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REPORT 02 OF THE COUNCIL ON MEDICAL SERVICE (A-23)
Medicare Coverage of Dental, Vision, and Hearing Services
(Referred Resolve Clause of Alternate Resolution 113-A-22)

EXECUTIVE SUMMARY

At the 2022 Annual Meeting, the House of Delegates partially referred Alternate Resolution 113, which asked the American Medical Association (AMA) to “support new funding that is independent of the physician fee schedule for Medicare coverage of 1) preventive dental care, including dental cleanings and x-rays, and restorative services, including fillings, extractions, and dentures; 2) visual aids, including eyeglasses and contact lenses; and 3) aural rehabilitative services and hearing aids.

Expansion of Medicare coverage to new services has been debated extensively by Congress. Proponents of expanding Medicare coverage for dental, vision, and hearing services have frequently suggested that Congress could change the law to add dental, vision, and hearing coverage under traditional Medicare Part B; beneficiaries could enroll in Medicare Advantage (Part C) plans; a new, optional part of Medicare for dental, vision, and hearing coverage that would be similar to Medicare Part D for prescription drug coverage could be created; or some form of cash assistance or debit card for beneficiaries who do not have access to coverage for dental, vision, and/or hearing services could be established.

Nonetheless, while many believe that Medicare beneficiaries should have coverage for a wider range of services, significant obstacles remain. Given the current rate of inflation, the \$358 billion projection from Congressional Budget Office in 2019 to include coverage for dental, vision, and hearing services in the Medicare program over the next decade would likely be substantially higher today. Further, given that Medicare is subject to statutory budget neutrality requirements, the Council believes it is impossible to consider this issue in a vacuum, and we must be sensitive to what implications adding these services could mean for payment and access to other current health care services for Medicare beneficiaries.

While the Council acknowledges the potential value of expanded Medicare benefits, it believes that the current options in place for beneficiaries to access these services are adequate. In terms of the current political environment, at the time that this report was written, Congress had failed to prevent a budget neutrality cut to the Medicare physician conversion factor and was facing a stalemate on how to move forward with managing the national debt. Broader Medicare physician payment reform remains one of the highest priorities of the AMA, under the AMA’s Recovery Plan for America’s Physicians.

The Council reemphasizes the importance of working with the American Dental Association regarding strategies to expand dental coverage to Medicare beneficiaries. The Council believes that the AMA can be most influential in addressing the need for hearing services by improving mechanisms already in place. Additionally, the AMA can encourage the United States Preventive Task Services Task Force to re-evaluate its decision not to recommend screening for hearing loss in asymptomatic adults over age 65, especially considering the new evidence that exists about the connection of hearing loss and dementia. Finally, the Council believes that AMA policy on vision coverage can be strengthened, and we recommend amendments to Policy H-25.990 to encourage programs and outreach efforts for affordable prescription eyeglasses.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 02-A-23

Subject: Medicare Coverage of Dental, Vision, and Hearing Services
(Referred Resolve Clause of Alternate Resolution 113-A-22)

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee A

At the 2022 Annual Meeting, the House of Delegates partially referred Alternate Resolution 113, which asked the American Medical Association (AMA) to “support new funding that is independent of the physician fee schedule for Medicare coverage of 1) preventive dental care, including dental cleanings and x-rays, and restorative services, including fillings, extractions, and dentures; 2) visual aids, including eyeglasses and contact lenses; and 3) aural rehabilitative services and hearing aids.

Resolution 119 was combined with similar resolutions 113 and 114 to become Alternate Resolution 113, which was passed in part to become Policy D-185.972, “Increasing Patient Access to Hearing, Dental, and Vision Services.” The policy states that the AMA will promote awareness of hearing impairment as a potential contributor to cognitive impairment later in life and encourage further research on this topic. This policy also encourages increased patient access to both vision and dental services.

There was mixed testimony heard on these related items. There were several calls for referral, but support for ensuring that patients have access to, and coverage for, essential hearing, dental, and vision services. Some testimony noted that some of the resolve clauses of the original resolutions did not align with the United States Preventive Task Services Task Force (USPSTF) recommendations for hearing and vision screening for older adults. Further testimony stressed that the expansion of health insurance coverage, and potentially Medicare benefits, for dental, vision, and hearing services needs to be considered not only from the patient perspective, but within the context of a Medicare payment infrastructure that is unsustainable for physician practices. In response to concerns regarding how coverage for these services would be paid for, an amendment was proffered to ensure that our AMA supports new Medicare funding that is independent of the Medicare Physician Payment Schedule to pay for these services. However, the Reference Committee noted in its report that expanding dental, vision, and hearing coverage would still require “pay-fors” in the current Congressional environment, pitting these coverage expansions against other AMA priorities that require funding. This referred clause was assigned by the Board of Trustees to the Council on Medical Service for study.

The Council has developed reports on these topics in recent years. In 2015, the Council authored CMS Report 6, “Hearing Aid Coverage” and concluded that a recommendation supporting adult hearing aid coverage mandates would conflict with Policies H-185.964 and H-165.856, which oppose new health benefit mandates unrelated to patient protections and which jeopardize coverage to currently insured populations, and supports the principle that benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage

options. Given the policy, the Council did not recommend that the AMA support Medicare coverage for hearing aids.

In 2019, the Council authored CMS Report 3, “Medicare Coverage for Dental Services” and concluded that the AMA should continue to explore opportunities to work with the American Dental Association (ADA) to improve access to dental care for Medicare beneficiaries, support initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, explore optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and examine the impact of expanded dental coverage on health care costs and utilization.

BACKGROUND

The most recent enrollment data from the Centers for Medicare & Medicaid Services (CMS) show that over 65 million individuals are enrolled in Medicare. This includes 35 million individuals enrolled in traditional fee-for-service Medicare plans and a little over 30 million individuals enrolled in Medicare Advantage plans.¹ According to a 2019 Kaiser Family Foundation (KFF) poll, 16 percent of Medicare beneficiaries reported they could not get access to dental, vision, or hearing care. These numbers were higher amongst those with low incomes, in poor health, and/or in communities of color.²

Another 2019 KFF poll indicated that 90 percent of the American public supported expanding Medicare to include dental, hearing, and vision care as a “top” or “important” priority for Congress.³ However, recent attempts at passing legislation in Congress have not been successful. In 2019, the House passed H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act. Title VI of this bill would have added new benefits for dental, vision, and hearing coverage under Medicare, such as dentures, glasses, hearing aids, and preventive services. The Congressional Budget Office (CBO) estimate for this bill was \$358 billion over the next ten years (\$238 billion for dental coverage, \$30 billion for vision coverage, and \$89 billion for hearing coverage).⁴ In 2021, H.R. 4311, the Medicare Dental, Vision, and Hearing Benefit Act was introduced in the House and proposed repealing the statutory exclusion that restricts coverage of dental, vision, and hearing benefits, and expanding coverage to offer these services under Medicare Part B. Neither of these bills advanced out of Congress. In March 2023, Senators Bob Casey (D-PA) and Ben Cardin (D-MD) introduced a similar bill, S.842, The Medicare and Medicaid Dental, Vision, and Hearing Benefit Act. This bill would also repeal the statutory exclusion that restricts coverage of dental, vision, and hearing services and expand coverage to offer:

- Dental and oral care, including coverage of routine cleanings and exams, fillings and crowns, major services such as root canals and extractions, emergency dental care and other necessary services, and payment for both full and partial dentures.
- Vision care, including routine eye exams, procedures performed to determine the refractive states of the eyes and other necessary services, and payment for eyeglasses, contact lenses, and low-vision devices.
- Hearing care, including hearing exams, exams for hearing aids and other necessary services, and payment for hearing aids.

This bill also encourages states to provide these optional services to people with Medicaid by increasing the associated Federal Medical Assistance Percentage rate to 90 percent. At the time that this report was written, this bill was referred to the Senate Committee on Finance and the full text of the bill was not yet available.

DENTAL CARE AND COVERAGE

The medical-dental coverage divide first began in the 20th century. In the early 1900s, oral health was widely thought to have little to no bearing on overall health and efforts to combine medical and dental fields were opposed by dentists. In the 1920s, William Gies, a biological chemist, insisted that oral health was directly related to overall health and recommended dentistry should be integrated into the medical field, but dentists again resisted this change. During the 1940s and 1950s, the AMA and the ADA joined efforts to oppose health insurance nationalization and/or expansion. During this same period, tap water fluoridation improved oral disease prevention among Americans, which some believed mitigated the need for some dental services and reduced demand for dental insurance coverage. Moreover, because dental service coverage began being widely included in employer-sponsored benefit packages later than medical health service coverage, it was considered a “perk” or cosmetic-only benefit, a perception that continues as dental care is still regarded by many as auxiliary to general health care even though current research clearly demonstrates the critical relationship between oral health and optimal overall health. When Medicare legislation was passed in 1965, oral health coverage was not included. As a result, the medical profession has frequently had to respond to the challenges of Medicare and Medicaid coverage and changes in payment policy over the years, while dentistry has not.⁵

A statutory exclusion in Section 1862(a)(12) of the Social Security Act expressly prohibits coverage for most dental services, specifically, “services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth” by Medicare for its beneficiaries.⁶ Therefore, traditional Medicare regulations do not include coverage for routine oral health care including checkups, cleanings, and x-rays, or restorative procedures, tooth extraction, and dentures. To integrate dental benefits in Medicare, Congress would need to remove this exclusion, and add statutory changes, such as establishing the scope of dental services and a mechanism for provider payment that is independent from the Medicare Physician Payment Schedule.

As of 2018, almost half of Medicare beneficiaries did not have a dental visit within the past year (47 percent), with higher rates among those who are Black (68 percent) or Hispanic (63 percent), have low incomes (73 percent), or who are in fair or poor health (63 percent). Nonetheless, 94 percent of Medicare Advantage enrollees in individual plans are in a plan that offers access to some dental coverage. Nearly two-thirds of Medicare Advantage enrollees (64 percent) with access to preventive benefits, such as oral exams, cleaning and/or x-rays, pay no cost sharing for these services, though their coverage is typically limited to an annual dollar amount. Average out-of-pocket spending on dental services among Medicare beneficiaries (both traditional fee-for-service and Medicare Advantage) who had any dental service was \$872 in 2019. Those enrolled in Medicare Advantage plans paid slightly less out-of-pocket than those enrolled in traditional Medicare (\$729 vs. \$995).⁷ A February 2023 study published in *Health Affairs* found substantial declines in dental service use and worsened health outcomes after individuals became eligible for traditional Medicare at age 65. Additionally, this study found that there was also evidence of lower dental service use by those beneficiaries who opted for a Medicare Advantage plan and who likely have some coverage for these services. The authors suggest that benefit and plan design should not only offer coverage of these services, but also address barriers to access to necessary care beyond whether or not a beneficiary has coverage (i.e., out of pocket affordability for co-pays/coinsurance, lack of familiarity with covered benefits, or inability to find local dentists accepting Medicare or Medicare Advantage patients).⁸

Historically, Medicare has paid for dental services when they are integral and inextricably linked to treating a beneficiary’s primary medical condition. However, the services Medicare paid for were

limited to those specified in sub-regulatory guidance, such as reconstruction of a ridge when performed as a result of and at the same time as the surgical removal of a tumor; stabilization or immobilization of teeth when done in connection with the reduction of a jaw fracture; extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease; dental splints only when used in conjunction with medically necessary treatment of a medical condition; and dental services – including both examination and treatment – prior to organ transplants, cardiac valve replacements, and valvuloplasty.⁹ Beginning in 2023, CMS formally codified these existing services in rulemaking and added additional services to the dental exclusion exception including dental examination and treatment when performed prior to a cardiac valve replacement and valvuloplasty or organ transplant procedures. In 2024, coverage will be expanded to include dental services to eliminate infection prior to treatment for head and neck cancers.

Additionally, the new regulation establishes an annual process to review public input and clinical evidence on other medical circumstances that may allow for payment of relevant dental services under the same exception.¹⁰ Medical associations and their members are encouraged to participate in this annual review process by submitting their comments.

ADA policy states that for the purpose of presenting potential legislation that includes dental benefits for adults age 65 and over in a tax payer-funded public program such as, Medicaid, Children’s Health Insurance Program (CHIP), privately administered Medicare or other federal or state programs, the ADA supports a program that: 1) covers individuals under 300 percent FPL; 2) covers the range of services necessary to achieve and maintain oral health; 3) is primarily funded by the federal government and not fully dependent on state budgets; 4) is adequately funded to support an annually reviewed reimbursement rate such that at least 50 percent of dentists within each geographic area receive their full fee to support access to care; 5) includes minimal and reasonable administration requirements; and 6) allows freedom of choice for patients to seek care from any dentist while continuing to receive the full program benefit.¹¹ The full text of the policy can be found here: <https://www.ada.org/about/governance/current-policies#medicare>.

VISION CARE AND COVERAGE

Medicare Part B covers certain vision services including treatment for glaucoma, macular degeneration, cataract surgery (if done using traditional surgical techniques or using lasers), annual eye exams for diabetic retinopathy for patients with diabetes, and annual glaucoma tests for patients at high risk for developing glaucoma. However, traditional Medicare does not typically cover routine eye examinations or refractions for eyeglasses or contact lenses, nor does it cover eyeglasses or contact lenses themselves, other than eyeglasses following cataract surgery or corrective lenses if a patient has cataract surgery that implants an intraocular lens.^{12,13}

Beneficiaries typically spend significantly less on vision coverage compared to dental and hearing services. Traditional Medicare does not generally cover routine eye exams. However, beneficiaries can seek supplemental vision coverage from Medicare Advantage or other private insurance coverage. As of 2021, 99 percent of Medicare Advantage enrollees have access to some vision coverage. 93 percent of Medicare Advantage enrollees are in plans that provide access to both eye exams and eyewear (contacts and/or eyeglasses). However, enrollees may be limited in terms of frequency of obtaining certain covered services and may be subject to annual dollar limits.¹⁴

Another option for seniors to receive an eye exam and eye health services is through EyeCare America, which connects eligible seniors 65 and older with local volunteer ophthalmologists who provide a medical eye exam often at no cost out-of-pocket, and up to one year of follow-up care for any condition diagnosed during the initial exam and for the physician services. To qualify, an

individual must be a U.S. citizen or legal resident, aged 65 or older, not belong to a Health Maintenance Organization or have eye care benefits through the Veterans Affairs, and not have seen an ophthalmologist in three or more years. Notably, EyeCare America does not directly cover the cost of eyeglasses, but can provide information to patients on where to get help paying for eyeglasses if they are needed.^{15,16}

HEARING CARE AND COVERAGE

When Medicare was enacted in 1965, it did not include any coverage for hearing aids. Hearing aids were considered “not routinely needed and low in cost” and many Americans did not live long enough to need them. Today, hearing loss affects one-third of adults over the age of 65 and has a significant impact on health.¹⁷ Traditional Medicare does not cover hearing exams, hearing aids, or aural rehabilitative services. Medicare Advantage charges additional premiums for hearing coverage, with out-of-pocket costs and annual limits varying across plans. Traditional Medicare covers medically reasonable and necessary hearing tests and treatments when ordered by a physician or a non-physician practitioner including diagnostic services related to hearing loss that is treated with surgically implanted hearing devices, and covers cochlear implants if a beneficiary meets specific hearing loss criteria.¹⁸ Starting January 1, 2023 Medicare Part B expanded coverage of audiology services to allow beneficiaries to receive care from an audiologist without a physician or practitioner order once every 12 months for non-acute hearing assessments that are unrelated to disequilibrium, hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids.^{19,20,21} AMA policy supports coverage of hearing tests administered by a physician or a physician-led team under Medicare’s benefit (H-185.929).

In 2021, the USPSTF reviewed the need to screen asymptomatic adults over the age of 50 for hearing loss and concluded that the current evidence is insufficient to assess the balance of benefits versus the harms of screening for hearing loss in older adults. The USPSTF also stated that additional research was necessary.²²

In 2022, the Biden Administration issued an executive order for the Food and Drug Administration (FDA) to allow over the counter (OTC) purchase of hearing aids for those with mild to moderate hearing loss. OTC purchase of hearing aids became available in October 2022 and provides an immediate, low-cost option for adults with mild to moderate hearing loss. OTC hearing aids range in price from \$99 to \$3400 per pair and are readily available at local pharmacies, large retailers, and online. By increasing competition among OTC hearing aid companies, the FDA rule is designed to create more options for those who experience hearing loss and who want to purchase affordable hearing aids.^{23,24}

MEDICARE PART B AND BUDGET NEUTRALITY

Medicare law requires that increases and decreases in payment rates by CMS must be budget neutral – i.e., any changes resulting from regulatory changes made by CMS must have no impact on total Medicare spending. Typically, this is done by lowering the Medicare “conversion factor.” Increases in total Medicare spending are set by law. Unlike hospitals and nursing homes, Medicare physician payments lack an automatic annual update. As a result, Medicare payments have failed to keep pace with rising inflation.

The Statutory Pay-As-You-Go Act of 2010 (PAYGO) requires that all new legislation changing taxes, fees, or mandatory expenditures, when assessed together, must not increase projected deficits. If legislation is enacted that cuts taxes or increases expenditures without fully offsetting the cost, PAYGO applies a budget enforcement mechanism called sequestration. Sequestration is

the automatic reduction of certain types of spending in the federal budget, generally by a uniform percentage.^{25,26}

If Congress adjourns at the end of a session with net costs on the Office of Management and Budget scorecard, the President is required to issue a sequestration order implementing across-the-board cuts to a select group of federal mandatory programs in an amount sufficient to offset the net costs. There are some exemptions from sequestration, such as Social Security, most unemployment benefits, interest on the national debt, federal retirement, and low-income entitlements (i.e., Medicaid, Supplemental Nutrition Assistance Program, and Supplemental Security Income). However, the major remaining mandatory programs are subject to sequestration – including Medicare. If sequestration is ordered, each non-exempt mandatory program is reduced for one year by the same percentage, with one notable exception: Medicare payments subject to sequestration cannot be reduced by more than four percent. If sequestration would require a percent reduction greater than four percent, other non-exempt mandatory programs must make up the difference. To date, a sequester pursuant to PAYGO has not been applied, as Congress has either exempted legislation from PAYGO requirements or otherwise deferred the application of such requirements.²⁷

POTENTIAL MEDICARE COVERAGE OPTIONS FOR DENTAL, VISION, AND HEARING SERVICES

Expansion of Medicare coverage to new services has been considered and debated extensively. While many believe that Medicare beneficiaries should have coverage for a wider range of services, there are significant challenges to expanded coverage. Proponents of expanding Medicare coverage for dental, vision, and hearing services have suggested the following:

- Congress could change the law to add dental, vision, and hearing coverage under traditional Medicare Part B. The benefits of this option are that it would impact all 65 million Medicare beneficiaries and could lead to enhanced benefits that are integrated into other Medicare-covered services. The challenges facing this option include determining new claims systems and payment schedules that are independent of the Medicare Physician Payment Schedule. Perhaps the largest challenge to this approach is the price tag assigned by CBO: \$358 billion over the next ten years is an enormous sum, especially when the current level of inflation is added to this previous score. Another major challenge involves budget neutrality requirements. If these services were covered under Medicare Part B, the conversion factor would need to be significantly reduced to balance the increased spending, thereby reducing payment for other Medicare Part B services. Alternatively, if the conversion factor were to remain the same and the new funding was independent of the Medicare Physician Payment Schedule, the pool of money allotted for Medicare Part B would still have to increase substantially, which is also untenable. Under either of these scenarios, funding for this option would be diverted from another program and there is potential risk for competing federal priorities for the AMA (i.e., the AMA's Recovery Plan for America's Physicians).
- Beneficiaries could enroll in Medicare Advantage (Part C) plans. Coverage for dental, vision, and hearing services under Medicare Advantage is already an option for most beneficiaries. These services are often offered through supplementary coverage under Medicare Advantage plans. Most Medicare Advantage enrollees are in plans that offer dental (96 percent), vision (99 percent), and hearing (98 percent) coverage. Medicare Advantage plans can vary, but most plans cover both preventive and extensive dental services, access to eye exams and eyewear (contacts and/or glasses), and hearing exams

and hearing aids. Medigap plans may also cover dental, vision, and hearing services to supplement traditional Medicare coverage.

