The following items are under consideration by Reference Committee G:

1. BOT Report 18 – Addressing Inflammatory and Untruthful Online Ratings
2. CMS Report 01 – Council on Medical Service Sunset Review of 2012 House Policies
3. CMS Report 02 – Prospective Payment Model Best Practices for Independent Private Practice
4. CMS Report 05 – Poverty-Level Wages and Health
5. Resolution 701 – Appeals and Denials – CPT Codes for Fair Compensation
6. Resolution 702 – Health System Consolidation
7. Resolution 703 – Mandating Reporting of All Antipsychotic Drug Use in Nursing Home Residents
8. Resolution 704 – Employed Physician Contracts
9. Resolution 705 – Fifteen Month Lab Standing Orders
10. Resolution 706 – Government Imposed Volume Requirements for Credentialing
11. Resolution 707 – Insurance Coverage for Scalp Cooling (Cold Cap) Therapy
12. Resolution 708 – Physician Burnout is an OSHA Issue
13. Resolution 709 – Physician Well-Being as an Indicator of Health System Quality
16. Resolution 712 – The Quadruple Aim – Promoting Improvement in the Physician Experience of Providing Care
17. Resolution 713 – Enforcement of Administrative Simplification Requirements – CMS
20. Resolution 716 – Discharge Summary Reform
21. Resolution 717 – Expanding the AMA’s Study on the Economic Impact of COVID-19
22. Resolution 718 – Degradation of Medical Records
24. Resolution 720 – Mitigating the Negative Impact of Step Therapy Policies and Nonmedical Switching of Prescription Drugs on Patient Safety
26. Resolution 722 – Eliminating Claims Data for Measuring Physician and Hospital Quality
27. Resolution 723 – Physician Burnout
28. Resolution 724 – Ensuring Medical Practice Viability through Reallocation of Insurance Savings during the COVID-19 Pandemic
29. Resolution 725 – Compensation to Physicians for Authorizations and Pre-Authorizations

30. Resolution 726 - Payment for the Cost of Electronic Prescription of Controlled Substances and Compensation for Time Spent Engaging State Prescription Monitoring Programs

(1) BOARD OF TRUSTEES REPORT 18 - ADDRESSING INFLAMMATORY AND UNTRUTHFUL ONLINE RATINGS

The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 702-Jun-21 and the remainder of the report be filed:

That our American Medical Association: (1) encourages physicians to take an active role in managing their online reputation in ways that can help them improve practice efficiency and patient care; (2) encourages physician practices and health care organizations to establish policies and procedures to address negative online complaints directly with patients that do not run afoul of federal and state privacy laws; and (3) will develop and publish educational material to help guide physicians and their practices in managing their online reputation, including recommendations for responding to negative patient reviews and clarification about how federal privacy laws apply to online reviews.

Your Reference Committee reviewed online testimony for this report. Testimony on BOT Report 18 was mostly supportive of the recommendations contained within the report. There was testimony from one individual that suggested the directives to take action are insufficient and do not go far enough. The suggestion was made to add a fourth recommendation that includes more proactive regulatory agency advocacy with the aim to facilitate physicians’ abilities to rebut or refute false statements about care provided when that care was disclosed by and misrepresented by a patient or a patient’s estate/power of attorney.

(2) COUNCIL ON MEDICAL SERVICE REPORT 1 - SUNSET REVIEW OF 2012 HOUSE POLICIES

The Council on Medical Service recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

Your Reference Committee reviewed online testimony for this report. Testimony on Council on Medical Service Report 1 was limited to one comment from a state delegation, which was supportive.

(3) COUNCIL ON MEDICAL SERVICE REPORT 2 - PROSPECTIVE PAYMENT MODEL BEST PRACTICES FOR INDEPENDENT PRIVATE PRACTICE

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 122-J-21, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support the consideration of prospective payment elements in the development of payment and delivery reform that are consistent with AMA principles. (New HOD Policy)
2. That our AMA support the following principles to support physicians who choose to participate in prospective payment models:
   a. The AMA, state medical associations, and national medical specialty societies should be encouraged to continue to provide guidance and support infrastructure that allow independent physicians to join with other physicians in clinically integrated networks, independent of any hospital system.
b. Prospective payment model compensation should incentivize specialty and primary care collegiality among independently practicing physicians.

