum and during the live hearing, and all of the amendments proffered, on the recommendations of Council on Medical Service Report 1. Your Reference Committee underscores that our AMA establishing new policy on auto-enrollment in health insurance coverage and defining the minimum requirements for any proposed public option is critical to expanding the coverage reach of our AMA proposal for reform, as well as achieving the Association's longstanding goal of covering the uninsured. Specifically, the report proposes that a public option meet the criteria outlined in Recommendation 1, and your Reference Committee believes that utilizing the term "must" at the beginning of the recommendation is critical to stress the importance of each individual guardrail contained in Recommendation 1.

Your Reference Committee does understand that the term "public option" has several different meanings and is a politically charged term. However, the chair of the Council on Medical Service testified that it is absolutely essential – and timely – for our AMA to take ownership of the term and define what we as an organization want a potential public option to look like. In addition, developing policy specific to a public option will enable the AMA to participate fully – to be "at the table" – in any further discussions of proposals to establish a public option. Removing the term "public option" from Recommendation 1 would create confusion and ambiguity as the AMA pursues policy formation and advocacy in this space.

The Council on Medical Service offered amendments to its report both in the online member forum, and during the live hearing. A member of the Council on Legislation testified in support of the amendments offered by the Council on Medical Service, stating that the report recommendations with the proposed amendments of the Council on Medical Service will be very helpful as the COL evaluates legislative proposals in the future. In response to testimony posted on the online member forum addressing Recommendation 1(b), the Council on Medical Service offered amended language to ensure that individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits are eligible for financial assistance to purchase the public option. Testimony clarified that Recommendation 1(b) would not restrict all individuals with employer-sponsored insurance from accessing financial assistance to purchase the public option. Rather, only individuals with unaffordable employer-sponsored coverage, or those with employer-sponsored coverage that does not meet standards for minimum value of benefits, would be eligible for financial assistance. The Reference Committee underscores that, with the suggested amendment to 1(b) offered by the Council on Medical Service, eligibility for financial assistance to purchase the public option would be the same as what currently exists to purchase private ACA marketplace plans, thereby increasing competition in the health insurance marketplace. The Council on Medical Service in its report underscored that the public option will not be disadvantaged by the guardrails proposed in Recommendation 1 of its report. Rather, the public option may have an advantage in the ACA marketplaces, as it may be more likely to be the plan against which premium tax credit amounts are based.

A member of the Council on Medical Service testified that opening up eligibility for financial assistance to purchase the public option to anyone with employer-sponsored coverage would have devastating consequences for physician practices. The Council member highlighted that the Urban Institute stated that the number of people enrolled in employer coverage is more than nine times the number in non-group coverage, and because employer-based plans tend to pay health care providers higher rates than do non-group insurers, introducing the public option could have far-reaching, substantial impacts on both spending and health care provider revenues. The Council member stressed that opening up eligibility for financial assistance to all individuals with employer-sponsored coverage to purchase the public option may in fact reduce the number of health plans available to patients, due to the public option becoming a dominant insurer, going against longstanding AMA policy in support of maximizing health plan choices for patients.

While Recommendation 1(b) stipulates that financial assistance should be made available to individuals to purchase the public option when employer-sponsored coverage is unaffordable, your Reference Committee heard testimony stressing that the public option would remain available for anyone to purchase. Only eligibility for financial assistance would be restricted – to purchase either the public option or private ACA marketplace plans. Financial assistance to purchase the public option, considering finite federal resources, would therefore be available to those who need it the most.

Building off of that premise, your Reference Committee also accepted an amendment to add a principle to Recommendation 1 offered by the Council on Medical Service, responding to testimony and amendments proffered in the online member forum, that stated that the public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid (2.3 million people in 2018) – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost. Your Reference Committee believes that covering this population – which has incomes of less than $12,760 for an individual and $26,200 for a family of four – is an essential step to fulfilling the goals of the AMA plan to cover the uninsured.

Your Reference Committee also accepted an amendment offered by the Council on Medical Service to Recommendation 1(c), which serves as an appropriate middle ground in guiding how payment rates under any public option should be established. The amendment maintains the ability of individual physician practices to meaningfully negotiate their payment levels and contracts. At the same time, the amendment opened the door for our AMA to support public option proposals that have physician payments higher than prevailing Medicare rates and importantly, at rates sufficient to sustain the costs of medical practice. Your Reference Committee believes that other amendments proffered to Recommendation 1(c) would have unintended consequences, ultimately removing the ability of individual physician practices to negotiate their own payment rates.

Principles 1(e) and 1(f) again highlight a goal of the Council on Medical Service for the public option to compete on a level playing field with private ACA marketplace plan offerings. Your Reference Committee did not accept an amendment made to 1(e) to require the public option to be “optimally” self-sustaining for that reason, as private ACA

marketplace plans also must be financially self-sustaining. Concerning 1(f), under the policy for a public option proposed by the Council on Medical Service, the coverage of lower-income people who choose the public option would be subsidized in the same manner as currently afforded to private ACA marketplace plans – premium and cost-sharing subsidies based on one's income. The public option would not receive advantageous government subsidies in comparison to those provided to other health plans. As outlined in the report, the Council on Medical Service believes that limited federal financial resources would be more effectively spent in expanding the eligibility for and increasing the size of premium tax credits and cost-sharing reductions.