- A new, optional part of Medicare for dental, vision, and hearing coverage that would be similar to Medicare Part D for prescription drug coverage could be created. Beneficiaries would have the option to sign up, likely for an additional premium. While this new part would not be subject to the specific budget neutrality requirements of adding coverage for these services under Medicare Part B, the challenge of how to pay for this coverage still remains. This solution could also further complicate the Medicare system and is largely redundant for Medicare Advantage beneficiaries since the vast majority of Medicare Advantage (Part C) plans already offer coverage for dental, vision, and hearing services for an additional premium. Again, there is also the risk that advocacy for this option would be in competition with other AMA priorities.
- A form of cash assistance or debit card for beneficiaries who do not have access to coverage for dental, vision, and/or hearing services could be established. While this option could be less costly than the others presented, there is still a funding challenge present. Other outstanding questions include the amount of money offered to each beneficiary, the impact on beneficiaries who already have some sort of supplemental coverage, and how government officials would ensure this assistance was only being utilized for covered services. More research would need to be completed before consideration of this option.

AMA POLICY

AMA Policy D-160.925 affirms the importance of oral health care. Policy H-330.872 affirms that the AMA supports continued opportunities to work with the ADA and other interested national organizations to improve access to dental care for Medicare beneficiaries. The policy goes on to affirm AMA support for initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization.

Policy H-25.990 states that the AMA encourages the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients.

Policy H-185.929 states that the AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the cost of hearing aid purchases, hearing-related exams and related services; supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's benefit; supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly; encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids; and supports the availability of over the counter hearing aids for the treatment of mild-to-moderate hearing loss.

Policy D-185.972, established with the adoption of Alternate Resolution 113-A-22, affirms that the AMA will promote awareness of hearing impairment as a potential contributor to the development of cognitive impairment or dementia later in life and encourage other stakeholders to promote the conduct and acceleration of research into specific patterns of hearing loss to determine those most linked to cognitive impairment or dementia and amenable to correction. The AMA will work with interested national medical specialty societies and state medical associations to encourage and

promote research into hearing loss as a contributor to cognitive impairment, and to increase patient access to hearing loss identification and remediation services; and promote research into vision and dental health and to increase patient access to vision and dental services.

More broadly, Policy H-185.964 states that the AMA opposes new health benefit mandates unrelated to patient protections, which jeopardize coverage to currently insured populations. Additionally, Policy D-390.946 affirms that the AMA will work towards the elimination of budget neutrality requirements within Medicare Part B; will eliminate, replace, or supplement budget neutrality in Merit-based Incentive Payment System with positive incentive payments; and will advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and that continued budget neutrality is not an option.

Other related policies include D-330.935 and H-425.988, which state that the AMA will collaborate with relevant stakeholders to actively promote the value of the Welcome to Medicare Visit, the Tobacco Cessation Benefit, and other Medicare-covered preventive services, as well as work with the federal government and other stakeholders to support providing preventive service coverage for seniors.

As part of its Recovery Plan for America’s Physicians, the AMA has dedicated an entire strategic pillar to reforming the Medicare physician payment system. In February 2023, the AMA led nearly 100 organizations in asking Congress to explore long-term solutions to the Medicare physician payment problems. The AMA is encouraging the 118th Congress to “work with us on long-term, substantive payment reforms and urge congressional hearings as soon as possible to begin exploring potential payment solutions to ensure America’s seniors continue to receive access to the high-quality care they deserve.”²⁸

DISCUSSION

There are several aspects to consider when exploring ways to expand coverage for dental, vision, and hearing services to Medicare beneficiaries, including cost, access, the current political environment, the relevance of these services to overall health, existing AMA efforts to improve Medicare payment to physicians, and the scope of the AMA’s influence.

Given the current rate of inflation, the \$358 billion projection from CBO in 2019 to include coverage for dental, vision, and hearing services in the Medicare program over the next decade would likely be substantially higher today. In an environment in which Medicare is subject to statutory budget neutrality requirements, the Council believes it is impossible to consider this issue in a vacuum and the AMA must acknowledge the likely impact that adding these services would mean for payment and access to current health care services for Medicare beneficiaries. At the time that this report was written, the bill recently introduced by Senators Casey and Cardin did not have a CBO score nor was the full text of the bill available.

The Council acknowledges the potential value of expanded Medicare benefits. Nonetheless, dental, vision, and hearing services already are frequently offered through supplementary coverage under Medicare Advantage (Part C) or Medigap plans. Veterans can receive coverage for these services through Veterans Health Administration (VHA) plans (including free hearing aids), and low-income individuals can often receive coverage through Medicaid. Other beneficiaries have private coverage offered through an employer or an individually purchased plan.

In terms of the current political environment, at the time that this report was written, Congress had recently failed to prevent a budget neutrality cut to the Medicare physician conversion factor and was facing a stalemate on how to move forward with managing the national debt. At a time when physicians are already fighting to keep practices open amid continued payment cuts due to lack of an annual inflation-based update, frozen Medicare payment rates under the Medicare Access and CHIP Reauthorization Act, and budget neutrality restrictions, pursuing broader Medicare coverage expansions would be extremely challenging. Enacting Medicare physician payment reform remains one of the AMA's highest priorities under our Recovery Plan for America's Physicians.

The Council also reemphasizes the importance of working with the ADA when it comes to strategies to expand dental coverage to Medicare beneficiaries. It is crucial for the ADA and the AMA to work together to navigate the current policy landscape regarding infringements on the Medicare Physician Payment Schedule. While the Council acknowledges that oral health care is a critical part of overall health care, we believe that our dental colleagues are best positioned to assess the payment structures that work best for their needs. Notably, in 2020, the ADA enacted new policy to address dental coverage under Medicare. The AMA will continue to work closely with the ADA to share data on oral health care's impact on overall health, as stated in AMA policy.

The Council believes that the AMA can be most influential in addressing the need for hearing services through improving mechanisms already in place. Physicians should educate and encourage their patients on lower cost hearing aids that are now available over the counter for mild to moderate hearing loss. Additionally, the AMA can encourage the USPSTF to re-evaluate its decision not to recommend screening for hearing loss in asymptomatic adults over age 65, especially considering the new evidence that exists about the connection of hearing loss and dementia. Hearing loss caught and treated early could prevent the onset of dementia and improve quality of life for the aging population.

Finally, the Council believes that AMA policy on vision coverage could be strengthened, and we recommend amendments to Policy H-25.990 to encourage programs and outreach efforts for affordable prescription eyeglasses.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted in lieu of the referred Resolve clause of Alternate Resolution 113-A-22, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support physician and patient education on the proper role of over the counter hearing aids, including the value of physician-led assessment of hearing loss, and when they are appropriate for patients and when there are possible cost-savings. (New HOD Policy)
2. That our AMA encourage the United States Preventive Services Task Force to re-evaluate its determination not to recommend preventive hearing services and screenings in asymptomatic adults over age 65 in consideration of new evidence connecting hearing loss to dementia. (New HOD Policy)
3. That our AMA amend Policy H-25.990 by addition to read as follows:

Our AMA (1) encourages the development of programs and/or outreach efforts to support periodic eye examinations and access to affordable prescription eyeglasses for elderly

1 patients; and (2) encourages physicians to work with their state medical associations and
2 appropriate specialty societies to create statutes that uphold the interests of patients and
3 communities and that safeguard physicians from liability when reporting in good faith the
4 results of vision screenings. (Amend HOD Policy)

5
6 4. That our AMA reaffirm Policy D-160.925, which recognizes the importance of managing
7 oral health and the importance of dental care to optimal patient care and supports the
8 exploration of opportunities for collaboration with the American Dental Association
9 (ADA) on comprehensive strategy for improving oral health care and education for
10 clinicians. (Reaffirm HOD Policy)

11
12 5. That our AMA reaffirm Policy H-330.872, which supports the American Medical
13 Association's continued work with the ADA to improve access to dental care for Medicare
14 beneficiaries and supports initiatives to expand health services research on the
15 effectiveness of expanded dental coverage in improving health and preventing disease in
16 the Medicare population, the optimal dental benefit plan designs to cost-effectively
17 improve health and prevent disease in the Medicare population, and the impact of
18 expanded dental coverage on health care costs and utilization. (Reaffirm HOD Policy)

19
20 6. That our AMA reaffirm Policy H-185.929, which supports coverage of hearing tests
21 administered by a physician or physician-led team as part of Medicare's benefit and
22 policies that increase access to hearing aids and other technologies and services that
23 alleviate hearing loss and its consequences for the elderly and supports the availability of
24 over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss. (Reaffirm
25 HOD Policy)

26
27 7. That our AMA reaffirm Policy D-390.946, which supports the American Medical
28 Association's work towards the elimination of budget neutrality requirements within
29 Medicare Part B. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

- ¹CMS.gov. Access to Health Coverage. January 31, 2023. <https://www.cms.gov/pillar/expand-access>
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APPENDIX

Policies Recommended for Amendment or Reaffirmation

Importance of Oral Health in Patient Care D-160.925

Our AMA: (1) recognizes the importance of (a) managing oral health and (b) access to dental care as a part of optimal patient care; and (2) will explore opportunities for collaboration with the American Dental Association on a comprehensive strategy for improving oral health care and education for clinicians. (Res. 911, I-16; Reaffirmed: CMS Rep. 03, A-19)

Medicare Coverage for Dental Services H-330.872

Our AMA supports: (1) continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization. (CMS Rep. 03, A-19)

Eye Exams for the Elderly H-25.990

Our AMA (1) encourages the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients; and (2) encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings. (Res. 813, I-05; Reaffirmed: CSAPH Rep. 1, A-15)

Hearing Aid Coverage H-185.929

1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.
4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit.
5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.
6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.
7. Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss. (CMS Rep. 6, I-15; Appended: Res. 124, A-19)

Sequestration D-390.946

Our AMA will: (a) continue to prioritize and actively pursue vigorous and strategic advocacy to prevent sequester and other cuts in Medicare payments due to take effect on January 1, 2022; (b) seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs; (c) ensure Medicare physician payments are sufficient to safeguard beneficiary access to care; (d) work towards the elimination of budget neutrality requirements within Medicare Part B; (e) eliminate, replace, or supplement budget neutrality in MIPS with positive incentive

payments; (f) advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and that continued budget neutrality is not an option; and (g) advocate for payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services. (Res. 212, I-21; Reaffirmed: Res. 240, A-22)

REPORT 03 OF THE COUNCIL ON MEDICAL SERVICE (A-23)
Private Insurer Payment Integrity
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2022 Annual Meeting, the House of Delegates referred Resolution 110-A-22, which asked the American Medical Association to advocate for private insurers to require, at a minimum, to pay for diagnosis and treatment options that are covered by government payers such as Medicare and seek legislation or regulation to ensure that private insurers shall not be allowed to deny payment for treatment options as “experimental and/or investigational” when they are covered under government plans.

Private insurers may each make their own medical coverage determinations, which can vary across their product lines. Private insurers sometimes are able to deny coverage by labelling a diagnostic or treatment “investigational,” “experimental,” or “not medically necessary,” which may be exacerbated by the burdensome appeals process required to request reconsideration of a denial or adverse determination.

Of government payers, Medicare is typically considered the national benchmark, particularly since it is a federal defined benefit program, with decisions centralized within the Centers for Medicare & Medicaid Services. Medicare develops National Coverage Determinations (NCDs) that are applied for all Medicare beneficiaries meeting the coverage criteria. The NCD process is a transparent, nine-month, evidence-based process with opportunities for public comment and supplemental technological assessment, which may include clinical studies. The supposition that private insurers’ medical coverage determinations are more restrictive than Medicare’s is not necessarily true and may be based on the perception that traditional Medicare fee-for-service coverage is more robust due to its paucity of prior authorization requirements.

While the Patient Protection and Affordable Care Act (ACA) establishes benefit mandates in the form of essential health benefits (EHB), private ACA marketplace insurers have demonstrated hesitancy in fully embracing the ACA EHB benefit mandate, even as it continues to be challenged by decisions such as *Braidwood Management Inc. et al. v. Becerra et al.*

While maintaining a commitment to minimizing benefit mandates is essential, there is clearly a need for transparency of coverage determinations, specifically regarding disparities across insurer product lines. The NCD process is very robust and might serve as a template for establishing a comprehensive, evidence-based process to allow for consistency in determinations of experimental/investigational status and transparency in coverage determinations from which insurers can develop benefit packages. Use of such a process would eliminate seemingly arbitrary decisions by private insurers to deem a diagnosis and treatment option as “experimental/investigational” in order not to have to pay for it.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 03-A-23

Subject: Private Insurer Payment Integrity
(Resolution 110-A-22)

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee A

At the June 2022 Annual Meeting, the House of Delegates referred Resolution 110, which was sponsored by the New York Delegation. Resolution 110-A-22 asked the American Medical Association (AMA) to advocate for private insurers to require, at a minimum, to pay for diagnosis and treatment options that are covered by government payers such as Medicare and seek legislation or regulation to ensure that private insurers shall not be allowed to deny payment for treatment options as “experimental and/or investigational” when they are covered under government plans. Testimony at the June 2022 Annual Meeting regarding the resolution was generally opposed, highlighting the complex issues surrounding private insurer versus governmental coverage, specifically regarding benefit mandates and the differential drivers utilized in making medical coverage determinations. This report focuses on the need for transparency of medical coverage determinations, studies how ‘investigational’ diagnosis and treatment options are determined, highlights essential AMA policy, and presents new policy recommendations.

BACKGROUND

Coverage Determinations by Private Insurers

Private insurers are a fragmented group of commercial plans operating under a broad range of federal regulations as well as insurance and coverage rules and regulations that vary by state. Some private insurers operate nationally. While they may look to governmental precedent in certain situations, they each make their own medical coverage determinations, which can vary across their product lines. Access to private insurers’ medical coverage decisions is limited, but not entirely restricted. For example, on the UnitedHealthcare (UHC) web site, the UHC commercial policy on coverage of “Off-Label/Unproven Specialty Drug Treatment” includes a Food & Drug Administration (FDA) section, noting that it is “to be used for informational purposes only...FDA approval alone is not a basis for coverage.”

Private insurers sometimes are able to deny coverage by labelling a diagnostic or treatment “investigational,” “experimental,” or “not medically necessary,” which may be exacerbated by the burdensome appeals process required to request reconsideration of a denial or adverse determination. Patients are typically not aware of their right to appeal or legal due process protections. This health insurance illiteracy is compounded among patients with limited access to technology and other resources, leading to the potential for substantial health inequities across private plans.

Coverage Determinations by the Centers for Medicare & Medicaid Services

Of government payers, Medicare is typically considered the national benchmark, particularly since it is a federal defined benefit program, with decisions centralized within the Centers for Medicare & Medicaid Services (CMS). Title XVIII of the Social Security Act established Medicare with coverage that is limited to items and services that are:

- reasonable and necessary for the diagnosis or treatment of an illness or injury; and
- within the scope of a Medicare defined benefit category.

National Coverage Determinations

The vast majority of Medicare coverage is determined on the local level by clinician contractors (Medicare Administrative Contractors [MACs] making Local Coverage Determinations [LCDs]). However, in some cases, Medicare develops National Coverage Determinations (NCDs) that are applied for all Medicare beneficiaries meeting the coverage criteria.

The NCD process is a nine-month, evidence-based process with opportunities for public comment and supplemental technological assessment by the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC), which may include clinical studies. If the NCD determines coverage of an item or service only in the context of clinical study, it falls under the Coverage with Evidence Development (CED) program. NCDs in the CED program use available evidence to fit that item or service within that benefit category. As such, CMS can act as a coverage gatekeeper via the NCD process. This mechanism has been used over the past few decades and includes evidence-based guidelines for coverage.

Since it has been nearly eight years since the criteria for CED were last evaluated, MEDCAC is currently re-examining the requirements for clinical studies submitted for CMS coverage under CED, acknowledging that the update is needed since technologies have become more complex. MEDCAC also has conveyed “a commitment to greater transparency in decision-making, to making certain that study methodologies are ‘fit to purpose’ as determined by the topic, questions asked, health outcomes studied, and to making certain that the populations studied are representative of the diversity in the Medicare beneficiary population.”¹

The NCD process has been amended on several occasions (e.g., The Medicare Prescription Drug, Improvement, and Modernization Act of 2003), with updates made to the process for opening, deciding, or reconsidering NCDs under the Social Security Act. The 2013 update developed an expedited administrative process utilizing specific criteria to remove certain NCDs older than ten years, thereby enabling MACs to determine coverage under the Social Security Act for sunset NCDs. For 2023, CMS has updated Medicare coverage policies for colorectal cancer screening in order to align with recent United States Preventive Services Task Force (USPSTF) and national medical specialty society recommendations.²

Transparency is a keystone to the process, as CMS issues an annual report listing the NCDs made in the previous calendar year in the form of a report to Congress. Additionally, there is an NCD dashboard, outlining the status of NCDs at each stage of the process (i.e., under review, reviewed but not yet opened, opened and undergoing national coverage analysis, and finalized). CMS houses all Medicare coverage determinations in the Medicare Coverage Database (MCD). The MCD includes LCDs as well as NCDs, along with reports on each.

The supposition that private insurers' medical coverage determinations are more restrictive than Medicare's may be based on the perception that traditional Medicare fee-for-service coverage is more robust due to its paucity of prior authorization requirements. Data indicates otherwise, such as with NCDs for medical devices. For each of the 47 medical devices considered for NCDs between February 1999 and August 2013, it was found that NCDs were equivalent to the corresponding private insurer policies roughly half of the time, more restrictive approximately a quarter of the time, and less restrictive about a quarter of the time.³

Food and Drug Administration

The notion that Medicare "adopts" diagnostic and treatment options once approved by the FDA is similarly problematic. Medicare does not automatically cover all FDA-approved devices and drugs. Between 1999 and 2011, Medicare covered FDA-approved drugs or devices only 80 percent of the time.⁴ Additionally, Medicare has been found to have more stringent requirements than the FDA, particularly for drugs or devices in patients with comorbidities.