c. Prospective payment models should take into consideration clinical data, where appropriate, in addition to claims data.

d. Governance within the model must be physician-led and autonomous.

e. Physician practices should be encouraged to work with field advisors on patient attributions and a balanced mix of payers.

f. Quality metrics used in the model should be clinically meaningful and developed with physician input.

g. Administrative burdens, such as those related to prior authorization, should be reduced for participating physicians. (New HOD Policy)

3. That our AMA reaffirm Policies H-165.844 and H-385.926, which support pluralism and the freedom of physician enterprise. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-385.907, which supports fair and accurate risk adjustment.


Your Reference Committee heard online testimony on this report. Testimony on Council on Medical Service Report 2 was limited to one comment from an individual and one comment from state delegation. Both were supportive of the recommendations in CMS Report 2.

(4) COUNCIL ON MEDICAL SERVICE REPORT 5 - POVERTY-LEVEL WAGES AND HEALTH

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 203-N-21 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) affirm that poverty is detrimental to health. (New HOD Policy)

2. That our AMA affirm that federal, state, and/or local policies regarding minimum wage should include plans for adjusting the minimum wage level in the future and an explanation of how these adjustments can keep pace with inflation. (New HOD Policy)

3. That our AMA affirm that federal, state, and/or local policies regarding minimum wage should be consistent with the AMA’s commitment to speak against policies that create greater health inequities and be a voice for our most vulnerable populations who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation. (New HOD Policy)

4. That our AMA affirm that federal, state, and/or local policies regarding minimum wage should be consistent with the AMA’s principle that the highest attainable standard of health, in all its dimensions, is a basic human right and that optimizing the social determinants of health is an ethical obligation of a civil society. (New HOD Policy)
5. That our AMA affirm that federal, state, and/or local policies regarding minimum wage should include an explanation of how variations in geographical cost of living have been considered. (New HOD Policy)

6. That our AMA affirm that federal, state, and/or local policies regarding minimum wage should include an estimate of the policy's impact on factors including:
   a. Unemployment and/or reduction in hours;
   b. First-time job seekers;
   c. Qualification for public assistance (e.g., food, housing, transportation, childcare, health care, etc.);
   d. Working conditions;
   e. Health equity, with specific focus on gender and minoritized and marginalized communities;
   f. Income equity;
   g. Local small business viability, including independent physician practices; and
   h. Educational and/or training opportunities. (New HOD Policy)

7. That our AMA reaffirm Policy D-440.922, which states that the AMA will enhance advocacy and support for programs and initiatives that strengthen public health systems to address health inequities and the social determinants of health. (Reaffirm HOD Policy)

8. That our AMA reaffirm Policy H-165.822, which encourages 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. (Reaffirm HOD Policy)

Your Reference Committee reviewed online testimony for this report. Testimony on Council on Medical Service Report 5 was supportive. There was testimony from one individual and one delegation. Both comments were supportive of the recommendations in the report and both offered an amendment to add to the list in Recommendation 6. The first amendment proffered by an individual recommended adding "Access to Public Health Services" to the list included in Recommendation 6. A second, separate amendment was also proffered from a delegation to add "Inflation" to the list included in Recommendation 6.

5) RESOLUTION 701 - APPEALS AND DENIALS - CPT CODES FOR FAIR COMPENSATION

RESOLVED, That our American Medical Association support the creation of CPT codes for consideration by the CPT® Editorial Panel to provide adequate compensation for administrative work involved in successfully appealing denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials, that reflect the actual time expended by physicians and healthcare practices to advocate on behalf of patients, appeal denials, and to comply with insurer and legal requirements and that compensate physicians fully for the time, effort, and legal risks inherent in such work (Directive to Take Action); and be it further

RESOLVED, That our AMA support the creation of CPT codes for consideration by the CPT Editorial Panel for primary, secondary, and tertiary appeals to independent review organizations (IROs), state and federal regulators, and ERISA plan appeals, including
codes for appeals, reconsiderations, and other forms of appeals of adverse determination (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for fair compensation based on CPT codes for appeal of denied services in any model legislation and as a basis for all advocacy for prior authorization reforms. (Directive to Take Action)