The Council on Medical Service also offered three amendments to Recommendation 2 of the report, in response to testimony posted in the online member forum. While the amendment to Recommendation 2(c) was clarifying in nature, the amendments to Recommendations 2(e) and 2(f) support individuals being auto-enrolled into plans with the highest possible actuarial values. For some, a zero-premium plan into which they would be auto-enrolled would be a bronze plan. For others, it may be a silver plan, which covers more benefits costs, and would also enable qualifying individuals to receive cost-sharing reductions. As bronze and silver plans will be the most common plans into which people will be auto-enrolled, calling for more pre-deductible coverage in silver plans in addition to bronze plans serves as a prudent policy addition.

Your Reference Committee believes that the recommendations of Council on Medical Service Report 1 should be adopted as amended, serving as a needed first step in our AMA having policy pertaining to a potential public option as well as auto-enrollment. Both of these policy options have tremendous potential to cover millions more patients under the AMA proposal for reform. Your Reference Committee underscores that our House of Delegates can refine and add to this policy at future meetings, to best serve our patients and our physician members.

(5) COUNCIL ON MEDICAL SERVICE REPORT 7 – HEALTH PLAN INITIATIVES ADDRESSING SOCIAL DETERMINANTS OF HEALTH

RECOMMENDATION A:

Recommendation 5 in Council on Medical Service Report 7 be <u>amended by addition</u> to read as follows:

5. That our AMA support mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, <u>while minimizing burdens on patients and physicians</u>. (New HOD Policy)

RECOMMENDATION B:

Recommendations in Council on Medical Service Report 7 be <u>adopted as amended</u> and the remainder of the Report be <u>filed</u>.

HOD ACTION: Recommendations in Council on Medical Service Report 7 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), recognizing that social determinants of health encompass more than health care, encourage new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health. (New HOD Policy)

2. That our AMA support continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs. (New HOD Policy)

3. That our AMA encourage public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training. (New HOD Policy)

4. That our AMA reaffirm Policies D-478.972 and D-478.996 supporting proactive and practical approaches to promote interoperability at the point of care. (Reaffirm HOD Policy)

5. That our AMA support mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health. (New HOD Policy)

6. That our AMA support research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs. (New HOD Policy)

7. That our AMA encourage coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs. (New HOD Policy)

There was highly supportive testimony on Council on Medical Service Report 7. In response to an amendment proffered on the online member forum, the Council on Medical Service offered an amendment to Recommendation 5 of the report during the live hearing. Your Reference Committee agrees with the amendment, as minimizing burdens on patients and physicians in data acquisition initiatives is essential.

While your Reference Committee understands the importance of other amendments offered to the report which addressed the integration of social determinants of health with quality measurement, they were not germane to this report.

Your Reference Committee believes that the recommendations of Council on Medical Service Report 7 as amended fulfill the need for our AMA to have additional policy to respond to innovative health plan initiatives that incorporate social determinants of

health in health insurance benefit design and coverage. Your Reference Committee believes that the recommendations of Council on Medical Service 7 should be adopted.

(6) RESOLUTION 114 – ESTABLISHING A PROFESSIONAL SERVICES CLAIMS-BASED PAYMENT ENHANCEMENT FOR ACTIVITIES ASSOCIATED WITH THE COVID-19 PANDEMIC

RECOMMENDATION A:

Resolution 114 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with ~~other~~ interested ~~parties~~ national medical specialty societies and state medical associations to advocate for regulatory action on the part of the Centers for Medicare & Medicaid Services to implement a professional services ~~claims-based~~ payment enhancement, similar to the HRSA COVID-19 Uninsured Program, to be drawn from additional funds appropriated for the public health emergency to ~~help~~ recognize the additional uncompensated costs ~~enhanced, non-separately reimbursable work~~ associated with COVID-19 incurred ~~performed~~ by physicians during the COVID-19 Public Health Emergency. (Directive to Take Action)

RECOMMENDATION B

Resolution 114 be amended by addition of new Resolves to read as follows:

RESOLVED, That our AMA work with interested national medical specialty societies and state medical associations to continue to advocate that the Centers for Medicare & Medicaid Services and private health plans compensate physicians for the additional work and expenses involved in treating patients during a public health emergency, and that any new payments be exempt from budget neutrality; (New HOD Policy) and be it further

RESOLVED, That our AMA encourage interested parties to work in the CPT Editorial Panel and AMA/Specialty Society RVS Update Committee (RUC) processes to continue to develop coding and payment solutions for the additional work and expenses involved in treating patients during a public health emergency (New HOD Policy)

RECOMMENDATION C:

Resolution 114 be adopted as amended.