The Medicare Benefit Policy Manual (Chapter 14 – Medical Devices) outlines that Medicare will cover FDA-approved and Institutional Review Board (IRB)-approved investigational devices "provided the investigational device meets certain requirements, including: (1) The device or services associated with the use of a device are provided to the beneficiary within the start and end dates contained in the master file; (2) There are no regulations, national coverage policies, or manual instructions that would otherwise prohibit Medicare coverage."

Medicare Investigational Device Exemption

While Medicare normally does not cover experimental or investigational procedures, it does offer an exemption for investigational devices to allow for coverage under some circumstances. The Medicare Investigational Device Exemption (IDE) was developed as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and includes two categories:

- Category A (Experimental): An innovative/experimental device for which "absolute risk" of the device type has not been established (i.e., initial questions of safety and effectiveness have not been resolved and the FDA is unsure whether the device type can be safe and effective). There is no Medicare coverage for a Category A device but Medicare covers routine care items and services in the trial. An example is the [CG-100 Intraluminal ByPass Device](#).
- Category B (Non-experimental/non-investigational): A device for which the underlying questions of safety and effectiveness of that device type have been resolved. Medicare allows for coverage of the Category B device as well as for routine care items and services in the trial. An example is the [Viper Catheter System](#).

In 2015, CMS shifted responsibility for review and approval of IDE studies from the MACs to a centralized CMS process, which includes a publicly accessible, updated list of Approved IDE Studies.

Medicare Coverage of Innovative Technology and Definition of Reasonable and Necessary

In January 2021, CMS released a final rule on The Medicare Coverage of Innovative Technology and Definition of "Reasonable and Necessary,"⁵ which established pathways to payment for innovative technologies supported by high-quality, validated clinical data. The rule automatically

provided four years of coverage for all Medicare beneficiaries for newly approved medical devices, in order to accelerate availability of medical devices approved through the FDA breakthrough pathway for innovative technologies.

As part of the rule, CMS proposed automatically transferring the coverage policy of commercial insurance to Medicare beneficiaries for new products. In two identical comment letters (November 2020 and April 2021), the AMA outlined several concerns with the proposal, namely the potential loss of transparency in Medicare coverage decisions if tied to commercial health insurer policies beholden to shareholder expectations. The independent, public comment process utilized by CMS to make coverage decisions appropriate for the Medicare population would be replaced with coverage decisions based on objectives such as litigation avoidance or competitive advantage. The AMA argued that the focus should remain on what is most suitable and safest for Medicare beneficiaries based on Medicare's determination.

After considering these and other comments, CMS rescinded the rule in November 2021, citing concerns about lack of sufficient patient protections and lack of evidence of clinical benefit for the newly approved medical devices in the Medicare population. At the present time, CMS is working on a new proposed rule to create an accelerated Medicare coverage pathway, building on prior initiatives such as CED.⁶

AFFORDABLE CARE ACT BENEFIT MANDATES

The Patient Protection and Affordable Care Act (ACA) requires non-grandfathered health plans in the individual and small group markets to cover the following essential health benefits (EHB): (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. The Department of Health and Human Services (HHS) regulations define EHB using state-specific benchmarks. Since 2020, states have been granted greater flexibility in establishing new standards for their EHB benchmark plans. Non-grandfathered health plans cannot refuse coverage or limit benefits for pre-existing conditions.

Since the passage of the ACA in 2010, there have been more than 2,000 state and federal actions attempting to limit, alter, or repeal it.⁷ Most recently, in *Braidwood Management Inc. et al. v. Becerra et al.*, a federal judge ruled that insurers are no longer required to provide preventive services recommended by USPSTF at no cost. While some states have challenged parts or all of the ACA through legislation, others have acted to preserve the ACA by codifying certain provisions into state law.

Private ACA marketplace insurers have demonstrated hesitancy in fully embracing the ACA EHB benefit mandate, even as it continues to be challenged. For example, while insurers were initially required to cover preexposure prophylaxis (PrEP), a medication that prevents the transmission of human immunodeficiency virus in high-risk populations (e.g., gay and bisexual men of color) without cost sharing, not all insurers extended the benefit to the ancillary services (e.g., venipuncture, office visits) required to provide PrEP. HHS had to issue subsequent guidance to clarify that insurers were required to cover PrEP ancillary services under their EHBs. As decisions such as *Braidwood Management Inc. et al. v. Becerra et al.*, erode the ACA EHB benefit mandate, it will become increasingly important that private ACA marketplace insurers are held accountable for covering all current ACA EHB benefit mandates.

AMA POLICY

The AMA’s longstanding goals to allow markets to determine benefit packages in order to permit a wide choice of coverage options and to refrain from jeopardizing coverage to currently insured populations are reflected in numerous AMA policies as well as in the AMA Proposal for Reform, which is grounded in AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients. AMA policy supports the minimization of benefit mandates to allow markets to determine benefit packages, permitting a wide choice of coverage options.

Among the most relevant policies are those that:

- Oppose new health benefit mandates unrelated to patient protections (Policy H-185.964);
- Advocate for the minimization of benefit mandates (Policy H-165.856);
- Support maximization of patient choice (Policy H-165.839) and free market choice of plans (Policy H-330.912);
- Encourage payers to utilize transparent and accountable processes for developing and implementing coverage decisions and policies (Policy D-185.986);
- Assure reasonable payment levels for mandated benefits in health insurance policies (Policy D-385.966); and
- Call for the AMA to develop model legislation and/or regulations to require that commercial insurance companies, state Medicaid agencies, or other third party payers utilize transparent and accountable processes for developing and implementing coverage decisions and policies (Policy D-185.986).

While AMA policy opposes blanket benefit mandates, there is policy on coverage of specific conditions and services. For example, Policy H-185.967 supports that treatment of pediatric congenital or developmental deformities or disorders due to trauma or malignant disease should be covered by all insurers, Policy H-185.957 supports legislation that requires all third party payers that cover surgical benefits to cover all strabismus surgery where medically indicated, and Policy D-185.973 encourages insurance coverage of and payment for reconstructive services for the treatment of physical injury sustained from intimate partner violence. The AMA defended Policy D-185.979 by filing an [amicus brief](#) in *Braidwood Management Inc. et al. v. Becerra et al.*, which challenged support for first dollar coverage of preventive services.

The AMA definition of “medical necessity” (Policy H-320.953), urges payers to share third party methodologies for determining medical necessity, and advocates for the opportunity for treating physicians to provide medical evidence toward those determinations (Policy H-320.995). The AMA’s definition of medical necessity is included in state model legislation and has been enacted in several states as a required definition, rather than allowing plans to develop their own definitions. Policies H-320.968 and H-320.982 support that denial of medical necessity of services or request for prior authorization be recommended by a physician of the same specialty as the treating physician.

Finally, there is AMA policy to protect patients and physicians and encourage innovation in the context of experimental or investigational treatments. Policy D-460.967 calls for the AMA to study the implementation of expanded access programs, accelerated approval mechanisms, and payment reform models to increase access to investigational therapies. Policy H-460.965 states that the AMA should pursue legislation and regulatory reform to mandate third party payer coverage of patient care costs of nationally approved scientifically based research protocols. Policy H-480.996 supports that regulations be promulgated or interpreted so as to not interfere with the

1 patient/physician relationship or impose regulatory burdens that may discourage creativity and
2 innovation in advancing device technology.

3 4 DISCUSSION

5
6 While maintaining a commitment to minimizing benefit mandates is essential, there is clearly a
7 need for transparency of coverage determinations, specifically regarding disparities across insurer
8 product lines. An insurer may cover something considered preventive under one product line yet
9 fail to cover the same thing under another product line. Such arbitrary coverage decisions not only
10 question payer integrity but also introduce superfluous physician administrative burdens, such as
11 prior authorization requirements.

12
13 While the AMA advocates for market-based solutions for coverage, there is presently a floor of
14 benefits nationally as ACA plans must cover certain conditions. ACA coverage decisions for non-
15 elective care at a basic level is necessary so that essential care is not determined by a patient's
16 socioeconomic status. While it would be helpful for private and governmental insurers to be
17 cognizant of each other's coverage decisions, it may not be ideal for them to be perfectly aligned
18 given that Medicare is sometimes more restrictive and sometimes less restrictive. However, to
19 encourage innovation, the process for gaining coverage must be transparent and expeditious. It
20 would be beneficial to continue to expand the ability of CMS to proactively engage coverage of
21 breakthrough therapies and devices at product launch – rather than having to wait for an NCD to be
22 established. When CMS requires additional studies prior to coverage, this feedback should ideally
23 be provided during the product development phase, not after the product is approved and available
24 to the public, when finding patients to enroll in trials is more difficult.

25
26 The NCD process is very robust and might serve as a template for establishing a comprehensive,
27 evidence-based process to allow for consistency in determinations of experimental/investigational
28 status and transparency in coverage determinations from which insurers can develop benefit
29 packages. The process could include online tools to allow physicians to easily check coverage
30 status rather than requiring completion of a prior authorization form and waiting for a response.
31 Implementation of such a process would not preclude private insurers from offering additional or
32 alternative benefits that would distinguish their products in the marketplace, allowing for a wide
33 choice of coverage options in keeping with AMA policy. In following established precedents, it
34 may amend the base level for what is considered medically necessary care (e.g., USPSTF grade A
35 or B recommendations are covered without cost-sharing under the ACA).

36
37 Use of such a process would eliminate seemingly arbitrary decisions by private insurers to deem a
38 diagnosis and treatment option as “experimental/investigational” in order not to have to cover it.
39 There is considerable variation in how “experimental/investigational” diagnosis and treatment
40 options are determined, which only escalates concerns regarding subjective and inequitable
41 decisions. While some insurers may define experimental/investigational services as an intervention
42 that has not yet been determined to be medically effective for the condition being treated, others
43 describe it as something that has undergone basic laboratory testing and received approval from the
44 FDA to be tested in human subjects. The definition of experimental/investigational is a continuum
45 rather than a standard as it is contingent upon discrete, independent evaluations that vary from
46 insurer to insurer. While insurers may profess applying reasonable interpretation of their policy
47 provisions, those are also variable and lacking a standard.

1 RECOMMENDATIONS

2
3 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
4 110-A-22, and the remainder of the report be filed:

- 5
6 1. That our American Medical Association (AMA) support the development of a
7 comprehensive, evidence-based process to establish consistency in determinations of
8 experimental/investigational status and transparency in coverage determinations from
9 which insurers can develop benefit packages. (New HOD Policy)
10
11 2. That our AMA support voluntary programs that expedite review for coverage by private
12 and governmental insurers when requested by either the manufacturer or third parties such
13 as national medical specialty societies. (New HOD Policy)
14
15 3. That our AMA amend Policy D-185.986 by the addition of one new clause, as follows:
16 4. Our AMA will advocate that when clinical coverage protocols are more restrictive than
17 governmental payers, that private insurers and benefit managers should include the clinical
18 rationale substantiating their coverage policies. (Modify Current HOD Policy)
19
20 4. That our AMA reaffirm Policy H-185.964, which opposes new health benefit mandates
21 unrelated to patient protections.(Reaffirm HOD Policy)
22
23 5. That our AMA reaffirm Policy H-165.856, which advocates for the minimization of benefit
24 mandates. (Reaffirm HOD Policy)
25
26 6. That our AMA reaffirm Policy H-320.995, which urges payers to share third party
27 methodologies for determining “medical necessity,” and advocates for the opportunity for
28 treating physicians to provide medical evidence toward those determinations. (Reaffirm
29 HOD Policy)
30
31 7. That our AMA reaffirm Policy D-460.967, which calls for study of the implementation of
32 expanded access programs, accelerated approval mechanisms, and payment reform models
33 to increase access to investigational therapies. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

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⁶ Fleisher LA, Blum JD. A Vision of Medicare Coverage for New and Emerging Technologies—A Consistent Process to Foster Innovation and Promote Value. *JAMA Intern Med*. 2022;182(12):1241–1242. doi:10.1001/jamainternmed.2022.5085. Available at: <https://pubmed.ncbi.nlm.nih.gov/36223138/>

⁷ Sobel L, Ranji U, Pestaina K, Dawson L, Cubanski J. Explaining Litigation Challenging the ACA’s Preventive Services Requirements: Braidwood Management Inc. v. Becerra. KFF Women’s Health Policy. October 26, 2022. Available at: <https://www.kff.org/womens-health-policy/issue-brief/explaining-litigation-challenging-the-acas-preventive-services-requirements-braidwood-management-inc-v-becerra/>

REPORT 04 OF THE COUNCIL ON MEDICAL SERVICE (A-23)
Bundled Payments and Medically Necessary Care
(Resolution 111-A-22)

EXECUTIVE SUMMARY

At the 2022 Annual Meeting, the House of Delegates referred Resolution 111, which asked the American Medical Association (AMA) to 1) advocate that coverage rules for Medicaid “episodes of care” be carefully reviewed to ensure that they do not incentivize limiting medically necessary services for patients to allow better reimbursement for recipients of the bundled payment; 2) study the issue of bundled payments and medically necessary care with a report back to explore the unintended long-term consequences on health care expenditures, physician reimbursement, and patient outcomes; and 3) advocate that functional improvement be a key target outcome for bundled payments.

The Council’s review of the literature on select Medicare bundled payment models and Medicaid episodes of care found that lower extremity joint replacement (LEJR) bundles, and some perinatal episodes of care, have produced the most—but still modest—savings without compromising care quality. Because the evidence is clear that the savings accrued under LEJR episodes has been due to decreased spending on skilled nursing and inpatient rehabilitation facilities, some physicians have questioned whether patient access to medically necessary care, including institutional post-acute care, could potentially be limited. The Council believes that performance metrics measuring key patient-centered outcomes, including functional improvements after orthopedic and other procedures, are important and necessary checks on the risk that some models may underserve patients. Because the AMA already has extensive policy on alternative payment models (APMs), we recommend amending Policies H-390.849[2, 3] and D-385.952[1, 2] to address this concern instead of crafting a separate policy statement specific to bundled/episode-based payments.

To address other concerns and obstacles under bundled/episode-based payment models, the Council recommends reaffirmation of Policy H-385.907, which supports fair and accurate risk adjustment systems, and Policy H-385.913, which outlines goals to be pursued as part of physician-focused APMs—including that models be designed by physicians or with significant input from physicians, provide flexibility to physicians to deliver the care patients need, provide adequate and predictable resources, and avoid placing physician practices at substantial financial risk—and directs the AMA to continue to work with national medical specialty societies and state medical associations to educate physicians on APMs. The Council believes that well-designed, patient-centered bundled payment models can improve care quality and patient outcomes in ways that also lower growth in health care spending. Designing these models to work effectively for patients, physicians, and payers remains challenging, and ongoing refinements to models may be needed to ensure optimal patient outcomes as these initiatives continue to expand.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 04-A-23

Subject: Bundled Payments and Medically Necessary Care
(Resolution 111-A-22)

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee A

At the 2022 Annual Meeting, the House of Delegates referred Resolution 111, which was cosponsored by the American Academy of Physical Medicine and Rehabilitation and the Ohio delegations. Resolution 111-A-22 asked the American Medical Association (AMA) to 1) advocate that coverage rules for Medicaid “episodes of care” be carefully reviewed to ensure that they do not incentivize limiting medically necessary services for patients to allow better reimbursement for recipients of the bundled payment; 2) study the issue of bundled payments and medically necessary care with a report back to explore the unintended long-term consequences on health care expenditures, physician reimbursement, and patient outcomes; and 3) advocate that functional improvement be a key target outcome for bundled payments.

The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates. This report adds to the body of reports developed by the Council on alternative payment models (APMs) by providing background information specific to bundled/episode-based payment models, summarizing the literature on prominent Medicare and Medicaid models, reviewing relevant AMA policy and advocacy, and making policy recommendations.

BACKGROUND

Bundled or episode-based payments are a type of APM in which a single comprehensive payment amount covers services delivered by multiple providers during an episode of care. An episode of care is the care delivery process for a certain condition or procedure delivered within a defined period of time. State Medicaid programs use the term episodes of care to describe payment models in which a single bundled payment is made for services associated with the treatment of a condition or procedure. The models aim to lessen variations in cost and quality by incentivizing providers (e.g., physicians, hospitals, post-acute care facilities, and others providing services during the episode) to work together and manage costs without compromising care quality. Providers able to keep costs below a risk-adjusted target price for an episode may share in any savings and, conversely, those exceeding that threshold may incur financial penalties. Savings can be generated if, as is often the case, the target price is a discount of what has historically been paid, or if lower-cost facilities and providers are utilized during the episode. To guard against underserving patients, some models impose limits on gainsharing payments and/or require that certain quality metrics be met.

Medicare, state Medicaid programs, and many private insurers have adopted bundled or episode-based payment models to varying degrees with perinatal and joint replacement models increasingly prevalent across multiple payers. Although Medicare has administered bundled payments for many years, provisions in the Affordable Care Act (ACA) accelerated their use, along with other APMs,

1 by establishing the Center for Medicare & Medicaid Innovation (CMMI) and authorizing it to
2 develop and test new payment models without the need for Congressional approval. In 2015, the
3 Department of Health and Human Services announced national goals for transitioning to value-
4 based medicine and APMs; the same year, Congress passed the Medicare Access and CHIP
5 Reauthorization Act (MACRA), which among other things established incentive payments for
6 physicians to participate in advanced APMs. Centers for Medicare & Medicaid Services (CMS)
7 and a handful of states continue to experiment with episode-based payment approaches, such as
8 lengthier and more inclusive episodes and those that span multiple providers and/or sites of service.
9 Importantly, there is substantial variance among bundled/episode payment designs, with larger and
10 more widely implemented models including Medicare's Bundled Payments for Care Improvement
11 (BPCI) Advanced initiative and the Comprehensive Care for Joint Replacement (CJR) model.

12
13 Medicare bundles have informed some Medicaid episodes of care although states have generally
14 adapted APMs to suit the unique needs of their Medicaid enrollees and health care in their states.¹
15 Notably, state Medicaid programs and Medicaid providers are at various stages of implementation
16 of value-based payment reforms and, to address ongoing budget pressures, many states have
17 pursued APMs to reduce cost growth in Medicaid while improving care quality. Because 70
18 percent of Medicaid enrollees are enrolled in managed care,² states often use contracting strategies
19 with managed care organizations (MCOs) to leverage the use of value-based payments, including
20 episodes of care. For example, more than half of states (20 of 37) that contract with MCOs to
21 manage care delivered to Medicaid enrollees require those plans to make a certain percentage of
22 provider payments through APMs, while some states require MCOs to adopt specific models.
23 Several states use financial incentives—and/or penalties—to compel MCOs to pursue value-based
24 payment models. To date, the use of episode-based payments has generally been limited to those
25 states that prescriptively define and require such models, including for joint replacement and
26 perinatal episodes of care.³ In a 2021 Kaiser Family Foundation survey, eight states (CO, NM, NY,
27 OH, PA, TN, VT, and VA) reported implementing episodes of care in Medicaid, although this
28 number changes as states implement new models while sunseting others.⁴

29
30 Most, but not all, bundled payment models are voluntary; the CJR initiative, which is mandatory in
31 certain areas and voluntary in others, and Medicaid models in some states, are exceptions. Beyond
32 that, bundled payment initiatives differ from each other in terms of duration, payment rules, and the
33 types of services included. Episodes can range from shorter durations to lengthier periods, as for
34 perinatal models that span the prenatal through postpartum periods. Although payments for
35 episodes of care can be determined prospectively or based on fee-for-service with retrospective
36 adjustments, most of the models discussed in this report adjust payments retrospectively.
37 Additionally, add-on payments covering high-cost or outlier cases may be made available to
38 varying degrees, depending on the model design. With respect to outliers, Policy H-385.907
39 advocates that bundled payments should recognize the differences in patients' needs and payment
40 amounts should be risk stratified to reflect patients who need more resource-intensive services. The
41 menu of services paid for in a bundle also varies significantly across models and affects the types
42 of providers that participate. Notably, the CJR model includes most Part A and Part B services,
43 except for hospice and a few other carve-outs, while other models pay for a narrower set of
44 services.