Your Reference Committee reviewed online testimony for this resolution. Testimony on Resolution 701 was mixed. There were several comments in support of the resolution and one in opposition. The individual speaking in opposition noted concern that even if adopted, CPT codes may not be reimbursed and may create more administrative work to bill for the code if it does get reimbursed. There was a suggestion by an individual to amend existing policy in lieu of creating a new policy and a suggestion by another individual to consider the overlap with and potential reaffirmation of Policy H-70.919. We also highlight testimony from an individual that states that HOD policy is not the appropriate avenue for recommending CPT codes. Instead, these must be petitioned via the CPT Editorial Panel process, as noted by the individual providing testimony. Finally, there was a suggested amendment to strike the word “successfully” from the first Resolve clause. We note that Resolution 701 shares similarities with Resolutions 710, 715, and 725.

(6) RESOLUTION 702 - HEALTH SYSTEM CONSOLIDATION

RESOLVED, That our American Medical Association undertake an annual report assessing nationwide health system and hospital consolidation in order to assist policymakers and the federal government in assessing healthcare consolidation for the benefit of patients and physicians who face an existential threat from healthcare consolidation. (Directive to Take Action)

Your Reference Committee reviewed online testimony for this resolution. Testimony on Resolution 702 was limited to one comment from an individual and one from a delegation. Both were supportive.

(7) RESOLUTION 703 - MANDATING REPORTING OF ALL ANTIPSYCHOTIC DRUG USE IN NURSING HOME RESIDENTS

RESOLVED, That American Medical Association Policy D-120.951, “Appropriate Use of Antipsychotic Medications in Nursing Home Patients,” be amended by addition and deletion to read as follows:

Our AMA will: (1) meet with the Centers for Medicare & Medicaid Services (CMS) for a determination that acknowledges that antipsychotics can be an appropriate treatment for dementia-related psychosis if non-pharmacologic approaches have failed and will ask CMS to cease and desist in issuing citations or financial penalties for medically necessary and appropriate use of antipsychotics for the treatment of dementia-related psychosis; and (2) ask CMS to discontinue the use of antipsychotic medication as a factor contributing to the Nursing Home Compare rankings, unless the data utilized is limited to medically inappropriate
administration of these medications; and (3) require the reporting of all antipsychotic drugs used and the diagnoses for which they are prescribed. (Modify Current HOD Policy)

There was no online testimony provided for Resolution 703. Your Reference Committee will be prepared to hear live testimony on this resolution at the Reference Committee hearing.

(8) RESOLUTION 704 - EMPLOYED PHYSICIAN CONTRACTS

RESOLVED, That our American Medical Association advocate in support of all employed physicians receiving all rights and due process protections afforded all other members of the medical staff. (New HOD Policy)

Your Reference Committee reviewed online testimony for this resolution. Testimony on Resolution 704 was mixed. There was one comment from an individual and one comment from a state delegation supporting the resolution, in addition to a suggestion by an individual to refer Resolution 704, as there could be potential legal concerns that are not addressed by the resolution. The individual recommending referral shared concerns that restrictive covenants complicate due process because of additional legal layers that may supersede medical staff bylaws. There were two other posts by individuals supporting referral of Resolution 704.

(9) RESOLUTION 705 - FIFTEEN MONTH LAB STANDING ORDERS

RESOLVED, That our American Medical Association advocate the Centers for Medicare and Medicaid Services to allow standing laboratory orders to be active for fifteen (15) months. (Directive to Take Action)

Your Reference Committee reviewed online testimony for this resolution. Testimony on Resolution 705 was limited to one comment from a delegation in support of the resolution as written.

(10) RESOLUTION 706 - GOVERNMENT IMPOSED VOLUME REQUIREMENTS FOR CREDENTIALING

RESOLVED, That our American Medical Association create guidelines and standards for evaluation of government-imposed volume requirements for credentialing that would include at least the following considerations:
(a) the evidence for that volume requirement;
(b) how many current practitioners meet that volume requirement;
(c) how difficult it would be to meet that volume requirement;
(d) the consequences to that practitioner of not meeting that volume requirement;
(e) the consequences to the hospital and the community of losing the services of the practitioners who can’t meet that volume requirement; and
(f) whether volumes of similar procedures could also reasonably be used to satisfy such a requirement. (Directive to Take Action)
Your Reference Committee reviewed online testimony for this resolution. Testimony on Resolution 706 was mixed, but mostly opposed to the resolution as written. All testimony was provided by individuals. Two posts suggested this needs to be studied further; another post opposed the resolution, and one post suggested that overlap with Policy H-230.953 should be reviewed for redundancy.