RECOMMENDATION D:

Title of Resolution 114 be changed to read as follows:

PHYSICIAN PAYMENT ADVOCACY FOR ADDITIONAL WORK AND EXPENSES INVOLVED IN TREATING PATIENTS DURING THE COVID-19 PANDEMIC AND FUTURE PUBLIC HEALTH EMERGENCIES

HOD ACTION: Resolution 114 adopted as amended with a change in title.

RESOLVED, That our American Medical Association work with other interested parties to advocate for regulatory action on the part of the Centers for Medicare & Medicaid Services to implement a professional services claims-based payment enhancement to help recognize the enhanced, non-separately reimbursable work performed by physicians during the COVID-19 Public Health Emergency. (Directive to Take Action)

Alternate language was submitted by the authors in response to feedback and concerns regarding the intent and implementation of original Resolution 114. The second and third suggested Resolve clauses were also put forth by a member of the Council on Medical Service, and these Resolves enjoyed widespread support among most speakers. Testimony conveyed that the second and third proffered Resolve clauses are consistent with AMA policy and advocacy, and that they support compensating physicians (including those on the front lines) for additional work and expenses involved in treating patients during the public health emergency. A member of the Council on Legislation expressed support for this language and spoke to the AMA's aggressive efforts to address the COVID-19 public health emergency as it pertains to funding and payment for health care-related expenses and losses. Testimony highlighted sign-on letters sent last week to the Centers for Medicare & Medicaid Services (CMS) and large private insurers asking them to implement and pay for CPT code 99072 to compensate practices for additional practice expenses included in an office visit or other non-facility service when performed during the public health emergency.

There was mixed testimony on the proffered amendment to the first Resolve clause which was very similar to original Resolution 114 but without the term "claims-based." Some speakers expressed concern that the proffered amendment to the first Resolve clause may not be aligned with longstanding AMA policy supporting the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee (RUC) processes. A speaker also raised reservations about the optics of establishing a professional services payment enhancement for activities associated with the COVID-19 pandemic.

Several speakers offered strong support of the intent of the proffered amendment to the first Resolve clause and the need for the AMA to support the efforts of physicians to engage CMS to use CARES Act funds to support the increased level of physician work associated with caring for patients during the COVID-19 public health emergency.

Testimony recognized that COVID-19 has been extremely challenging and that physicians are spending more time on patient care and performing additional activities associated with managing the pandemic. Supporters of the proffered amendment to the first Resolve also testified that it does not require a new CPT code. Accordingly, your Reference Committee recommends adoption of Resolution 114 as amended with a change in title.

RECOMMENDED FOR ADOPTON IN LIEU OF

(7) RESOLUTION 105 – ACCESS TO MEDICATION

RECOMMENDATION:

Alternate Resolution 105 be <u>adopted in lieu of Resolution 105</u>.

RESOLVED, That our American Medical Association advocate against pharmacy practices that interfere with patient access to medications by refusing or discouraging legitimate requests to transfer prescriptions to a new pharmacy, to include transfer of prescriptions from mail-order to local retail pharmacies. (New HOD Policy)

HOD ACTION: Alternate Resolution 105 <u>adopted in lieu of Resolution 105</u>

RESOLVED, That our American Medical Association seek regulations on a national level that would prohibit pharmacy benefit plans from limiting patient access to medications because an initial prescription was placed and/or filled by mail-order.

There was generally supportive testimony on Resolution 105. However, a member of the Council on Medical Service testified that prescription transfers fall under the jurisdiction of state boards of pharmacy, and therefore are not under the purview of federal regulations. As such, the member of the Council on Medical Service offered alternate language to fulfill the intent of the resolution. Your Reference Committee accepts the alternate language proffered by the Council on Medical Service, and recommends that it be adopted in lieu of Resolution 105.

RECOMMENDED FOR REFERRAL

(8) RESOLUTION 101 – END OF LIFE CARE PAYMENT

RECOMMENDATION:

Resolution 101 be referred.

HOD ACTION: Resolution 101 referred.

RESOLVED, That our American Medical Association petition the Centers for Medicare & Medicaid Services to allow hospice patients to cover the cost of housing ("room and board") as a patient in a nursing home or assisted living facility (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that patients be allowed to use their skilled nursing home benefit while receiving hospice services. (Directive to Take Action)

Most of the testimony called for referral of Resolution 101. Comments highlighted the complex issues related to Medicare's skilled nursing facility (SNF) and hospice benefits and concerns about end-of-life patients having to choose between SNF and hospice care. Additional testimony pointed out that Resolution 101 proposes a new Medicare room and board coverage benefit, which represents a significant change in Medicare coverage that requires further analysis before new AMA policy is adopted. Your Reference Committee agrees that Resolution 101 raises important policy issues worthy of further study and recommends that it be referred.

Mister Speaker, this concludes the report of Reference Committee A. I would like to thank Jorge Alsip, MD; Brooks F. Bock, MD; Richard A. Geline, MD; Kristina Novick, MD; William Reha, MD; Janet West, MD; and all those who testified before the Committee. I would also like to thank AMA staff: Courtney Perlino, MPP, and Jane Ascroft, MPA.

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