45
46 Physician participation in bundled payment models has increased steadily over the past decade, as
47 evidenced by data from the AMA's Physician Practice Benchmark Surveys, which are nationally
48 representative samples of non-federal physicians who provide care to patients at least 20
49 hours per week. According to recent Benchmark surveys, 32.0 percent of physicians were in
50 practices involved in bundled payments in 2012. This increased to 34.8 percent in 2016 and topped
51 40 percent in 2020 and 2022 for a cumulative increase of eight percentage points. Additionally, in

2022, an average of 10 percent of practice revenue (at the physician level) came from bundled payments.⁵

The main obstacles to effective bundled payments are accurately defining care episodes, pricing the bundles, and ensuring adequate payment for care provided by all team members across all sites of service. Physicians have expressed concerns regarding both the financial arrangements and administrative burdens incurred, including the degree of financial risk required to participate, the potential for financial strain if the fixed payment amount does not accurately reflect the costs of the episode, the potential for decreased payments, and administrative hurdles, especially when participating in more than one APM. Additional concerns include high dropout rates among hospitals participating in some models, the potential for some models to become mandatory, and the ability of small physician practices to participate. In the Whereas clauses, the authors of Resolution 111-A-22 highlighted concerns about the occurrence of unrelated—and costly—events during a care episode, increased expenses for complex patients, the need for skilled nursing care by some patients, and possible incentives to lessen costs by decreasing patient access to services they may need.

Defining what is related and unrelated to a bundle can be problematic with episode models, yet decisions about covered services are critical to ensuring appropriate payment. Care for unrelated conditions and procedures that takes place within the duration of an episode can be costly and potentially increase spending beyond the target price of the bundle. Importantly, the AMA maintains that APMs should be designed by physicians or with significant input from physicians in part so they can influence decisions about covered services and advocate that care for unrelated events (e.g., cataract surgery during a 90-day lower extremity joint replacement (LEJR) episode) not be paid for out of the bundled payment. The AMA also advocates that financial risk requirements be limited to costs that physicians participating in an APM are able to influence or control.

An additional shortcoming of many of the larger Medicare bundled payment models is that they start with a hospitalization for a procedure. If, for example, episodes began with an evaluation for hip, knee, or back pain, or other condition, there would be more opportunities to save money and improve quality by, for example, engaging in patient-physician shared decision making strategies that could potentially prevent hospitalizations and procedures altogether. Specific to Medicaid, staffing, resource, and leadership capacity to develop and implement new models can be major obstacles to implementing payment initiatives and, for this reason, state Medicaid directors have asked CMS to provide upfront resources for states to engage in delivery system and payment reforms.⁶ Additionally, risk thresholds may dissuade some Medicaid providers, especially those practicing in states with particularly low payment rates, from participating in episode-based payment models if they feel they cannot take on financial risk. Importantly, Medicaid enrollees may have complex care needs and/or experience inequities in social determinants of health—such as housing instability, food insecurity, or lack of transportation—that impact their care and health outcomes. They also face unique barriers to care and may churn in and out of Medicaid, which could lead some Medicaid providers to believe they will be disproportionately penalized under APMs without sufficient risk adjustment.

Many of these obstacles have been addressed in previous reports and policy development by the Council on Medical Service. [Council on Medical Service Report 9-A-16](#) established foundational policy on physician-focused APMs while [Council on Medical Service Report 10-A-17](#) focused on reducing some of the barriers to participating in these models and the need for changes to risk adjustment systems, attribution methods, and performance target setting. AMA policy established by [Council on Medical Service Report 10-A-19](#) addressed concerns raised by many that physicians

1 serving people who are sicker or experiencing poverty are disproportionately penalized by APMs.
2 [Council on Medical Service Report 3-I-19](#) established new policy on improving risk adjustment in
3 APMs, including that risk stratification systems should use fair and accurate payments based on
4 patient characteristics, and that risk adjustment systems should use fair and accurate outlier
5 payments if spending on an individual patient exceeds a predefined threshold. Concerns about
6 APMs, and AMA advocacy to improve upon value-based payment models, were also discussed in
7 [Council on Medical Service Report 2-A-22](#), which focused on prospective payment model best
8 practices for independent private practice.
9

10 EVIDENCE OF EFFECTIVENESS

11 *Select Medicare Bundled Payment Models*

12
13
14 Bundled/episode-based payments have been implemented for numerous surgical procedures and
15 medical conditions and remain a leading value-based payment reform in Medicare. Lacking the
16 capacity to thoroughly study the impact of all Medicare bundled payment models implemented
17 over the years, the Council reviewed independent evaluations of the larger CMS initiatives and
18 more recent analyses in the literature examining the impact of multiple bundles on Medicare
19 spending, quality of care, and unintended consequences. Information on a unique episode program
20 for non-hospital physicians developed as part of Maryland's statewide CMMI initiative is also
21 provided.
22

23 *BPCI*: One of the largest Medicare models was the voluntary BPCI initiative—four model designs
24 that offered episode-based payments to over 1,000 hospitals, physicians, and post-acute care
25 providers for 48 different clinical episodes over five years (2013-2018).⁷ Consistent with previous
26 findings, the final BPCI evaluation showed that the initiative reduced Medicare spending per
27 episode due primarily to declines in institutional post-acute care utilization and decreases in the
28 number of skilled nursing facility (SNF) days for those that needed SNF care. However, after
29 accounting for reconciliation payments to eligible providers, BPCI did not increase net Medicare
30 savings; instead, the initiative resulted in net increased Medicare spending beyond what it was
31 estimated to be in absence of the model.⁸ Evaluations further demonstrated that BPCI generally did
32 not affect quality of care as measured by emergency department visits, mortality, and hospital
33 readmissions. The evidence was mixed and included both positive and negative associations
34 between BPCI models and patient functioning,⁹ and fewer BPCI patients reported the highest level
35 of satisfaction with their care.¹⁰ Importantly, two studies analyzing outcomes of high-risk patients
36 found that participation in BPCI did not adversely impact their quality of care.^{11,12}
37

38 *BPCI Advanced*: Building on the experiences and lessons learned from BPCI, the BPCI Advanced
39 initiative—which includes bundles with one risk track and a 90-day duration—was launched in
40 2018 and has been extended to run through 2025. BPCI Advanced links performance on select
41 quality metrics to incentive payments and qualifies as an Advanced APM. Accordingly,
42 participating physicians who meet certain cost thresholds may be eligible for a five percent APM
43 incentive payment. Participation in BPCI Advanced is currently voluntary and notably widespread,
44 with 1,295 hospitals and physician groups participating in years one and two (2018 and 2019) and
45 more than 2,000 participating in year three (2020).¹³ CMS continues to use results from its
46 independent evaluations to refine the initiative, which reduced episode payments overall in 2018
47 and 2019 and produced greater savings (\$1,353 per episode) for surgical episodes than for medical
48 episodes (\$564 per episode).¹⁴ After accounting for reconciliation payments made to BPCI
49 Advanced providers in 2018 and 2019, the independent evaluator found that the initiative resulted
50 in net Medicare savings for surgical episodes and net increased Medicare spending for medical
51 episodes with an overall increase in Medicare spending of \$65.7 million.¹⁵ Consistent with BPCI

1 and other bundles, episode savings were primarily attributed to lower payments to post-acute care
 2 sites, including SNFs and inpatient rehabilitation facilities. Importantly, quality of care was not
 3 adversely impacted; in fact, BPCI Advanced has been found by the evaluators to reduce
 4 readmissions for surgical episodes and to not worsen mortality rates.¹⁶ A separate study of BPCI
 5 Advanced, published in 2022, also found the initiative to be associated with a net increase in
 6 Medicare spending because bonuses paid to eligible hospitals exceeded episode payment
 7 reductions.¹⁷ This study further found that hospitals caring for historically marginalized
 8 populations received large bonuses under BPCI Advanced, possibly due to initial episode target
 9 pricing, which was subsequently adjusted by CMS.¹⁸

10
 11 *CJR*: The CJR model pays for care episodes that extend through 90 days after discharge from both
 12 inpatient and outpatient settings for some of the most common surgeries among Medicare
 13 patients—hip, knee, and, more recently, ankle replacements, also referred to as LEJR.¹⁹ CJR began
 14 in 2016 and has been mandatory since 2017 for hospitals in 34 geographic areas where spending
 15 had been historically high.²⁰ Over CJR’s first four years, payments across LEJR episodes in CJR’s
 16 mandatory areas were 5.2 percent lower than the baseline, with payments averaging \$1,511 less per
 17 episode. An independent evaluation estimated small net savings for the Medicare program in
 18 earlier years but was unable to conclude definitively that Medicare realized net savings over the
 19 first four years of the initiative. Over the four-year period, independent evaluators estimated that,
 20 after accounting for reconciliation payments, net savings ranged from a possible \$15.3 million
 21 more in Medicare spending to \$167.2 million in savings.²¹ Similar to other surgical bundles,
 22 changes in post-acute care utilization drove the decrease in average episode payments, as fewer
 23 patients were discharged to SNFs and rehabilitation facilities, and patients who went to SNFs spent
 24 fewer days there. When compared to the control group, a larger proportion of CJR patients were
 25 discharged to home health agencies, which cost significantly less than institutional post-acute
 26 care.²² CJR patient care quality, as measured by unplanned readmissions, emergency department
 27 use, and mortality rates, was maintained over the four-year period. Furthermore, patients in the
 28 CJR and control groups reported similar functional status gains, pain levels, and overall
 29 satisfaction, although some CJR patients reported that they required more caregiving help at home
 30 and CJR hip replacement patients reported less improvement on three of eight functional status
 31 measures.²³ In terms of unintended consequences, evaluators identified a decrease in patient
 32 complexity that could indicate some level of risk selection but no evidence of increased LEJR
 33 volume.²⁴ Although a *New England Journal of Medicine* study of CJR’s first two years did not find
 34 adverse effects on complications, hospital readmissions, or mortality, it did not look at functional
 35 status, pain, and patient satisfaction indicators. This study examined whether the CJR program
 36 incentivizes hospitals to 1) treat healthier rather than sicker patients (risk selection); and/or 2)
 37 reduce the use of SNF and inpatient rehabilitation. With regard to risk selection, the study noted
 38 inconsistent evidence in previous studies and no changes in patient selection in the current study
 39 other than some evidence that fewer disabled patients underwent procedures.²⁵ Because CJR did
 40 not negatively affect complications, readmissions, or mortality, the study authors concluded that
 41 hospitals may have correctly identified patients who could be appropriately discharged home with
 42 home health instead of being referred to institutional post-acute settings.²⁶

43
 44 A systemic review of CMS’s Acute Care Episode Demonstration (a three-year bundled payment
 45 model for inpatient cardiac and orthopedic surgeries), BPCI, and CJR initiatives found no
 46 associations between these Medicare models and 1) quality of care—as measured by readmissions,
 47 emergency department visits, and mortality—and 2) unintended consequences, such as increased
 48 utilization or risk selection.²⁷ This review further found that, in six out of 16 studies that evaluated
 49 spending, bundled payments significantly decreased episode costs; importantly, these six studies
 50 focused on orthopedic surgery and four of the six looked at LEJR episodes. Other clinical or
 51 medical episodes were not found to be associated with episode savings.²⁸ A separate review of 16

Medicare bundled payment initiatives similarly found that Medicare spending decreased for LEJR episodes but not for most other bundled payment models unless provider fees were heavily discounted.²⁹ This review found limited evidence of risk avoidance across models although the evidence was mixed.³⁰ The authors highlighted the association between bundled payments and post-acute care spending, with payments and service intensity more likely to decrease under bundles that included post-acute care services in the bundle and increased post-acute care utilization in models that did not include post-acute care services in the bundle. Like other studies, no association was found between bundled payments and increased episode volume.³¹

Episode Programs in Maryland: Within its Total Cost of Care All-Payer Model, Maryland has several CMMI-approved advanced payment initiatives specific to that state, including the Episode Quality Improvement Program (EQIP) launched in 2022 for specialist physicians in Medicare.³² This program provides opportunities for more non-hospital providers to participate in bundles relevant to a range of specialties, including gastroenterology, cardiology, and orthopedics, which were implemented in year one, as well as additional episodes that have been rolled out since. As of January 2023, 43 medical specialties were represented in 45 episodes available under EQIP.³³

Select Medicaid Episodes of Care

Although Medicaid programs employ a range of value-based payment programs, including episodes of care for various conditions and procedures, they have not been as high profile as some Medicare-focused models. Furthermore, while there is a wealth of published studies of Medicare bundled payment initiatives, the research literature is less robust for Medicaid models and not all states implementing episodes of care make cost and performance data publicly available. Accordingly, the Council reviewed available data from select states that were early adopters of episodes of care, including Tennessee, Ohio, and Arkansas, as well as a Medicaid and CHIP Payment and Access Commission (MACPAC) analysis of perinatal episodes implemented across three states.

Perinatal: Because Medicaid covers nearly half (42 percent in 2020) of all births in the U.S.,³⁴ several states have implemented episode-based payments for perinatal care. A 2021 MACPAC analysis reviewed perinatal episodes of care implemented in Arkansas, Colorado, and Tennessee. Although the Arkansas and Tennessee models were generally viewed positively in terms of reducing cost variations, Arkansas sunset its model, which had been mandatory, in 2021, due in part to administrative burdens on providers and diminishing returns as cost variations narrowed over time. The Tennessee and Arkansas models reduced costs per episode but produced mixed results on quality measures.³⁵ Because the Colorado model began later, in 2020, with only a few participants at the start, data on its impact on episode costs was not available at the time this report was written. Although high-risk pregnancies were excluded from episode-based payments in Arkansas and Tennessee, the Colorado model, which is voluntary, includes some high-risk patients, including those with substance use disorders. Importantly, while certain quality measures are tracked by states, there is no published evidence on the impact of perinatal episodes of care on maternal health or birth outcomes. Moreover, incentives are generally not tied to key metrics related to reductions in maternal morbidity and mortality, or impact on health disparities.³⁶

Tennessee: Aside from its perinatal model, Tennessee's Medicaid program, known as TennCare, has administered close to 50 episodes of care since 2013. TennCare reported that, in 2018, 22 of the 27 episodes of care tied to incentive payments saved the state an estimated \$38.3 million. The five that did not show savings were for acute percutaneous coronary intervention, non-acute percutaneous coronary intervention, gastrointestinal hemorrhage, bariatric surgery, and human immunodeficiency virus episodes, which the state described as low volume, making savings more

difficult to achieve. Episodes producing the most savings in 2018 included the perinatal model (\$13.5 million in savings), respiratory infection episode (\$6.8 million), and the asthma acute exacerbation episode (\$4.2 million).³⁷ Quality of care, as measured by certain performance metrics, was mostly maintained or improved except for low-volume episodes in which quality metric performance declined.³⁸ Because TennCare waived all episodes of care incentives through 2021 due to the Covid-19 pandemic, more recent evaluation data was not available for review.

Ohio: Ohio's Department of Medicaid, which has administered 43 episodes of care since 2015, similarly suspended its episodes of care incentives between 2020 and 2022 due to Covid-19's impact on the state's providers. Data from 2019 showed that Ohio's episodes of care covered more than 1.5 million patients that year, or 51 percent of the state's Medicaid enrollees.³⁹ From 2013 to 2019, Ohio participated in CMMI's State Innovation Model (SIM) initiative, which helped facilitate the design and launch of the state's episodes of care as well as its comprehensive primary care program. Results from the first two years of Ohio's episodes of care program were generally positive and showed reductions in average episode costs overall with no adverse effects on care quality. For the nine episodes linked to incentives in 2017 (asthma exacerbation, chronic obstructive pulmonary disease exacerbation, perinatal, cholecystectomy, upper respiratory infection, gastrointestinal bleed, urinary tract infection, colonoscopy, and esophagogastroduodenoscopy), average non-risk-adjusted spending decreased by 0.9 percent annually, saving an estimated \$31.8-\$92.2 million.⁴⁰ That same year, providers received \$4 million in positive incentives and were accountable for \$4 million in negative incentives.⁴¹ In its final SIM report issued in 2019, the Ohio Department of Medicaid identified several factors that were key to the successful design and implementation of its episodes of care, including ongoing provider engagement, addressing provider challenges, streamlining reporting burdens, engaging private insurers in the state, facilitating consistency across public and private health plans, and aligning episodes of care with population health priorities. The episodes of care initiative further benefited from strong leadership in the state, a dedicated innovation team, and alignment with federal models. In 2019, Ohio's episodes of care model was approved as an advanced APM.⁴²

Arkansas: Support from the federal SIM initiative also helped Arkansas develop new payment models and refine and expand episodes of care that were first implemented by the state's Medicaid program in 2011.⁴³ By the end of the SIM initiative in 2016, Arkansas had produced 14 episodes of care that were mandatory for Medicaid providers and voluntary for the state's two private payers.⁴⁴ Challenges early on ranged from a degree of provider hesitation and pushback to evidence that coding had been used by some providers to avoid triggering certain episodes. The state reported that average costs for attention-deficit/hyperactivity disorder and joint replacement episodes had decreased significantly while the costs of other episodes, and episodes of care overall, remained relatively constant.⁴⁵ One of the most prevalent models in Arkansas, for upper respiratory tract infections (URIs), showed significant quality improvements after two years, including greater reductions in antibiotic use and improvements in appropriate care for children, relative to a comparison group. However, emergency department visits increased during that time span and some physicians reported in focus groups using alternate coding to avoid triggering an episode.⁴⁶ Between 2011 and 2014, URI-related professional and outpatient spending increased while spending on prescription drugs (antibiotics and others) did not change. Over the same time period, the state's perinatal episode was found to decrease emergency department visits but increase inpatient hospital utilization and, importantly, perinatal expenditures declined, and improvements were made across most quality metrics.⁴⁷ A 2020 analysis of perinatal and URI episodes of care in Arkansas concluded that: linking incentives to performance metrics may help improve quality of care; episodes of care may successfully discourage the overuse of services; and unintended consequences are possible, including episode avoidance through coding, a shift of services to outside of the episode, and increased emergency department use.⁴⁸

1 A study of Arkansas' perinatal episode that included privately insured patients found that spending
2 decreased 3.8 percent when compared to nearby states, with savings due primarily to decreased
3 inpatient care prices.⁴⁹ Notably, although some states implementing episodes of care involve
4 commercial payers in their program design and implementation, fewer published analyses have
5 assessed the impact of bundled/episode-based payments among commercially insured patients or
6 across multiple payers. Accordingly, much less is known about the impact of commercial models
7 on spending and care quality. A 2022 meta-analysis looking at various value-based care models in
8 the commercial sector, including nine studies of bundled/episode-based payments, found mixed
9 results on spending and quality but cited significant savings incurred under UnitedHealthcare's
10 cancer bundle.⁵⁰ A recent study of the use of bundled payments for certain surgical procedures
11 among self-insured employers found considerable reductions in episode prices.⁵¹ As more research
12 becomes available and models are refined, increased alignment of bundled/episode-based payments
13 across Medicare, Medicaid, and private insurers may help expand successful models and align
14 quality reporting.