(11) RESOLUTION 707 - INSURANCE COVERAGE FOR SCALP COOLING (COLD CAP) THERAPY

RESOLVED, That our American Medical Association advocate for and seek through legislation and/or regulation, universal insurance coverage for Scalp Cooling (Cold Cap) Therapy (Directive to Take Action); and be it further

RESOLVED, That our AMA work with consumer and advocacy groups to challenge insurers on medical necessity denials for Scalp Cooling (Cold Cap) Therapy and encourage appeals to independent third-party reviewers. (Directive to Take Action)

There was no online testimony provided for Resolution 707. Your Reference Committee will be prepared to hear live testimony on this resolution at the Reference Committee hearing.

(12) RESOLUTION 708 - PHYSICIAN BURNOUT IS AN OSHA ISSUE

RESOLVED, That our American Medical Association seek legislation/regulation to add physician burnout as a Repetitive Strain (Stress) Injury and subject to Occupational Safety and Health Administration (OSHA) oversight. (Directive to Take Action)

Your Reference Committee reviewed online testimony for this resolution. Testimony on Resolution 708 was mixed, but generally opposed the resolution as written. There were posts from two individuals and one state delegation in opposition to the resolution and one delegation that commented in support. Con testimony highlighted the fear of more government entanglements with physician practices. The delegation offering pro testimony suggested this could be a creative solution to compel institutions to preemptively address burnout.

(13) RESOLUTION 709 - PHYSICIAN WELL-BEING AS AN INDICATOR OF HEALTH SYSTEM QUALITY

RESOLVED, That our American Medical Association support policies that acknowledge physician well-being is both a driver and an indicator of hospital and health system quality (New HOD Policy); and be it further

RESOLVED, That our AMA promote dialogue between key stakeholders (physician groups, health-system decision makers, payers, and the general public) about the components needed in such a quality-indicator system to best measure physician and organizational wellness (Directive to Take Action); and be it further
RESOLVED, That our AMA (with appropriate resources) develop the expertise to be available to assist in the implementations of effective interventions in situations of suboptimal physician wellness. (Directive to Take Action)

Your Reference Committee reviewed online testimony for this resolution. Testimony on Resolution 709 was mixed, but generally supportive. There were two posts from individuals suggesting reaffirmation of existing policy, a suggested amendment from a state delegation to add “while maintaining physician privacy” to the end of the second Resolve clause, and three posts from three separate delegations that support the resolution.

(14) RESOLUTION 710 - PRIOR AUTHORIZATION - CPT CODES FOR FAIR COMPENSATION

RESOLVED, That our American Medical Association include in any model legislation and as basis for all advocacy, fair compensation based on CPT codes for appeal of wrongfully denied services, including those for prior authorization reforms and that CPT codes must fully reflect the aggregated time and effort expended by physician practices (Directive to Take Action); and be it further

RESOLVED, That our AMA evaluate and propose a CPT code for consideration by the CPT® Editorial Panel to account for administrative work involved in prior authorizations that reflects the actual time expended by physician practices to advocate on behalf of patients and to comply with insurer requirements (Directive to Take Action); and be it further

RESOLVED, That our AMA evaluate and propose a CPT code for consideration by the CPT® Editorial Panel to account for administrative work that reflects the actual time expended by physician practices and their billing vendors involved in successfully appealing wrongful pre- and post-service denials. (Directive to Take Action)

There was no online testimony provided for Resolution 710, however, this resolution is similar to Resolution 701, which received mixed testimony. This topic is also addressed in Resolutions 715 and 725. Your Reference Committee will be prepared to hear live testimony on this resolution at the Reference Committee hearing.