15 16 AMA POLICY

17
18 The AMA has an abundance of policies addressing persistent concerns with value-based payment
19 and APMs (Policies D-385.963, H-385.913, H-385.908, and H-390.849). Under Policy D-385.963,
20 the AMA works with CMS and other payers on evolving payment reforms and ensuring sufficient
21 payments so that patients and families have access to care coordination supports that they need to
22 achieve optimal outcomes. Policy H-385.913 supports goals that should be pursued as part of an
23 APM, including that models be designed by physicians or with significant input from physicians,
24 provide flexibility to physicians to deliver the care their patients need, provide adequate and
25 predictable resources to support the services physician practices need to deliver to patients (and
26 include mechanisms for updating payment amounts), limit physician accountability to aspects of
27 spending and quality that they can reasonably influence, and avoid placing physician practices at
28 substantial financial risk. Policy H-385.913 also directs the AMA to continue to educate physicians
29 about APMs and provide educational resources and support. Policy H-385.908 urges CMS to limit
30 financial risk requirements to costs that physicians participating in an APM have the ability to
31 influence or control and directs the AMA to work with stakeholders to improve risk adjustment
32 systems, attribution methods, and performance target setting. Policy H-390.849 advocates for
33 physician payment reforms that: promote improved patient access to high-quality, cost-effective
34 care; are designed with input from physicians; ensure that physicians have an appropriate level of
35 authority over bonus or shared-savings distributions; and include ongoing evaluations to ensure the
36 reforms are improving patient care and increasing value.

37
38 Policy H-390.849 also opposes bundling of payments in ways that limit care or otherwise interfere
39 with a patient's ability to provide high quality care, while Policy H-385.913 supports the provision
40 of flexibility under APMs so that physicians can deliver the care patients need. Policy H-385.908
41 focuses on reducing barriers to APMs, including limiting financial risk requirements to costs that
42 physicians can control and working with stakeholders to improve attribution methods, risk
43 adjustment systems, and performance target setting. Under Policy H-70.949, the AMA will take
44 steps to ensure that public and private payers do not bundle services inappropriately; Policy
45 D-390.961 directs the AMA to work with appropriate officials to ensure that bundled payments, if
46 implemented, do not lead to hospital-controlled payments to physicians. Additional policy on
47 physician-focused payment reforms includes Policies D-390.953, H-390.844, H-450.931, and
48 H-450.961. Policy H-450.931 directs the AMA to help physician practices address concerns about
49 APMs and harmonize key components of APMs across multiple payers, including performance
50 measures.

Improving risk adjustment across payment models is addressed by Policies H-385.907 and H-285.957, and D-385.952, which also support linking quality measures and payments to outcomes specific to high-risk populations and reductions in health care disparities. Policy H-385.907 supports: 1) risk stratification systems that use fair and accurate payments based on patient characteristics, including socioeconomic factors; 2) risk adjustment systems that use fair and accurate outlier payments if spending on a patient exceeds a pre-defined threshold, and fair and accurate payments for external price changes beyond the physician's control; 3) risk adjustment systems that use risk corridors using fair and accurate payment if spending on all patients exceeds a pre-defined percentage above the payments; 4) accountability measures that exclude from risk adjustment methodologies any services that the physician does not deliver, order, or otherwise have the ability to influence; and 5) risk adjustment mechanisms that allow for flexibility to account for changes in science and practice. Policy H-165.837 advocates for protecting the patient-physician relationship in the context of bundled payments and affirms the obligation of physicians to prioritize patient care above financial interests.

AMA ADVOCACY

Many of the concerns about bundled/episode-based payment models have previously been addressed by AMA policy and advocacy on [payment reform](#) and [APMs](#). Key characteristics of value-based care, including that new models and incentives must be tailored to the distinct characteristics of different specialties and practice settings, were also incorporated into the [Medicare payment system principles](#) crafted by the AMA in collaboration with 120 other physician and health care organizations. The AMA has worked diligently over the years to improve MACRA and advance the transition to value-based care and now leads the charge to reform Medicare's payment system to increase physician payment stability, reduce burnout, and improve the financial viability of physician practices. Although the Consolidated Appropriations Act of 2023 extended the five percent advanced APM incentive payment for 12 months, the AMA is advocating that it be extended for additional years.

The AMA continues to encourage and enable physician participation in physician-focused APMs, including bundled/episode-based payments. The AMA believes that well-designed, patient-centered APMs can provide significant opportunities to improve the quality and outcomes of patients' care in ways that also lower growth in health care spending. However, the AMA maintains that physicians must be involved in the design of APMs to ensure that models successfully remove certain barriers and do not require physicians to be accountable for spending or outcomes they cannot control. The AMA continues to carefully examine APMs that are proposed by CMS and provide feedback to the agency regarding needed modifications, including when APMs impose unreasonable requirements on physicians or require them to take on excessive financial risk. Because the AMA believes that APMs are significantly improved when physicians are directly and actively involved in their design, the AMA continually advocates for consideration of physician input on models and approval of APMs that have been designed by physicians.

The AMA works closely with national medical specialty societies to review proposed APMs, recommend model improvements, and comment on regulations governing APMs. A more recent example is the AMA's advocacy focused on Medicare's proposed Radiation Oncology (RO) Model, a bundled payment for cancer patients receiving radiotherapy, which the AMA urged be delayed so that CMS could work with radiation oncology specialty societies to redesign some of the model's key features.⁵² The RO Model that CMS had previously developed could have had serious unintended consequences for patients because practices would have been mandated to participate and take steep payment cuts. Accordingly, the AMA expressed general support for the creation of a bundled payment model for radiation oncology but advocated that several changes be

made to CMS's proposal, namely that payments be stratified based on patients' clinical characteristics, adjusted to account for the higher costs of delivering services in rural areas, and adjusted annually to reflect changes in evidence, technology, and inflation.⁵³ The AMA has further urged CMS to conduct a limited scale test of the RO Model on a voluntary basis rather than mandating participation in an untested model.

In 2015, the AMA recommended numerous changes to the proposed CJR model and urged CMS to make participation voluntary and available to physicians in all localities. Among other modifications to its original design, the AMA recommended that payments be risk-adjusted based on patients' functional status and other characteristics that affect the types of post-acute care they need so that physicians could assign patients to one of several acuity/risk levels and receive higher payments for higher-risk patients.⁵⁴ Additional advocacy on CJR and other episode-based payment models has repeatedly urged CMS to incorporate input from relevant national medical specialty societies in model design and revisions; listen to affected specialty societies that have experience with the different risks facing patients treated under the models; allow voluntary participation; begin episodes at the time of diagnoses of a condition instead of at hospital admission; and ensure that payment is adequate and predictable while limiting physicians' accountability to costs within their control. More recent AMA advocacy with CMS on episode-based payment models in Medicare included support for bundled payments for office-based management of patients with substance use disorders and bundled payments for chronic pain management.

To be successful, the AMA believes a physician-focused APM needs three key components:

1. Flexibility for physicians to deliver the most appropriate services to meet patients' needs;
2. Adequate payments to support the costs physicians incur in delivering high-quality care; and
3. Accountability by physicians for delivering high-quality services and avoiding unnecessary services, but without penalties for things that physicians cannot control.

The AMA has held educational seminars about APMs for physicians and organized several workshops in which physicians have shared their experiences in designing and implementing APMs. Physicians who want to learn more about episodes of care and other APMs are encouraged to read the following AMA resources: [Evaluating Medicaid Value-Based Care Models](#), [Evaluating Bundled or Episode-Based Contracts](#), and [Medicare Alternative Payment Models](#).

DISCUSSION

Although the concerns highlighted in referred Resolution 111-A-22 focused primarily on Medicaid episodes of care, the Council reviewed available research on both Medicaid and Medicare bundled payment models. Evidence in the literature suggests that certain Medicare bundles may contain overall costs more effectively than fee-for-service payment but, after accounting for provider bonuses, aside from joint replacement models, most have not produced net Medicare savings. Additionally, although studies have been mixed and vary across initiatives, most bundled payment models have neither significantly improved nor worsened quality of care.⁵⁵ The Council found that LEJR bundles, and some perinatal episodes of care, have produced the most—but still modest—savings. LEJR episode savings have been driven by reductions in institutional post-acute care (e.g., SNFs and inpatient rehabilitation facilities) spending while hospital pricing contributed to reductions in perinatal episode spending. The Council was unable to locate published studies analyzing the impact of bundled/episode-based payment models on physician payment; however, we reviewed several studies looking at other possible unintended consequences of these models. For example, studies have found some evidence of risk selection across certain Medicare bundles,

1 although the evidence has been mixed, and no evidence of increased episode volume, which had
2 been an early concern among some stakeholders. A study of episodes of care in Arkansas revealed
3 other possible unintended consequences, including episode avoidance through coding, a shift of
4 some services outside of the bundles, and increased emergency department use.

5
6 Because the evidence is clear that the savings accrued under LEJR episodes has been due to
7 decreased spending on SNFs and inpatient rehabilitation facilities, some physicians have
8 questioned whether patient access to medically necessary care, including SNF services, could
9 potentially be limited. The Council believes that performance metrics measuring key patient-
10 centered outcomes, including functional improvements after orthopedic and other procedures, are
11 important and necessary checks on the risk that some models may underserve patients. Because the
12 AMA already has extensive policy on APMs, we recommend amending Policies H-390.849[2, 3]
13 and D-385.952[1, 2] to address this concern instead of crafting a separate policy statement specific
14 to bundled/episode-based payments.

15
16 Although evidence across models is limited, high-risk patients have not been found to be adversely
17 impacted under the BPCI initiative; more research is needed on how historically marginalized
18 patients fare, in terms of outcomes, under a broader range of episodes. One study we reviewed
19 found that hospitals serving historically marginalized individuals performed well, and received
20 large bonuses, under BPCI Advanced; however, more studies are needed to ensure that
21 implementation of episode-based models is meaningfully supporting equity goals. The Council
22 previously addressed concerns about the impact of APMs on high-risk populations and points to
23 Policy D-385.952, which we recommend amending. To address other concerns and obstacles under
24 bundled/episode-based payment models, the Council recommends reaffirmation of Policy
25 H-385.907, which supports fair and accurate risk adjustment systems, and Policy H-385.913, which
26 outlines goals to be pursued as part of physician-focused APMs—including that models be
27 designed by physicians or with significant input from physicians, provide flexibility to physicians
28 to deliver the care patients need, provide adequate and predictable resources, and avoid placing
29 physician practices at substantial financial risk—and directs the AMA to continue to work with
30 national medical specialty societies and state medical associations to educate physicians on APMs.

31
32 As previously noted, one of the frustrations with episode-based payment models concerns the
33 definition of related or unrelated services. For example, since some LEJR models include most
34 Medicare Part A and Part B services, payment for seemingly unrelated procedures (e.g., eye, skin,
35 or sinus surgeries) completed within 90 days of a joint replacement may be paid for out of the
36 bundled payment. AMA policy addresses this concern by advocating that physician accountability
37 be limited to aspects of spending and quality that they can reasonably influence or control. Notably,
38 the services covered under joint replacement models can vary significantly across payers so that
39 services included in a state Medicaid model may differ from CJR's list of covered services.

40
41 Although the Council discussed the need for bundled payment models to clearly define the services
42 included and allow mechanisms for shifting unrelated services outside of the bundle, we believe
43 this is best addressed at the design stage, with meaningful physician involvement, as highlighted by
44 Policy H-385.913. The Council encourages physicians interested in participating in bundled
45 payment models to determine ahead of time which services and Current Procedural Terminology
46 codes are included and not included in an episode, and to review the AMA's [Evaluating Bundled or](#)
47 [Episode-Based Contracts](#) for more information. Finally, the Council believes well-designed,
48 patient-centered bundled payment models can improve care quality and patient outcomes in ways
49 that also lower growth in health care spending. Designing these models to work effectively for
50 patients, physicians, and payers remains challenging, and ongoing refinements to models may be
51 needed to ensure optimal patient outcomes as these initiatives continue to expand.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 111-A-22, and that the remainder of the report be filed:

1. That our American Medical Association (AMA) amend Policy H-390.849[2, 3] by addition and deletion to read as follows:
 2. Our AMA opposes bundling of payments in ways that limit medically necessary care, including institutional post-acute care, or otherwise interfere with a physician's ability to provide high quality care to patients.
 3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, ~~verifiable, accurate, and based on current data~~ reliable, and consistent with national medical specialty society-developed clinical guidelines/standards. (Modify HOD Policy)
2. That our AMA amend Policy D-385.952[1, 2] by addition and deletion to read as follows:

Our AMA: (1) supports alternative payment models (APMs) that link quality measures and payments to outcomes specific to vulnerable and high-risk populations, ~~and~~ reductions in health care disparities, and functional improvements, if appropriate; (2) will continue to encourage the development and implementation of physician-focused APMs that provide services to improve the health of vulnerable and high-risk populations and safeguard patient access to medically necessary care, including institutional post-acute care. (Modify HOD Policy)
3. That our AMA reaffirm Policy H-385.907, which supports risk stratification systems that use fair and accurate payments based on patient characteristics, including socioeconomic factors; risk adjustment systems that use fair and accurate outlier payments if spending on a patient exceeds a pre-defined threshold, and fair and accurate payments for external price changes beyond the physician's control; and accountability measures that exclude from risk adjustment methodologies any services that the physician does not deliver, order, or otherwise have the ability to influence. (Reaffirm HOD Policy)
4. That our AMA reaffirm Policy H-385.913, which outlines goals for physician-focused APMs—including that models be designed by physicians or with significant input from physicians, provide flexibility to physicians to deliver the care patients need, limit physician accountability to aspects of spending and quality that they can reasonably influence, and avoid placing physician practices at substantial financial risk—and directs the AMA to continue working with national medical specialty societies and state medical associations to educate physicians on APMs. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

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APPENDIX

Policies Recommended for Reaffirmation and Amendment

Improving Risk Adjustment in Alternative Payment Models H-385.907

Our AMA supports: (1) 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; (2) 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; (3) 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; (4) risk adjustment systems that use fair and accurate payments for external price changes beyond the physician's control; (5) accountability measures that exclude from risk adjustment methodologies any services that the physician does not deliver, order, or otherwise have the ability to influence; and (6) risk adjustment mechanisms that allow for flexibility to account for changes in science and practice as to not discourage or punish early adopters of effective therapy. (CMS Rep. 03, I-19; Reaffirmed: CMS Rep. 2, A-22)

Physician-Focused Alternative Payment Models H-385.913

1. Our AMA recognizes that the physician is best suited to assume a leadership role in transitioning to alternative payment models (APMs).
2. Our AMA supports that the following goals be pursued as part of an APM:
 - A. Be designed by physicians or with significant input and involvement by physicians;
 - B. Provide flexibility to physicians to deliver the care their patients need;
 - C. Promote physician-led, team-based care coordination that is collaborative and patient-centered;
 - D. Reduce burdens of Health Information Technology (HIT) usage in medical practice;
 - E. Provide adequate and predictable resources to support the services physician practices need to deliver to patients, and should include mechanisms for regularly updating the amounts of payment to ensure they continue to be adequate to support the costs of high-quality care for patients;
 - F. Limit physician accountability to aspects of spending and quality that they can reasonably influence;
 - G. Avoid placing physician practices at substantial financial risk;
 - H. Minimize administrative burdens on physician practices; and
 - I. Be feasible for physicians in every specialty and for practices of every size to participate in.
3. Our AMA supports the following guidelines to help medical societies and other physician organizations identify and develop feasible APMs for their members:
 - A. Identify leading health conditions or procedures in a practice;
 - B. Identify barriers in the current payment system;
 - C. Identify potential solutions to reduce spending through improved care;
 - D. Understand the patient population, including non-clinical factors, to identify patients suitable for participation in an APM;
 - E. Define services to be covered under an APM;
 - F. Identify measures of the aspects of utilization and spending that physicians can control;
 - G. Develop a core set of outcomes-focused quality measures including mechanisms for regularly updating quality measures;
 - H. Obtain and analyze data needed to demonstrate financial feasibility for practice, payers, and patients;
 - I. Identify mechanisms for ensuring adequacy of payment; and
 - J. Seek support from other physicians, physician groups, and patients.

4. Our AMA encourages CMS and private payers to support the following types of technical assistance for physician practices that are working to implement successful APMs:

- A. Assistance in designing and utilizing a team approach that divides responsibilities among physicians and supporting allied health professionals;
- B. Assistance in obtaining the data and analysis needed to monitor and improve performance;
- C. Assistance in forming partnerships and alliances to achieve economies of scale and to share tools, resources, and data without the need to consolidate organizationally;
- D. Assistance in obtaining the financial resources needed to transition to new payment models and to manage fluctuations in revenues and costs; and
- E. Guidance for physician organizations in obtaining deemed status for APMs that are replicable, and in implementing APMs that have deemed status in other practice settings and specialties.

5. Our AMA will continue to work with appropriate organizations, including national medical specialty societies and state medical associations, to educate physicians on alternative payment models and provide educational resources and support that encourage the physician-led development and implementation of alternative payment models. ([CMS Rep. 09, A-16](#); [Reaffirmed: CMS Rep. 10, A-17](#); [Reaffirmed: CMS Rep. 10, A-19](#); Reaffirmed: BOT Rep. 13, I-20; [Reaffirmed: CMS Rep. 2, A-22](#))

Alternative Payment Models and Vulnerable Populations D-385.952

Our AMA: (1) supports alternative payment models (APMs) that link quality measures and payments to outcomes specific to vulnerable and high-risk populations and reductions in health care disparities; (2) will continue to encourage the development and implementation of physician-focused APMs that provide services to improve the health of vulnerable and high-risk populations; and (3) will continue to advocate for appropriate risk adjustment of performance results based on clinical and social determinants of health to avoid penalizing physicians whose performance and aggregated data are impacted by factors outside of the physician's control. (CMS Rep. 10, A-19)

Physician Payment Reform H-390.849

1. Our AMA will advocate for the development and adoption of physician payment reforms that adhere to the following principles:

- a) promote improved patient access to high-quality, cost-effective care;
- b) be designed with input from the physician community;
- c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions;
- d) not require budget neutrality within Medicare Part B;
- e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice;
- f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process;
- g) make participation options available for varying practice sizes, patient mixes, specialties, and locales;
- h) use adequate risk adjustment methodologies;
- i) incorporate incentives large enough to merit additional investments by physicians;
- j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols;
- k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization;
- l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and

m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.

2. Our AMA opposes bundling of payments in ways that limit care or otherwise interfere with a physician's ability to provide high quality care to patients.

3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data.

4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.

5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment. (CMS Rep. 6, A-09; Reaffirmation A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-12; Modified: CMS Rep. 6, A-13; Reaffirmation I-15; Reaffirmation: A-16; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17; Reaffirmation: A-19; Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19; Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19; Reaffirmed: Res. 212, I-21; Reaffirmed: Res. 240, A-22; Reaffirmation: A-22)

REPORT 07 OF THE COUNCIL ON MEDICAL SERVICE (A-23)
Reporting Multiple Services Performed During a Single Patient Encounter
(Resolution 824-I-22)

EXECUTIVE SUMMARY

At the 2022 Interim Meeting, the House of Delegates referred Resolution 824-I-22, which asked the American Medical Association to recognize that there is greater value to the patient, improved access to care, greater patient satisfaction, and improved overall patient care by advocating for appropriate payment for multiple services (two or more) to be performed during a single patient encounter.

“Multiple services” can refer to two evaluation and management (E/M) services, a procedure plus an E/M service, or two or more procedures provided by the same physician during a single patient encounter, all of which can be appropriately reported with the existing Current Procedural Terminology (CPT®) nomenclature. CPT codes create a uniform language for reporting medical services and procedures to allow accurate and efficient claims processing and adjudication. In addition to codes, CPT includes two-digit modifiers, which are appended to codes to indicate that a service or procedure has been altered by a specific circumstance but not changed in its definition. While CPT includes several modifiers, the one most commonly reported for multiple services is modifier 25, which is appended to an E/M service code on a claim to indicate the code is a significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the procedure or other service. Its use allows two E/M services or a procedure plus an E/M service that are distinctly different but required for the patient’s condition to be appropriately reported and, therefore, appropriately paid.

Unfortunately, there is a disconnect between physicians and payers regarding the feasibility of providing, documenting, reporting, and paying for multiple services. This can be confounded further by use of electronic health records (EHR), which can make it difficult to ensure accurate data if codes and medical terms are not used consistently. Therefore, it becomes imperative that both physicians and payers are well educated on the appropriate way to report multiple services as well as the circumstances that justify such reporting. It is also important that the CPT guidelines used to recognize the validity of claims for multiple services are consistently applied, which may be facilitated by the development of EHR tools.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 07-A-23

Subject: Reporting Multiple Services Performed During a Single Patient Encounter
(Resolution 824-I-22)

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee A

At the November 2022 Interim Meeting, the House of Delegates referred Resolution 824-I-22, which was sponsored by the Private Practice Physicians Section. Resolution 824-I-22 asked the American Medical Association (AMA) to recognize that there is greater value to the patient, improved access to care, greater patient satisfaction, and improved overall patient care by advocating for appropriate payment for multiple services (two or more) to be performed during a single patient encounter. Testimony at the November 2022 Interim Meeting regarding the resolution was mixed, with some speakers offering vignettes to support the need for Resolution 824-I-22 and others questioning the need for it given recent revisions to Current Procedural Terminology (CPT®) Evaluation and Management (E/M) codes that allow physicians to report encounters involving multiple services during a single patient encounter. This report focuses on the need for education of physicians and payers on appropriate reporting of multiple services using CPT nomenclature, provides a snapshot of strategies insurers use to deny claims, highlights AMA advocacy efforts and essential policy, and presents new policy recommendations.

BACKGROUND

As outlined in Resolution 824-I-22, “multiple services” can refer to two E/M services, a procedure plus an E/M service, or two or more procedures provided by the same physician during a single patient encounter. CPT is the most widely accepted US medical nomenclature for reporting singular or multiple medical services and procedures under public and private health insurance programs. In addition to being the code set adopted under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) for outpatient services and procedures¹, CPT codes create a uniform language for reporting medical services and procedures to allow accurate and efficient claims processing and adjudication. In addition to codes, CPT includes two-digit modifiers, which are appended to codes to indicate that a service or procedure has been altered by a specific circumstance but not changed in its definition. The use of modifiers provides supplementary information for payer policy requirements.

While CPT provides a valid way to report multiple services, the resulting claims can result in high rates of denials. Payers may flag all multiple services claims for prepayment claim validation prior to payment or require submission of documentation with the claim, both of which create unjustifiable administrative burden for physicians, an incumbrance exacerbated in rural communities and other areas with limited health care resources. Addressing rural health inequities is a cornerstone of the Centers for Medicare & Medicaid Services’ (CMS) effort to improve health

equity,² a goal that can be achieved by consistent application of CPT across all payers given its ability to promote health equity.³

Unfortunately, there is a disconnect between physicians and payers regarding the feasibility of providing, documenting, reporting, and paying for multiple services. This can be confounded further by use of electronic health records (EHR), which can make it difficult to ensure accurate data if codes and medical terms are not used consistently. Therefore, it becomes imperative that both physicians and payers are well educated on the appropriate way to report multiple services as well as the circumstances that justify such reporting. It is also important that the CPT guidelines used to recognize the validity of claims for multiple services are consistently applied, which may be facilitated by the development of EHR tools.

MODIFIER 25

CPT modifier 25 is appended to an E/M service code on a claim to indicate the code is a significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the procedure or other service.⁴ Its use allows two E/M services or a procedure plus an E/M service that are distinctly different but required for the patient's condition to be appropriately reported and, therefore, appropriately paid. The CPT Professional Edition also states that a significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported.⁵ While CPT does not outline required documentation for modifier 25, its use indicates that documentation is available in the patient's record to support the reported E/M service as distinct and separately identifiable. Further, the E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date.

There are two scenarios where modifier 25 is typically used:

- 1) A Preventive Medicine E/M service provided with a problem-oriented Office or Other Outpatient E/M service:

This is a common scenario in pre- or non-verbal patients. For example, a 2-year-old is seen for their well child visit and the physician finds otitis media during the physical examination. When a significant problem is encountered while performing a Preventive Medicine E/M service, requiring additional work to perform the key components of the E/M service, the appropriate Office or Other Outpatient E/M code also should be reported for that service with modifier 25 appended. Modifier 25 allows separate payment for these visits without requiring documentation with the claim form.

- 2) A minor surgical procedure provided with a problem-oriented Office or Other Outpatient E/M service:

CPT codes for minor surgical procedures include preoperative evaluation services (i.e., assessing the site or problem, explaining the procedure, risks, and benefits, and obtaining consent). Therefore, the E/M service has to involve work "above and beyond" the preoperative evaluation services. For example, when a patient presents with a head laceration, and the physician also performs a neurological examination before repairing the laceration, the neurological exam would merit a separate E/M service reported with modifier 25.

The CPT Professional 2023 codebook definition of a significant, separately identifiable service relies on satisfying the relevant criteria for determining the correct level of E/M service to be reported. The following questions can be used to determine whether an E/M service justifies use of modifier 25 according to CPT guidelines:

- Did the physician perform and document the level of medical decision making or total time necessary to report a problem-oriented Office or Other Outpatient E/M service for the complaint or problem?
- Could the work to address the complaint or problem stand alone as a billable service?
- Did the physician perform extra work that went above and beyond the typical pre- or postoperative work associated with the procedure code?

If all answers are “yes,” then use of modifier 25 is consistent with CPT guidelines.

CMS requires that modifier 25 be used:

- Only on claims for E/M services and
- Only when the E/M service is provided by the same physician on the same day as another procedure or service.

While these two requirements are consistent with CPT guidelines, Medicare policy is more restrictive in that it will not pay for more than one E/M service provided by the same physician on the same day unless the visits are for unrelated problems and could not be provided during the same patient encounter. For example, Medicare will not pay separately when a patient is seen for their annual preventive checkup and the physician finds otitis media during the physical examination – even with the use of modifier 25. However, Medicare will pay for a patient who presents for blood pressure medication evaluation and then returns five hours later that same day for evaluation of leg pain following an accident – if modifier 25 is used.

Under certain circumstances, Medicare will allow use of modifier 25 when an E/M service is reported with a global procedure. Global procedures include visits and other physician services provided within 24 hours prior to the service, provision of the service, and visits and other physician services for a specified number of days after the service is provided.

CMS defines global surgical packages based on the number of postoperative days it assigns to the service:

- XXX: Global period does not apply
- 0-day global period: Includes procedure and visit on day of procedure
- 10-day global period: Includes procedure, visit on day of procedure, and visits 10 days immediately following the day of the procedure
- 90-day global period: Includes procedure, visit on day of procedure, and visits 90 days immediately following the day of the procedure

Modifier 25 may be appended to E/M services reported with minor surgical procedures (i.e., 0-day and 10-day global periods) or procedures not covered by a global period (i.e., XXX). Since minor surgical procedures and XXX-global procedures include pre-service, intra-service, and post-service work inherent in the procedure, the physician cannot report an E/M service for this work in most circumstances when the minor surgical procedure or XXX-global is the primary procedure. Furthermore, Medicare policy prevents the reporting of a separate E/M service for the work associated with the decision to perform a minor surgical procedure.

All E/M services provided on the same day as a procedure are considered part of the procedure and Medicare only makes separate payment if an exception applies. Modifier 25 is used to provide

justification for a visit that is “generally not payable,” as Medicare payment is made only if the physician indicates that the service is for a significant, separately identifiable E/M service that is above and beyond the usual pre-service and post-service work required on the day of the procedure. Modifier 25 may be used in the rare circumstance of an E/M service the day before a procedure which represents a significant, separately identifiable service; it typically is linked to a different diagnosis than the underlying reason for the procedure (e.g., evaluation of a cough that might contraindicate surgery).⁶ Medicare requires that the physician appropriately and sufficiently document both the medically necessary E/M service and the procedure in the patient’s medical record to support the claim for these services, even though the documentation is not required to submit with the claim.⁷

CMS has focused on the potential misuse of modifier 25 since 2005, when the Office of the Inspector General (OIG) published an analysis indicating that 35 percent of Medicare claims involving modifier 25 did not meet CMS requirements.⁸ Since that time, both Medicare and private payers have increased their scrutiny of claims submitted with modifier 25, which has led to substantial recoupment of physician payments. The OIG continues to maintain modifier 25 as a target of its work plan and is expected to release a report of modifier 25 use in dermatology in late 2023.

OTHER CPT MODIFIERS USED FOR REPORTING MULTIPLE SERVICES

In addition to modifier 25, CPT includes other modifiers to allow the reporting of multiple services:⁹

- Modifier 24: Unrelated E/M service provided by the same physician or other qualified health care professional during a postoperative period
- Modifier 51: Multiple procedures, non-E/M procedures provided by the same individual at the same session
- Modifier 57: Decision for surgery, an E/M service that resulted in the initial decision to perform surgery
- Modifier 58: Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period
- Modifier 59: Distinct procedural service, an independent non-E/M service performed on the same day Modifier 59 is used to identify non-E/M procedures/services that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. Modifier 59 should only be used if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances.
- Modifier 78: Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period
- Modifier 79: Unrelated procedure or service performed by the same physician or other qualified health care professional during the postoperative period

CPT CODES AND GUIDELINES THAT FACILITATE THE REPORTING OF MULTIPLE SERVICES

Prolonged Service

There are Prolonged Service CPT codes that permit the reporting of time spent beyond the highest time in the range of total time of the primary E/M service. Prolonged Service CPT codes are reported in 15 minute increments, allowing physicians to be paid for providing extended services during a single patient encounter (even if the time on that date is not continuous) that contribute toward the total time of the visit.

The AMA is currently advocating to align CMS's interpretation of the Prolonged Service codes with the CPT definition as described above. Medicare, however, requires that the physician surpass the maximum time of the highest E/M level by 15 minutes. Until such time that CPT and CMS interpretations are reconciled, Medicare requires reporting of Healthcare Common Procedure Coding System Level II codes in lieu of CPT codes for reporting prolonged services.

Care Management

Care Management CPT codes are E/M codes reported monthly for physician oversight and management of clinical staff in the development and implementation of the care plan and care coordination in patients with one or more complex chronic conditions. Care Management codes can be reported in addition to other E/M codes (e.g., Office or Other Outpatient Services). Time that is spent providing services within the scope of the Care Management service on the same day as an E/M visit can be counted towards Care Management codes, as long as the time is not counted towards the other reported E/M code(s).

Total Visit Time Versus Medical Decision Making

E/M codes are selected based on either the total time spent or medical decision making (MDM) required. The decision of which component to use in selecting the appropriate E/M code is determined by the reporting physician or qualified health care professional based on the available criteria.

MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. There are three elements to MDM:

- Number and complexity of problems addressed at the encounter
- Amount and/or complexity of data to be reviewed and analyzed
- Risk of complications and/or morbidity or mortality of patient management

Time is based on the total time spent on the date of the encounter. It includes both face-to-face time with the patient and non-face-to-face time spent on things such as care coordination, consulting with other health care professionals, and ordering medications, tests, and procedures.

Caring for a patient with multiple issues is likely to increase the total time of the encounter, which may allow the physician to report a single, higher level E/M code rather than two lower level E/M codes appended with modifier 25.

RESOURCE-BASED RELATIVE VALUE SCALE (RBRVS)

CMS considers recommendations from the AMA/Specialty Society Relative Value Scale Update Committee (RUC) process to determine relative value units (RVUs) for the RBRVS. The RBRVS is based on the principle that payments for physician services should vary with the resource costs for providing those services and is intended to improve and stabilize the payment system while providing physicians an avenue to continuously improve it. Determining RVUs through the RUC ensures that potential overlap is eliminated from the physician work, practice expense, and professional liability insurance (PLI) for services that are frequently provided together. The physician work component accounts for an average of 51 percent of the total RVU for each service while practice expense accounts for 45 percent. PLI accounts for the remaining four percent. The factors used to determine physician work include the time it takes to perform the service, the technical skill and physical effort, the required mental effort and judgment, and stress due to the potential risk to the patient. The practice expense components include clinical staff time, medical supplies, and medical equipment.

The process of valuing CPT codes on the RBRVS contributes to determining whether use of modifier 25 is warranted. Global procedure CPT codes are valued to include pre-service (e.g., evaluation time, patient positioning, scrub/dress/wait time), intra-service (e.g., performing the procedure, also known as “skin-to-skin” time), and post-service (e.g., patient stabilization, communicating with the patient and other professionals) work.

For example, Medicare payment for CPT code 64635 (*Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint*), includes 28 minutes pre-service time. Reporting a problem-oriented Office or Other Outpatient E/M code in addition to CPT code 64635 when evaluation is limited to assessing the specific problem is essentially double billing for the pre-service evaluation. Therefore, use of modifier 25 would not be appropriate in this situation.

However, when a patient presents for their annual skin examination and a suspicious lesion is discovered, it is appropriate for the physician to proceed with a diagnostic or therapeutic procedure at the same visit after obtaining the patient’s medical history, completing a review of systems, and conducting a clinical examination. This situation would warrant the use of modifier 25. The ability to assess and intervene during the same visit is optimal for patients who subsequently may require fewer follow-up visits and experience more immediate relief from their symptoms.

MULTIPLE PROCEDURE PAYMENT REDUCTIONS

In addition to two E/M services or a procedure plus an E/M service, “multiple services” can refer to two or more procedures provided by the same physician during a single patient encounter. Payers may utilize the CMS Multiple Procedure Payment Reduction (MPPR) policy to adjudicate claims involving more than one procedure.

Under the MPPR, Medicare makes full payment for the professional component (PC) and technical component (TC) of the highest priced procedure. Payment is made at 95 percent for subsequent PC services furnished by the same physician to the same patient in the same session on the same day. Payment is made at 50 percent for subsequent TC services furnished by the same physician to the same patient in the same session on the same day.¹⁰

The rationale behind CMS’ MPPR policy is similar to that of its global surgical package definitions in that “most medical and surgical procedures include pre-procedure, intra-procedure, and post-

1 procedure work. When multiple procedures are performed at the same patient encounter, there is
2 often overlap of the pre-procedure and post-procedure work. Payment methodologies for surgical
3 procedures account for the overlap of the pre-procedure and post-procedure work.”¹¹

4 CLAIMS ADJUDICATION AND COMPLIANCE

5 Policies on payment for multiple services during a single patient encounter are typically
6 communicated via claims adjudication with the use of coding edits. Most private payers utilize
7 customizable, propriety claims edit systems, while Medicare and Medicaid use the coordinated
8 National Correct Coding Initiative (NCCI).

9 NCCI reinforces Medicare policies, and since it is common for private payers to adopt NCCI as
10 part of their customizable claims editing systems, allowing physicians the opportunity to comment
11 on NCCI takes on increased importance. Through a process coordinated by CMS and the AMA,
12 national medical specialty societies are able to review and comment on proposed NCCI updates on
13 a quarterly basis. In recent years, however, the NCCI review process has become less transparent
14 and the AMA has continued to advocate toward a return to the “solid, transparent, collaborative
15 track among all parties (CMS, AMA and specialty societies) that has been so beneficial in the
16 past.” ([June 2021 letter](#), [November 2021 letter](#))

17 Edits on code pairs may be overridden by appending the appropriate modifier on one of the codes.
18 For example, NCCI includes an edit on the codes for vision screening (CPT code 99173) and a
19 level 3 established patient Office or Other Outpatient visit (CPT code 99213) – but allows override
20 of the edit with use of the appropriate modifier (i.e., modifier 25 appended to 99213). Payers’
21 increased use of claims edits has resulted in a commensurate increase in physicians’ use of
22 modifiers in an effort to override restrictive payment policies. However, that strategy may backfire
23 as some payers’ code auditing processes will flag all claims billed with modifier 25 for prepayment
24 claim validation prior to payment. Once a claim is validated, it is either released for payment or
25 denied for incorrect use of the modifier. A significant, separately identifiable E/M service is
26 defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M
27 service to be reported. If claim history or assigned diagnosis codes do not indicate that significant,
28 separately identifiable services were performed, payers typically cover the primary procedure or
29 other service and deny the secondary E/M billed with modifier 25.

30 Some payers have instituted policies where use of modifier 25 triggers an automatic reduction in
31 payment for the second code to account for what they perceive to be “overlap” between the two
32 codes (e.g., a Preventive Medicine Service E/M code reported with an Office or Other Outpatient
33 Service E/M code appended with modifier 25 allows payment of the Preventive Medicine Service
34 code at 100 percent and the Office or Other Outpatient code at 50 percent). While the work
35 associated with performing the history, physical examination, and MDM for the problem-oriented
36 E/M service may include some overlap with those performed as part of the comprehensive
37 preventive medicine E/M service, the physician’s use of modifier 25 signals that they performed a
38 significant, separately identifiable problem-oriented E/M service. An insignificant or trivial
39 problem or abnormality is not reported separately from the preventive medicine E/M service.

40 Reporting both preventive and problem-oriented E/M services during a single patient encounter can
41 produce inconsistent results in terms of claims payment across payers. While some payers will pay
42 the full allowable amount for both the problem-oriented E/M code and the preventive medicine
43 services E/M code, some will assess a co-pay for each service, some will carve out the payment for
44 the problem-oriented E/M service from the payment for the preventive medicine E/M service
45 (which results in a total charge that does not exceed that of a comprehensive preventive

examination alone), and some will reject the claim on the basis that they do not accept coding for both a preventive and problem-oriented service on the same date regardless of the amount of the charge due to the perception of overlap between the two services. In response, physicians may decide to report only one of the services, depending on which of the two is the primary focus of the visit and requires the most amount of physician time and work; however, this is not a tenable solution as it fails to recognize the value of services provided. Alternatively, the physician may ask the patient to return for another visit to address the management of the problem or the preventive care; however, many physicians are hesitant to do this as it places significant burden on patients, particularly those with limited resources, and may risk deterioration of the patient's condition until another appointment can be scheduled.