(15) RESOLUTION 711 - REDUCING PRIOR AUTHORIZATION BURDEN

RESOLVED, That our American Medical Association seek regulation and legislation that:
- restricts insurance companies from requiring prior authorizations for generic medications;
- contains disincentives for insurers demanding unnecessary prior authorizations, including payments to physicians’ practices for inappropriate prior authorizations;
- requires payment be made to the physician practice for services related to prior authorization when those services do not coincide with a visit; and
- ensures a requirement for an independent external review organization to review disputes involving prior authorizations and require insurer payments be made to the
practice when the review organization agrees with the physician practice. (Directive to Take Action)

Your Reference Committee reviewed online testimony for this resolution. Testimony on Resolution 711 was mostly supportive of the resolution. Two individuals supported the resolution as written. There was one amendment proffered by a state delegation that suggested striking “inappropriate” in the second bullet point, “when those services do not coincide with a visit” in the third bullet point, and “when the review organization agrees with the physician practice” in the fourth bullet point.

(16) RESOLUTION 712 - THE QUADRUPLE AIM - PROMOTING IMPROVEMENT IN THE PHYSICIAN EXPERIENCE OF PROVIDING CARE

RESOLVED, That to the Triple Aim which was established by Dr. Berwick and the Institute of Healthcare Improvement, our American Medical Association adopt a fourth goal: namely the goal of improving physicians’ experience in providing care. (Directive to Take Action)

Your Reference Committee reviewed online testimony for this resolution. Testimony on Resolution 712 was mixed, but overall supportive of the spirit of the resolution. There were three posts from individuals in support of reaffirmation of Policy H-405.955, which already asks for a quadruple aim of “improving the work-life balance of physicians and other health care providers” and two in support of reaffirmation of H-480.939, which addresses the use of augmented intelligence with consideration to the physician experience in achieving the quadruple aim, one post from an individual encouraging others to watch the debate on this item, and three posts from state delegations in support of the importance of both the goals of the Quadruple Aim and this resolution as written.

(17) RESOLUTION 713 - ENFORCEMENT OF ADMINISTRATIVE SIMPLIFICATION REQUIREMENTS - CMS

RESOLVED, That our American Medical Association take the position that the failure by the National Standards Group at the Centers for Medicare and Medicaid Services Office of Burden Reduction to effectively enforce the HIPAA administrative simplification requirements as required by the law and its failure to impose financial penalties for non-compliance by health plans is clearly unacceptable (New HOD Policy); and be it further

RESOLVED, That our AMA take the position that the National Standards Group at the Centers for Medicare and Medicaid Services Office of Burden Reduction practices of closing complaints without further investigation and ignoring overwhelming evidence that contradicts health plan assertions is also unacceptable (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for enhanced reinforcement of the HIPAA Administrative Simplification requirements for health plans. (Directive to Take Action)

Your Reference Committee reviewed online testimony for this resolution. Testimony on Resolution 713 was limited to one post from a delegation in support of the resolution as written.
(18) RESOLUTION 714 - PRIOR AUTHORIZATION REFORM FOR SPECIALTY MEDICATIONS

RESOLVED, That our American Medical Association encourage Congress and the President to issue a moratorium on the specialty medicine prior authorization process for one year to allow further study (New HOD Policy); and be it further

RESOLVED, That our AMA work with other stakeholders to encourage pharmaceutical companies and other entities that offer assistance programs to increase eligibility for their assistance programs. (Directive to Take Action)

There was no online testimony provided for Resolution 714. Your Reference Committee will be prepared to hear live testimony on this resolution during the Reference Committee hearing.

(19) RESOLUTION 715 - PRIOR AUTHORIZATION - CPT CODES FOR FAIR COMPENSATION

RESOLVED, That our American Medical Association support the creation of CPT codes to provide adequate compensation for administrative work involved in prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians and healthcare practices to advocate on behalf of patients and to comply with insurer requirements and that compensates physicians fully for the time, effort, and legal risks inherent in such work (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for CPT codes to be developed for prior authorizations to fully reflect the aggregated time and effort involved in prior authorization, including multiple contacts, wait time on the phone, chat, or other platforms preferred by payers or their agents, among other costs to physician practice (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for fair compensation based on CPT codes for prior authorization in any model legislation and as a basis for all advocacy for prior authorization reforms. (Directive to Take Action)

Your Reference Committee reviewed online testimony for this resolution. Testimony on Resolution 715 was limited and mixed. There was one post from an individual in support of the resolution as written, one post from an individual encouraging review of Policy H-70.919 for reaffirmation, and one post from a state delegation suggesting a clerical amendment to the second Resolve clause in order to change “multiple contacts” to “multiple contracts.” We note that Resolution 715 shares similarities with Resolutions 701, 710 and 725.