Certain payers have considered requiring documentation for all modifier 25 claims. Most recently, Cigna proposed a policy requiring practices to send documentation with "a cover sheet indicating the office notes support the use of modifier 25 appended to the E/M code."¹² While advocacy by the California Medical Association and the AMA was initially able to delay implementation, Cigna has re-released the policy, which was scheduled to become effective in May 2023. At the time this report was written, the AMA was preparing a sign-on letter to allow state medical associations and national medical specialty societies to join in opposition against Cigna's policy. Previous AMA advocacy efforts opposing proposed modifier 25 payment reductions by Anthem (November 2017) and UnitedHealthcare (July 2018) have proven successful.

Misunderstanding and/or misuse of modifier 25 has made it a top billing compliance risk area. It has been the focus several False Claims Act and civil monetary penalty settlements,¹³ as well as CMS comparative billing reports (CBR). The CMS CBR program is an educational tool intended to encourage accurate reporting and support physicians' internal compliance activities. A CBR tracks a given physician's billing patterns as compared to their peers' patterns within a Medicare service area. Since CBRs are private and shared only with the physician, CMS is able to maintain that "receiving a CBR is not an indication of or precursor to an audit, and it requires no response on a provider's part."¹⁴

Compliance is impacted by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which only allows extrapolation of overpayments based on statistical sampling when there's "a determination of sustained or high level of payment error, or documentation that educational intervention has failed to correct the payment error."¹⁵ If an audit does not use a random sample of claims, MMA dictates that extrapolation of that sample invalidates any claim of overpayment.

AMA POLICY

The AMA has robust policy to guide advocacy for appropriate payment for multiple services performed during a single patient encounter.

Among the most relevant policies are those that:

- Focus on recognition of modifier 25 by:
 - Advocating for the acceptance of CPT modifiers, particularly modifier 25, and the appropriate alteration of payment based on CPT modifiers (Policy D-70.971);
 - Aggressively and immediately advocating through any legal means possible to ensure that when an E/M code is reported with modifier 25, that both the procedure and E/M codes are paid at the non-reduced, allowable payment rate (Policy D-385.956);

- 1 • Supporting insurance company payment for E/M services and procedures performed
- 2 on the same day (Policy H-385.944); and
- 3 • Advocating that a CPT code representing a service or procedure that is covered and
- 4 paid for separately should also be paid for when performed at the same time as another
- 5 service or procedure (Policy D-70.959).
- 6
- 7 • Preserve discrete E/M code levels by:
- 8 • Communicating to CMS and private payers that the current levels of E/M services
- 9 should be maintained and not compressed, with appropriate payment for each level
- 10 (Policy D-70.979) and
- 11 • Opposing any health insurance code collapsing policies that result in unfair payment
- 12 practices (Policy H-70.995).
- 13
- 14 • Combat bundling and downcoding by:
- 15 • Opposing the bundling of procedure and laboratory services within the E/M services
- 16 (Policy H-70.985);
- 17 • Opposing the use of time elements to deny or downgrade services submitted based on a
- 18 cumulative time (Policy H-70.976);
- 19 • Advocating to ensure that public and private payers do not bundle services
- 20 inappropriately by encompassing individually coded services under other separately
- 21 coded services (Policy H-70.949);
- 22 • Vigorously opposing the practice of unilateral, arbitrary recoding and/or bundling by
- 23 all payers (Policy H-70.937);
- 24 • Introducing or supporting legislation that would require managed care plans to be
- 25 monitored and prohibited from the arbitrary and inappropriate bundling of services to
- 26 reduce payment (Policy H-70.962); and
- 27 • Working with CMS to provide physician expertise commenting on the medical
- 28 appropriateness of code bundling initiatives for Medicare payment policies (Policy
- 29 H-70.980).
- 30
- 31 AMA policy targets payer policies that deviate from CPT guidelines, such as those that:
- 32 • Oppose inappropriate bundling of medical services by third party payers (Policy
- 33 D-70.983);
- 34 • Support the recognition and payment for all CPT codes by all third party payers (Policy
- 35 H-70.974);
- 36 • Seek legislation and/or regulation to ensure that all insurance companies and group payers
- 37 recognize all published CPT codes including modifiers (Policy H-70.954);
- 38 • Intensify efforts to ensure uniform application of coding principles (Policy H-70.986);
- 39 • Assure that CMS and local carriers appropriately reimburse all E/M services (Policy
- 40 H-385.952);
- 41 • Develop national (state) standards and model legislation that require full disclosure in plain
- 42 English of multiple procedure reimbursement policies (Policy H-285.946);
- 43 • Step up ongoing review of the proper use of CPT codes in medical billing claims payments
- 44 by the US Health Insurance Industry (Policy D-385.949);
- 45 • Support the elimination of Medicare arbitrary visit frequency parameters (Policy H-280-
- 46 974); and
- 47 • Pursue proper use of CPT codes, guidelines, and modifiers by software claims editing
- 48 vendors and their customers (Policy H-70.927).

Given that CPT is copyrighted by the AMA, there are many policies that support the development, updating, and maintenance of clinically valid codes in order to accurately reflect current clinical practice and innovation in medicine, including those that:

- Work with CMS to continue to refine E/M coding (Policy H-70.961);
- Advocate that the Department of Health and Human Services designate CPT guidelines and instructions as contained in the CPT codebook and approved by the CPT Editorial Panel as the national implementation standards for CPT codes (Policy D-70.987); and
- Limit future efforts to substantially revise E/M codes to the CPT Editorial Panel (Policy H-70.921) to appropriately allow the accurate reporting of E/M services provided by all physicians (Policy H-70.982).

AMA policy advocates that payer policies must align with CPT guidelines and reduce the burden of documentation for E/M services (Policy H-70.952), including opposition to the requirement that all Level 4 or Level 5 E/M codes require submission of medical record documentation (Policy D-70.991). Furthermore, AMA policy indicates that payer audit tools must be based on the factors for arriving at complexity as defined in the CPT codebook (Policy H-70.918).

The AMA is invested in ensuring that CPT codes are appropriately valued on the RBRVS via the RUC process. AMA policy advocates that annually updated and rigorously validated RBRVS values should provide a basis for physician payment schedules, opposes CMS' policy that reduces payment for additional surgical procedures after the first procedure by more than 50 percent, and encourages third party payers and other public programs to utilize the most current CPT codes, modifiers, and RBRVS relative values (Policy D-400.999). CMS is urged to adopt RUC recommendations for new and revised CPT codes (Policy H-400.969).

AMA policy supports development of CPT educational programs for physicians and health insurance carriers (Policy H-70.993) and working with national medical specialty societies to educate their members concerning CPT coding issues (Policy H-70.973). Policy H-400.972 states that the AMA will take all necessary legal, legislative, and other action to assure that all modifiers are well publicized and include adequate descriptors.

In addition to advocating for compliance with CPT modifier 25 guidelines, AMA policy has addressed other relevant issues:

- Recognition of modifiers 54, 55, and 56 for postoperative care of surgical patients (Policy D-70.955) and modifier 26 to report the professional component separate from the technical component for the interpretation of laboratory tests (Policy D-70.957);
- Appropriate payment for office-based procedures (Policy H-330.925), emergency care (Policy H-130.978), telephone consultations (Policy H-390.889), counseling of serious medical problems (Policy H-385.977), diagnostic and laboratory panel tests (Policy H-390.923 and Policy H-70.950), vaccine administration (Policy D-440.937), consultations (Policy D-70.953 and Policy H-70.939), care plan oversight services (Policy H-70.960), and after hours services (Policy H-385.940);
- Delineation of the physician role and responsibility in supervising patient care in non-office ambulatory settings, including fair and equitable payment for those services (Policy H-70.991);
- Insurer recognition of CPT codes that allow primary care physicians to report and receive payment for physical and behavioral health care services provided on the same date of service (Policy H-385.915);

- Development of coding for non-physician services (Policy H-70.994); and
- Appropriate payment for the additional work and expenses required in treating patients during the COVID-19 pandemic (Policy D-390.947).

DISCUSSION

There is currently robust infrastructure to allow the reporting of multiple services during a single patient encounter. However, there may be a need to ensure that key stakeholders are well educated on the various reporting options. It is essential that both physicians and payers understand the nuanced concepts involved, such as existing CPT nomenclature, how the RUC process eliminates overlap of physician work and practice expense between services and procedures, and how appropriate reporting and payment for multiple services can lead to greater value to the patient, improved access to care, increased patient satisfaction, and improved overall patient care.

With the ongoing development of coding resources, it is imperative that CMS align with CPT guidelines in order to reduce potential confusion. For example, CPT and CMS do not presently agree on the interpretation of the Prolonged Service CPT codes, which have a direct bearing on physicians' ability to accurately report multiple services during a single patient encounter. This has resulted in many payers challenging physicians' use of the Prolonged Service codes or denying them all together. As such, the AMA is strongly advocating for alignment of CMS's interpretation of the Prolonged Service codes with the CPT definition. This approach is consistent with past AMA advocacy initiatives, most of which have been successful in reducing the gaps between CMS and CPT.

A comprehensive education on the appropriate reporting of multiple services should start early in physicians' careers, possibly during residency. A curriculum could focus on concepts such as how to use total visit time to report a higher-level E/M service rather than two E/M codes plus modifier 25, allowing them to bypass the administrative rigor imposed by payers who routinely flag modifier 25 claims. It would be ideal if a similar curriculum could be shared with, and undertaken by, the payer community, possibly through organizations such as America's Health Insurance Plans. With these potential resolutions, both "sides" would be cognizant of the guidelines, fostering full transparency between claims submission and claims adjudication.

As of 2021, 78 percent of office-based physicians used certified EHR systems.¹⁶ Most EHRs include software tools to help physicians determine the appropriate E/M codes for patient encounters and when used correctly, they support accurate coding. However, these EHR-based computer-assisted E/M coding (CAEMC) tools are generally associated with higher levels of E/M coding due to factors such as "cloning" of documentation from the previous visit, which may contribute to restrictive payer policies that require burdensome documentation in order to justify payment. OIG is concerned about EHRs "aiding" providers with coding and documentation decisions, but there has been limited testing of how EHRs capture and use information to recommend E/M codes.

EHR CAEMC tools are limited in their ability to assist physicians in documenting and reporting multiple services. As such, it may be beneficial for EHR CAEMC tools to be developed to facilitate the appropriate reporting of modifier 25. Such tools might include an algorithm to ascertain the potential areas of perceived overlap between two services, which could then be synchronized to the documentation provided for each service.

1 RECOMMENDATIONS
2

3 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
4 824-I-22, and the remainder of the report be filed:

- 5 1. That our American Medical Association (AMA) support mechanisms to report modifiers
6 appropriately with the least administrative burden possible, including the development of
7 electronic health record tools to facilitate the reporting of multiple, medically necessary
8 services supported by modifier 25. (New HOD Policy)
9
- 10 2. That our AMA support comprehensive education for physicians and insurers on the
11 appropriate use of modifier 25. (New HOD Policy)
12
- 13 3. That our AMA reaffirm Policy D-70.971, which advocates for the acceptance of Current
14 Procedural Technology (CPT®) modifiers, particularly modifier 25, and the appropriate
15 alteration of payment based on CPT modifiers. (Reaffirm HOD Policy)
16
- 17 4. That our AMA reaffirm Policy D-385.956, which directs the AMA to aggressively and
18 immediately advocate through any legal means possible to ensure that when an evaluation
19 and management (E/M) code is reported with modifier 25, that both the procedure and E/M
20 codes are paid at the non-reduced, allowable payment rate. (Reaffirm HOD Policy)
21
- 22 5. That our AMA reaffirm Policy H-385.944, which supports insurance company payment for
23 E/M services and procedures performed on the same day. (Reaffirm HOD Policy)
24
- 25 6. That our AMA reaffirm Policy D-70.959, which advocates that a CPT code representing a
26 service or procedure that is covered and paid for separately should also be paid for when
27 performed at the same time as another service or procedure. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 101
(A-23)

Introduced by: Young Physicians Section

Subject: Updating Physician Job Description for Disability Insurance

Referred to: Reference Committee A

1 Whereas, Many disability insurance products contain language and provisions such as “own
2 occupation” and “own specialty” that may not be consistently defined and whose definitions are
3 not readily available in marketing and policy paperwork; and
4

5 Whereas, The Department of Labor (DOL) developed the Dictionary of Occupational Titles
6 (DOT), the main source of occupational information, in 1938; however, the DOL stopped
7 updating the DOT in 1991¹; and
8

9 Whereas, The DOL and Social Security Administration (SSA) are developing a new
10 Occupational Information System (OIS),² which will replace the DOT as the primary source of
11 occupational information that SSA staff and private insurers commonly use in the disability
12 adjudication process; and
13

14 Whereas, This pandemic has led to many physicians contracting COVID-19 with health care
15 workers and their families, representing up to one-sixth of hospitalized COVID-19 patients³; and
16

17 Whereas, Up to one-third of those infected with COVID-19 will develop Long COVID,^{4,5} which
18 can last for a year or more⁶; and
19

20 Whereas, Many with Long COVID cannot return to work on a full time basis⁷ requiring reliance
21 on long-term disability insurance to supplement income; and
22

23 Whereas, While the DOT contains discrete and well-established descriptions of the physical
24 demands of occupations, it does not provide sufficiently specific information on associated
25 mental and cognitive requirements; and
26

27 Whereas, Working with the U.S. Bureau of Labor Statistics allows the SSA the unique
28 opportunity to consider including descriptions of the mental and cognitive requirements of work
29 in the new OIS; and
30

31 Whereas, In the absence of more specific definitions in the disability insurance application,
32 many long-term disability insurers use a “national economy” standard to establish a job
33 description; and
34

35 Whereas, Application of such a national standard may lead to long-term disability denials and
36 financial hardship for physicians; therefore be it
37

38 RESOLVED, That our American Medical Association study the most effective approach to
39 developing specialty-specific job descriptions that reflect the true physical and cognitive
40 demands of each given specialty for use in the Occupational Information System under

- 1 development by the Social Security Administration so as to ensure that physician disability
- 2 policies are robust and protective if a coverage trigger occurs. (Directive to Take Action)

Fiscal Note: Not yet determined.

Received: 3/17/23

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 102
(A-23)

Introduced by: Medical Student Section

Subject: Reforming the Medicare Part B “Buy and Bill” Process to Encourage Biosimilar Use

Referred to: Reference Committee A

1 Whereas, Medicare Part B spending on physician-administered drugs (PADs), 77% of which are
2 injectable biologics, constitutes a large financial outlay (\$39 billion in 2019) and grew at an
3 average annual rate of 9.7% from 2009 to 2019¹; and
4

5 Whereas, Reimbursement for PADs under current Medicare Part B regulations is governed by
6 the “Buy and Bill” system, in which physicians purchase PADs from wholesalers or distributors,
7 stock the drug (incurring the associated inventory costs), and are reimbursed by Medicare (and
8 other commercial insurers) at an amount equal to the Average Sales Price (ASP) of a given
9 drug plus 6% of the ASP^{2,3}; and
10

11 Whereas, Currently, each individual manufacturer’s biosimilar are reimbursed at different
12 amounts based on distinct codes, each with a unique ASP⁴; and
13

14 Whereas, Health economists and policymakers note that this remuneration structure removes
15 incentives for physicians to pick the least costly version of the drug (and may even incentivize
16 physicians to pick the most expensive drug in a class) when several biosimilars exist, which
17 allows manufacturers to maintain high ASPs and thus results in elevated part B spending^{3,4}; and
18

19 Whereas, Biosimilar market penetration is substantially lower in the U.S. than in other high-
20 income countries, in which a large number of biosimilars have been approved and market
21 penetration for approved agents is higher, leading to significant (~60-85%) price reductions⁵;
22 and
23

24 Whereas, Medicare Part B’s “buy and bill” regulations drive the use of more costly versions of a
25 biologic (often the originator agent) and may thus reduce the market penetration of additional
26 competitor biosimilars that may be less expensive^{5,6}; and
27

28 Whereas, Greater market penetration and competition of biosimilars in the United States could
29 save between \$2 and \$7 billion per year (~1% of total Medicare Part B spending and ~30% of
30 Medicare Part B pharmaceutical expenditure)⁴; and
31

32 Whereas, Moving towards a fixed-fee structure may expose losses if the costs of acquiring and
33 storing drugs changes significantly from year to year²; and
34

35 Whereas, Allowing the fixed fee to be modifiable and indexed to an appropriate healthcare cost
36 inflation index can ensure that changes to the PAD remuneration policy cover the costs that
37 physicians bear in purchasing and storing PADs, consistent with AMA policy D-330.960⁷; and

Whereas, At the N-21 Special Meeting of the House of Delegates, our AMA passed new policy “support[ing] legislation that limits Medicare annual drug price increases to the rate of inflation”; therefore be it

RESOLVED, That our American Medical Association encourage the Centers for Medicare and Medicaid Services (CMS) to: (a) identify groups of Physician-Administered Drugs (PADs), each comprised of the reference biologic and its biosimilars (based on FDA approvals), to be reimbursed at the same rate to incentivize selection of less expensive PADs while preserving access for patients and reimbursement for physicians; and (b) determine the method rate by which a group of PADs will be reimbursed such that physicians are compensated appropriately for acquisition, inventory, carrying, and administration costs, including but not limited to creating fixed add-on fees to be used for all PADs in a group and indexing rate increases for a group of PADs to the rate of inflation. (New HOD Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 3/27/23

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RELEVANT AMA POLICY

Cuts in Medicare Outpatient Infusion Services D-330.960

1. Our AMA will actively support efforts to seek legislation to ensure that Medicare payments for drugs fully cover the physician's acquisition, inventory and carrying cost and that Medicare payments for drug administration and related services are adequate to ensure continued patient access to outpatient infusion services.
2. Our AMA will continue strong advocacy efforts working with relevant national medical specialty societies to ensure adequate physician payment for Part B drugs and patient access to biologic and pharmacologic agents.

Citation: Res. 926, I-03; Reaffirmed and Modified: CMS Rep. 3, I-08; Reaffirmation A-15; Reaffirmed: CMS Rep. 10, A-16; Reaffirmation: I-18;

Opposition to the CMS Medicare Part B Drug Payment Model D-330.904

1. Our AMA will request that the Centers for Medicare & Medicaid Services (CMS) withdraw the proposed Part B Drug Payment Model.
2. Our AMA will support and actively work to advance Congressional action to block the proposed Part B Drug Payment Model if CMS proceeds with the proposal.
3. Our AMA will advocate against policies that are likely to undermine access to the best course of treatment for individual patients and oppose demonstration programs that could lead to lower quality of care and do not contain mechanisms for safeguarding patients.

4. Our AMA will advocate for ensuring that CMS solicits and takes into consideration feedback from patients, physicians, advocates, or other stakeholders in a way that allows for meaningful input on any Medicare coverage or reimbursement policy that impacts patient access to medical therapies, including policies on coverage and reimbursement.