(20) RESOLUTION 716 - DISCHARGE SUMMARY REFORM

RESOLVED, That our American Medical Association coordinate with the American Hospital Association with input from the Centers for Medicare and Medicaid Services and other professional organizations as appropriate to revive the concise discharge summary
that existed prior to electronic medical records for the sake of much improved patient care and safety (Directive to Take Action); and be it further

RESOLVED, That our AMA internally develop a model hospital discharge summary in such a manner as to be concise but informational, include to promote excellent, safe patient care and improve coordinated discharge planning. This model use shall be promoted to our AMA and federation of medicine colleagues. (Directive to Take Action)

Your Reference Committee reviewed online testimony for this resolution. Testimony on Resolution 716 was mixed, but mostly supportive of the resolution as written. There were posts from three individuals and one state delegation in support of the resolution, and one post from an individual opposed to the resolution. Con testimony raised concerns that trying to make discharge summaries “concise” could result in poor documentation.

(21) RESOLUTION 717 - EXPANDING THE AMA'S STUDY ON THE ECONOMIC IMPACT OF COVID-19

RESOLVED, That our American Medical Association work with relevant organizations and stakeholders to study the economic impact and long-term recovery of the COVID-19 pandemic on healthcare institutions in order to identify and better understand which groups of physicians, patients and organizations may have been disproportionately affected by the financial burdens of the COVID-19 pandemic (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant organizations and stakeholders to study the overall economic impact of office closures, cancellations of elective surgeries and interruptions in patient care, as well as the economic impact of utilizing telemedicine for an increasing percentage of patient care. (Directive to Take Action)

Your Reference Committee reviewed online testimony for this resolution. Testimony on Resolution 717 was mixed. There were posts from two delegations and one individual in support of the resolution as written. The AMA Council on Medical Service pointed out potential financial concerns and the potential for a high fiscal note with limited ability to get clear data due to the inability to separate COVID-19 changes from economic or other changes and highlighted existing AMA efforts in these areas, and one post from a state delegation in support of the resolution with an amendment to the first Resolve clause, to add the phrase "physician practices and" in addition to other healthcare institutions addressed by this resolution.

Ongoing AMA work was summarized by the Council on Medical Service and includes: a COVID-19 impact survey administered to physicians in July and August of 2020; analysis and continued monitoring of changes in Medicare physician spending; analysis and continued monitoring of changes in National Health Expenditures estimates from the Centers for Medicare & Medicaid Services; analysis and continued monitoring of changes in consumer spending for health care and physician services from the Bureau of Economic Analysis; analysis and continued monitoring of changes in employment in health care and physician offices from the Bureau of Labor Statistics; and general monitoring of the Economics, Health Services Research and trade literature for studies on the impacts of COVID-19.
(22) RESOLUTION 718 - DEGRADATION OF MEDICAL RECORDS

RESOLVED, That our American Medical Association publish available data about the amount of time physicians spend on data entry versus direct patient care, in order to inform patients, insurers, and prospective primary care physicians about the real expectations of the medical profession. (Directive to Take Action)

Your Reference Committee reviewed online testimony for this resolution. Testimony on Resolution 718 was mostly supportive, with posts from two delegations and one individual in support of the resolution as written and one post from an individual in opposition. Testimony in opposition questioned the cost of this ask, as well as why the resolution was only directed at "prospective PCPs" and not all medical students.

(23) RESOLUTION 719 - SYSTEM WIDE PRIOR AND POST-AUTHORIZATION DELAYS AND EFFECTS ON PATIENT CARE ACCESS

RESOLVED, That our American Medical Association encourage and advocate health care insurers and Medicare/Medicaid Products to ensure that the systems of communication for prior authorization include: live personnel access, simplification of website navigation, immediate response with confirmation number and an expedient decision for authorizations. (Directive to Take Action)

Your Reference Committee reviewed online testimony for this resolution. Testimony on Resolution 719 was limited to one post from a state delegation in support of the resolution.

(24) RESOLUTION 720 - MITIGATING THE NEGATIVE IMPACT OF STEP THERAPY POLICIES AND NONMEDICAL SWITCHING OF PRESCRIPTION DRUGS ON PATIENT SAFETY

RESOLVED, That our American Medical Association adopt policy supporting the recommendations of the American College of Physicians with respect to insurance step therapy and nonmedical drug switching policies, including:

a) All step therapy and medication switching policies should aim to minimize care disruption, harm, side effects and risks to the patient;

b) All step therapy and nonmedical drug switching policies should be designed with patients at the center, while accounting for unique needs and preferences;

c) All step therapy and nonmedical drug switching protocols should be designed with input form frontline physicians and community pharmacists; feature transparent, minimally burdensome processes that consider the expertise of a patient’s physician; and include a timely appeals process; and

d) Data concerning the effectiveness and potential adverse consequences of step therapy and nonmedical drug switching programs should be made transparent to the public and studies by policymakers. Alternative strategies to address the rising cost of prescription drugs that do not inhibit patient access to medications should be explored. (New HOD Policy)
Your Reference Committee reviewed online testimony for this resolution. Testimony on Resolution 720 was limited to one post from an individual and one post from a state delegation. All testimony provided was supportive of the resolution as written.


RESOLVED, That our American Medical Association amend policy H-215.981, “Corporate Practice of Medicine,” by addition to read as follows:

4. Our AMA acknowledges that the corporate practice of medicine has led to the erosion of the physician-patient relationship, erosion of physician-driven care and created a conflict of interest between profit and training the next generation of physicians. (Modify Current HOD Policy)

Your Reference Committee reviewed online testimony for this resolution. Testimony on Resolution 721 was mixed, but generally supportive. There were three posts from delegations in support of the resolution and one post from an individual suggesting referral of this item for further study. Con testimony noted that the wording of the amendment is ineffective and does not fit within the original policy this resolution seeks to amend. The individual recommending referral specifically proposed a report to update the HOD on the AMA’s monitoring of the corporate practice of medicine.

(26) RESOLUTION 722 - ELIMINATING CLAIMS DATA FOR MEASURING PHYSICIAN AND HOSPITAL QUALITY

RESOLVED, That our American Medical Association (AMA) collaborate with the U.S. Centers for Medicare and Medicaid Services (CMS) and other appropriate stakeholders to ensure physician and hospital quality measures are based on the delivery of care in accordance with established best practices; and be it further

RESOLVED, That our AMA collaborate with CMS and other stakeholders to eliminate the use of claims data for measuring physician and hospital quality.

Your Reference Committee reviewed online testimony for this resolution. Testimony on Resolution 722 was mixed, but generally supportive of the concept of the resolution. There was concern about outright elimination of the use of claims data and there were two amendments proposed to address this. The first was proposed by an individual to add “when other means of capturing data that is less burdensome to physicians and patients exist” to the end of the second Resolve clause. This amendment was supported by the author of the resolution as well as one other individual. The second amendment was proposed by the AMA Council on Medical Service and recommended a one word change to the second Resolve clause, to strike “eliminate” and replace it with “improve.”

(27) RESOLUTION 723 - PHYSICIAN BURNOUT

RESOLVED, That our American Medical Association will work with the Centers for Medicare and Medicaid Services and The Joint Commission to assure that clinician, including physician, wellbeing is a component of standards for hospital certification; and be it further
RESOLVED, That our AMA work with hospitals and other stakeholders to determine areas of focus on clinician wellbeing, to include the removal of intrusive questions regarding clinician physical or mental health or related treatments on initial or renewal hospital credentialing applications.

Your Reference Committee reviewed online testimony for this resolution. Testimony on Resolution 723 was mixed, but overall supportive of the spirit of the resolution. There were posts from three individuals in opposition to the resolution, three delegations in support of the resolution, and one delegation and one individual in support of the concept of addressing physician burnout and the importance of physician well-being in general. Individual testimony opposed to the resolution is concerned about the lack of clarity and questioned the feasibility of monitoring both employee and non-employee physician well-being. Individuals speaking in opposition to the resolution also suggest referral as a potential option. The author of the resolution responded to testimony provided and suggested removing the first Resolve clause to address the concerns stated.

(28) RESOLUTION 724 - ENSURING MEDICAL PRACTICE VIABILITY THROUGH REALLOCATION OF INSURANCE SAVINGS DURING THE COVID-19 PANDEMIC

RESOLVED, That our American Medical Association continue to advocate for and educate members about practice viability issues; and be it further

RESOLVED, That our AMA work with private payers to encourage them to pass along savings generated during the pandemic to patients; and be it further

RESOLVED, That our AMA advocate that all plans follow medical loss ratio requirements and, as appropriate and with particular mindfulness of the public health emergency, issue rebates to patients; and be it further

RESOLVED, That our AMA urge health plans to offer practices per-patient-per-month fees for innovative practice models to improve practice sustainability.

Your Reference Committee reviewed online testimony for this resolution. Testimony on Resolution 724 was limited to posts from one individual and one delegation. Both posts were in support of the resolution. The individual testimony highlighted the financial struggles faced by solo and small group practices during the COVID-19 pandemic due to the sharp decline in patient visits and revenue, especially those practices that see a large population of Medicaid patients.

(29) RESOLUTION 725 - COMPENSATION TO PHYSICIANS FOR AUTHORIZATIONS AND PRE-AUTHORIZATIONS

RESOLVED, That our American Medical Association support legislation that requires insurance and managed care companies, including companies managing governmental insurance plans (“payers”), to compensate physicians for the time physicians and their staff spend on authorization and preauthorization procedures. Such compensation shall be paid in full by payers to physicians without deductible, coinsurance, or copayment billable to patients; thus, patients will not bear the burden for such processes imposed by
Physicians shall bill payers for time spent physicians and their staff in performing such tasks at a rate commensurate with that of the most highly trained professionals. Payers shall pay physicians promptly upon receiving such a bill with significant interest penalties assessed for delay in payment. Billable services for authorization and preauthorization include, but are not limited to, time spent filling out forms, making telephone calls (including time spent negotiating phone trees and hold time), documenting in the patient’s medical record, communicating with the patient, altering treatment plans (such as changing medications to comply with formularies), printing, copying, and faxing.

Your Reference Committee reviewed online testimony for this resolution. Testimony on Resolution 725 was supportive of the resolution as written. There were posts from three individuals and two delegations supporting the resolution as written and one suggestion from an individual to combine this with Resolution 701 for a more comprehensive policy. We note that Resolution 725 also shares similarities with Resolutions 710 and 715, in addition to Resolution 701. There was one post from an individual suggesting these ancillary costs are already worked into payment, but wanted more information to confirm that was the case. Individual testimony shared personal stories and challenges with the prior authorization process.

RESOLVED, That our American Medical Association advocate for appropriate physician payment through the resource-based relative value scale to cover the expense of technology required to electronically prescribe controlled substances; and be it further resolved, That our AMA advocate for appropriate physician payment to cover the extra time and expense to query state prescription monitoring programs as required by law.

Your Reference Committee reviewed online testimony for this resolution. Testimony on Resolution 726 was unanimously supportive of the resolution as written. Testimony was provided by one individual and two delegations.

RESOLVED, That our American Medical Association advocate for implementation of a federal version of Texas’ “gold card” law (House Bill 3459), which aims to curb onerous prior authorization practices by many state-regulated health insurers and health maintenance organizations; and be it further resolved, That our AMA adopt a similar policy to Texas’ “gold card” law (House Bill 3459); and be it further
RESOLVED, That our AMA Council on Ethical and Judicial Affairs devise ethical opinions similar to the TMA Board of Councilors’ opinions regarding medical necessity determination and utilization review.

Your Reference Committee reviewed online testimony for this resolution. Testimony on Resolution 727 was generally supportive. There were posts from one individual and two delegations in support of the resolution as written and one post from an individual supporting the first Resolve clause and opposing the second and third Resolve clauses due to unclear policy language for the AMA to adopt in Resolve two, and Resolve three asking CEJA to adopt a specific ethical opinion instead of asking for a CEJA opinion on this topic.