Citation: Res. 241, A-16;

Medicare Part B Competitive Acquisition Program (CAP) H-110.983

Our AMA will advocate that any revised Medicare Part B Competitive Acquisition Program meet the following standards to improve the value of the program by lowering the cost of drugs without undermining quality of care:

- (1) it must be genuinely voluntary and not penalize practices that choose not to participate;
- (2) it should provide supplemental payments to reimburse for costs associated with special handling and storage for Part B drugs;
- (3) it must not reduce reimbursement for services related to provision/administration of Part B drugs, and reimbursement should be indexed to an appropriate healthcare inflation rate;
- (4) it should permit flexibility such as allowing for variation in orders that may occur on the day of treatment, and allow for the use of CAP-acquired drugs at multiple office locations;
- (5) it should allow practices to choose from multiple vendors to ensure competition, and should also ensure that vendors meet appropriate safety and quality standards;
- (6) it should include robust and comprehensive patient protections which include preventing delays in treatment, helping patients find assistance or alternative payment arrangements if they cannot meet the cost-sharing responsibility, and vendors should bear the risk of non-payment of patient copayments in a way that does not penalize the physician;
- (7) it should not allow vendors to restrict patient access using utilization management policies such as step therapy; and
- (8) it should not force disruption of current systems which have evolved to ensure patient access to necessary medications.

Citation: Res. 216, I-18; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 4, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 103
(A-23)

Introduced by: Medical Student Section

Subject: Movement Away from Employer-Sponsored Health Insurance

Referred to: Reference Committee A

1 Whereas, More than 50% of Americans rely on employer-sponsored health insurance (ESHI),
2 which was first offered as a benefit to attract workers during the wage freeze of WWII^{1,2}; and
3

4 Whereas, With health insurance linked to employment, job loss can decrease access to
5 healthcare, including important preventative services and chronic disease management^{3,4}; and
6

7 Whereas, Economic downturns due to global recessions or pandemics can result in millions of
8 people losing their employer-sponsored health insurance, including an estimated 7 million
9 individuals who have lost ESHI due to the COVID-19 pandemic and associated recession⁵⁻¹¹;
10 and
11

12 Whereas, Due to variation in insurer networks, patients who switch jobs and as a result change
13 their health insurance may have to change doctors, creating a barrier to continuity of care^{12,13};
14 and
15

16 Whereas, In 2019, 36% of employers offered only a single health insurance plan and an
17 additional 40% of employers offered only two plans, decreasing patient choice and preventing
18 the functioning of a free market¹⁴⁻¹⁶; and
19

20 Whereas, By linking health insurance to employment, employer-sponsored health insurance
21 creates job lock and decreases entrepreneurship^{17,18}; and
22

23 Whereas, A 2016 study in the Journal of Economic Perspectives found that people in the
24 bottom fifth of family income receive annual benefits of less than \$500, while those in the top
25 fifth receive benefits averaging \$4,500, demonstrating that employer-sponsored health
26 insurance tax deduction disproportionately benefits the wealthy¹⁹; and
27

28 Whereas, Self-insurance refers to the practice wherein employers collect premiums from
29 employees and pay for healthcare benefits for plan beneficiaries directly, with or without the
30 assistance of third party administrators who may negotiate networks, process claims, and
31 provide other services^{20,21}; and
32

33 Whereas, Because of financial and legal incentives that favor the practice, between 75-80% of
34 employers self-insure, meaning that many firms become de facto health insurance companies in
35 addition to the main business activities they are engaged in^{22,23}; and
36

37 Whereas, Self-insured plans have proven incapable of controlling healthcare costs, with one
38 RAND study focusing on predominantly self-insured employer plans showing that hospital costs
39 increased from 236% of Medicare rates to 241% of Medicare rates in the two year period from
40 2015-2017^{23,24}; and

1 Whereas, The administrative costs of private, employer-based plans far exceed the
2 administrative costs of public plans in the United States and insurance systems in other
3 industrialized peer nations²⁵⁻²⁹; and
4

5 Whereas, The excessively fragmented nature of the employer-sponsored health insurance
6 market in the United States is a significant contributor to the higher costs of medical goods and
7 services in the United States relative to other countries²⁹⁻³¹; and
8

9 Whereas, Multiple different models exist for the provision of health insurance coverage,
10 including systems based wholly on individually owned private insurance plans, the Bismarckian
11 model wherein payroll taxes are used to fund competing nonprofit insurance providers, and the
12 national health insurance model wherein government insurance plans funded by taxes contract
13 with privately owned healthcare providers^{32,33}; and
14

15 Whereas, All of the assorted health insurance systems employed in other industrialized
16 countries outperform the ESHI-based American insurance system on key metrics such as health
17 outcomes, cost, and administrative efficiency^{29,30,34-36}; and
18

19 Whereas, Under the Affordable Care Act, patients who are offered an “affordable” ESHI plan
20 that meets the minimum value standard are ineligible to receive premium tax credits and cost
21 sharing reductions (a requirement known as the “ESHI firewall”), thus significantly impairing
22 their ability to buy a plan on the ACA’s Health Insurance Marketplaces at an affordable rate³⁷;
23 and
24

25 Whereas, An ESHI plans needs to cover only 60% of the total cost of expected healthcare
26 expenses to meet the minimum value standard, leaving up to 40% of these costs to be covered
27 by the patient³⁷; and
28

29 Whereas, A survey of employer-sponsored health insurance beneficiaries conducted by the
30 Kaiser Family Foundation in 2019 found that over 40% of beneficiaries had difficulty paying for
31 some aspect of their coverage, including the premium, deductibles, or other expenditures³⁸; and
32

33 Whereas, Under current law, the cost of individual ESHI coverage is exclusively used to
34 calculate plan affordability even if the employee wants to or needs to purchase a family plan,
35 meaning that millions of Americans are ineligible for premium tax credits but may also be unable
36 to afford a plan through their employer³⁹⁻⁴²; and
37

38 Whereas, Eliminating the ESHI firewall would allow individuals who are offered ESHI to still be
39 eligible for premium tax credits and cost sharing reductions, thus enabling them to choose a
40 plan that is the most affordable and best meets their needs from either their employer-
41 sponsored plans or other plans offered on their state’s Health Insurance Marketplace^{43,44}; and
42

43 Whereas, Roughly 10-20 million Americans with ESHI could choose a plan on the ACA
44 Exchanges with lower premiums than their current employer-based plan if the ESHI firewall
45 were eliminated^{44,45}; and
46

47 Whereas, In 2017, 2.7 million uninsured Americans who otherwise would be eligible for
48 premium tax credits to lower the cost of insurance coverage were ineligible for those tax credits
49 because of an offer of ESHI⁴⁶; and

Whereas, Removing the ESHI firewall could contribute to substantial insurance coverage gains by making insurance options on the ACA Exchanges significantly more affordable for individuals who may not be able to afford insurance offered through their employer⁴⁷⁻⁵⁰; and

Whereas, The American Medical Association “supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage” (Policy H-165.920), but has not recognized the deficiencies of the employer-sponsored insurance system, nor the need to move towards a health insurance system that does not rely on employer-sponsored insurance; therefore be it

RESOLVED, That our American Medical Association recognize the inefficiencies and complexity of the employer-sponsored health insurance system and the existence of alternative models that better align incentives to facilitate access to high quality healthcare (New HOD Policy); and be it further

RESOLVED, That our AMA support movement toward a healthcare system that does not rely on employer-sponsored health insurance and enables universal access to high quality healthcare (New HOD Policy); and be it further

RESOLVED, That our AMA amend Policy H-165.828, “Health Insurance Affordability”, by addition and deletion to read as follows:

HEALTH INSURANCE AFFORDABILITY, H-165.828

~~1. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to that which applies to the exemption from the individual mandate of the Affordable Care Act (ACA).~~ Our AMA advocates for the elimination of the employer-sponsored insurance firewall such that no individual would be ineligible for premium tax credits and cost-sharing assistance for marketplace coverage solely on the basis of having access to employer-sponsored health insurance.

2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the affordability of employer-sponsored coverage with respect to the cost of family-based or employee-only coverage.

3. Our AMA 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 (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy.

4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible.

5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.

6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.
7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.
8. Our AMA supports the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace. (Modify Current HOD Policy) and be it further

RESOLVED, That our AMA amend Policy H-165.823, "Options to Maximize Coverage under the AMA Proposal for Reform", by deletion to read as follows:

**OPTIONS TO MAXIMIZE COVERAGE UNDER THE AMA
PROPOSAL FOR REFORM, H-165.823**

1. That our AMA advocate for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians.
2. Our AMA will advocate that any 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 that meets standards for minimum value of benefits.~~
 - ~~be.~~ 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.
 - ~~cd.~~ 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.
 - ~~de.~~ The public option is financially self-sustaining and has uniform solvency requirements.
 - ~~ef.~~ The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
 - ~~fg.~~ 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.
3. Our AMA supports 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

1 auto-enrollment would, therefore, include individuals eligible for
2 Medicaid/Children's Health Insurance Program (CHIP) or zero-
3 premium marketplace coverage.

4 c. Individuals should have the opportunity to opt out from health
5 insurance coverage into which they are auto-enrolled.

6 d. Individuals should not be penalized if they are auto-enrolled into
7 coverage for which they are not eligible or remain uninsured despite
8 believing they were enrolled in health insurance coverage via auto-
9 enrollment.

10 e. Individuals eligible for zero-premium marketplace coverage should
11 be randomly assigned among the zero-premium plans with the
12 highest actuarial values.

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

17 g. Individuals enrolled in a zero-premium bronze plan who are
18 eligible for cost-sharing reductions should be notified of the cost-
19 sharing advantages of enrolling in silver plans.

20 h. There should be targeted outreach and streamlined enrollment
21 mechanisms promoting health insurance enrollment, which could
22 include raising awareness of the availability of premium tax credits
23 and cost-sharing reductions, and establishing a special enrollment
24 period.

25 4. Our AMA: (a) will advocate that any federal approach to cover
26 uninsured individuals who fall into the "coverage gap" in states that
27 do not expand Medicaid--having incomes above Medicaid eligibility
28 limits but below the federal poverty level, which is the lower limit for
29 premium tax credit eligibility--make health insurance coverage
30 available to uninsured individuals who fall into the coverage gap at
31 no or nominal cost, with significant cost-sharing protections; (b) will
32 advocate that any federal approach to cover uninsured individuals
33 who fall into the coverage gap provide states that have already
34 implemented Medicaid expansions with additional incentives to
35 maintain their expansions; (c) supports extending eligibility to
36 purchase Affordable Care Act (ACA) marketplace coverage to
37 undocumented immigrants and Deferred Action for Childhood
38 Arrivals (DACA) recipients, with the guarantee that health plans and
39 ACA marketplaces will not collect and/or report data regarding
40 enrollee immigration status; and (d) recognizes the potential for state
41 and local initiatives to provide coverage to immigrants without regard
42 to immigration status. (Modify Current HOD Policy)

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

Received: 3/27/23

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RELEVANT AMA POLICY

Individual Health Insurance H-165.920

Our AMA:

- (1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services;
- (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite

resources, as a necessary interim step toward universal access;

(3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, our AMA will:

(a) Continue to support equal tax treatment for payment of health insurance coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes;

(b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly;

(c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and

(d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes;

(4) will identify any further means through which universal coverage and access can be achieved;

(5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it;

(6) supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage;

(7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons;

(8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health insurance premium expenditures;

(9) supports legislation requiring a "maintenance of effort" period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan;

(10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage;

(11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one;

(12) supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax;

(13) advocates that, upon replacement, with tax credits, of the exclusion of employer-sponsored health insurance from employees' federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies; and

(14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured.

(15) Our AMA reaffirms our policies committed to our patients and their individual responsibility and freedoms consistent with our United States Constitution.

Citation: BOT Rep. 41, I-93; CMS Rep. 11, I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Amended by CMS Rep. 2, I-96; Amended and Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97;

Reaffirmed: CMS Rep. 5, I-97; Res. 212, I-97; Appended and Amended by CMS Rep. 9, A-98; Reaffirmation I-98; Reaffirmation I-98; Res. 105 & 108, A-99; Reaffirmation A-99; Reaffirmed: CMS Rep. 5 and 7, I-99; Modified: CMS Rep. 4, CMS Rep. 5, and Appended by Res. 220, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 2, I-01; Reaffirmed CMS Rep. 5, A-02; Reaffirmation A-03; Reaffirmed: CMS Rep. 1 and 3, A-02; Reaffirmed: CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation I-03; Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Modified: CMS Rep. 3, A-06; Reaffirmed in lieu of Res. 105, A-06; Reaffirmation A-07; Appended and Modified: CMS Rep. 5, A-08; Modified: CMS Rep. 8, A-08; Reaffirmation A-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: Res. 239, A-12; Appended: Res. 239, A-12; Reaffirmed: CMS Rep. 6, A-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed in lieu of: Res. 805, I-17;

Universal Health Coverage H-165.904

Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories; (2) seeks federal legislation that would require the federal government to provide financial support to any individuals, organizations, and institutions providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans
Citation: Sub. Res. 138, A-94; Appended: Sub. Res. 109, I-98; Reaffirmation A-02; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 1, A-22;

Evaluating Health System Reform Proposals H-165.888

1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:

- A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
- B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
- C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.
- D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.
- E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.
- F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.
- G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.
- H. True health reform is impossible without true tort reform.

2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.

3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.

4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.

Citation: Res. 118, I-91; Res. 102, I-92; BOT Rep. NN, I-92; BOT Rep. S, A-93; Reaffirmed: Res. 135, A-93; Reaffirmed: BOT Reps. 25 and 40, I-93; Reaffirmed in lieu of Res. 714, I-93; Res. 130, I-93; Res. 316, I-93; Sub. Res. 718, I-93; Reaffirmed: CMS Rep. 5, I-93; Res. 124, A-94; Reaffirmed by BOT Rep. 1- I-94; CEJA Rep. 3, A-95; Reaffirmed: BOT Rep. 34, I-95; Reaffirmation A-00; Reaffirmation A-01; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CME Rep. 2, A-03; Reaffirmed and Modified: CMS Rep. 5, A-04; Reaffirmed with change in title: CEJA Rep. 2, A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation I-07; Reaffirmed in lieu of Res. 113, A-08; Reaffirmation A-09; Res. 101, A-09; Sub. Res. 110, A-09; Res. 123, A-09; Reaffirmed in lieu of Res. 120, A-12; Reaffirmation: A-17;

Health System Reform Legislation H-165.838

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:

- a. Health insurance coverage for all Americans
- b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
- c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
- d. Investments and incentives for quality improvement and prevention and wellness initiatives
- e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
- f. Implementation of medical liability reforms to reduce the cost of defensive medicine
- g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens

2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.

3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.

4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.

5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.

6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.

7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.

8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:

- a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
- b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
- c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
- d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
- e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another

f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest

9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.

10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.

11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.

12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.

Citation: Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed in lieu of: Res. 805, I-17; Reaffirmed: CMS Rep. 03, A-18; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmation: A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 104
(A-23)

Introduced by: Medical Student Section

Subject: Support for Medicare Expansion to Wheelchair Accessibility Home
Modifications as Durable Medical Equipment

Referred to: Reference Committee A

1 Whereas, The 2010 United States Census reported that 3.6 million individuals utilize a
2 wheelchair and 11.6 million used a cane, crutches or walker to assist with ambulation¹; and
3

4 Whereas, A report from the U.S. Department of Housing and Urban Development Office of
5 Policy Development and Research reports that 89.2% of persons with disability live in
6 inaccessible housing²; and
7

8 Whereas, Over 50% of households with a resident reliant on wheeled mobility equipment have
9 homes with stairs at the front entrance that may inhibit their ability to freely enter their home²;
10 and
11

12 Whereas, The United Nations Convention on the Rights of Persons with Disabilities, Article 9
13 safeguards the right of persons with disabilities to live in an accessible environment⁵; and
14

15 Whereas, A Joint Statement by the Department of Justice and Department of Housing and
16 Urban Development on the Fair Housing Act requires that passage into and within all premises
17 of covered dwellings may have an accessible route for wheelchair users¹⁴; and
18

19 Whereas, The Fair Housing Act also require usable kitchen and bathrooms such that an
20 individual using a wheelchair can maneuver about and use this space¹⁴; and
21

22 Whereas, One study noted that 16% of injuries from wheelchair accidents from falls required
23 medical intervention, most commonly for fractures and concussions³; and
24

25 Whereas, A study that employed wheeled mobility device users found that 90% of participants
26 reported that their participation was limited when surfaces higher than their wheeled device
27 were encountered, indicating the value that wheelchair ramps can provide¹²; and
28

29 Whereas, Researchers at the National Disability Institute found that on average households
30 containing an adult with a physical disability required 28% more income, or an additional
31 \$17,690 a year to obtain the same standard of living^{4,11}; and
32

33 Whereas, Medicare Part B covers medically necessary equipment defined as Durable Medical
34 Equipment including wheelchairs, scooters, traction equipment, however not including
35 wheelchair ramps as medically necessary¹³; and
36

37 Whereas, A single-blind randomized controlled trial in New Zealand found a 31% reduction in
38 the rate of fall injuries at home per year following home stairs modification intervention
39 compared with households in the control group without home modification⁷; and

Whereas, A study that assessed the factors that influence the risk of falling after spinal cord injury found lack of necessary home modification to be a major determinant⁹; and

Whereas, Spinal cord injury patient participants in the 2020 BMJ Open study noted that “egregious cost of home modifications” are reason for lack of proper accommodations and increased incidence of fall⁹; and

Whereas, Independence in mobility, as provided by necessary wheelchair home modifications, has been deemed a key factor in preserving function and maintaining life satisfaction among wheelchair users^{6,8,10}; therefore be it

RESOLVED, That our American Medical Association support that Medicare Part B cover wheelchair ramps and associated home installation for beneficiaries for whom using a wheelchair at home is “medically necessary.” (New HOD Policy)

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

Received: 3/27/23

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RELEVANT AMA POLICY

Support for Housing Modification Policies H-160.890

Our AMA supports improved access to housing modification benefits for populations that require modifications in order to mitigate preventable health conditions, including but not limited to the elderly, the disabled and other persons with physical and/or mental disabilities.

Citation: Res. 806, I-19;

Protect Medicare Beneficiary Access to Complex Rehabilitation Wheelchairs D-330.907

Our AMA strongly encourages the Centers for Medicare and Medicaid Services (CMS) to refrain from implementing policies on January 1, 2016 that would curtail access to complex rehabilitation technology (CRT) wheelchairs and accessories by applying competitively bid prices to these specialized devices. In the event that CMS does not refrain from implementing policies limiting access to CRT wheelchairs, our AMA will encourage Congress to support legislation (e.g. H.R. 3229) that would provide a technical correction to federal law to clarify that CMS cannot apply Medicare competitive bidding pricing to CRT wheelchairs.

Citation: (Res. 816, I-15)

Protecting Patient Access to Seat Elevation and Standing Features in Power Wheelchairs D-330.899

Our AMA will request that the Centers for Medicare and Medicaid Services render a benefit category determination 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 when used in a power wheelchair.

Citation: Res. 808, I-19;

Appropriate Reimbursement for Evaluation and Management Services for Patients with Severe Mobility-Related Impairments H-390.835

Our AMA supports: (1) additional reimbursement for evaluation and management services for patients who require additional time and specialized equipment during medical visits due to severe mobility-related impairments; (2) that no additional cost-sharing for the additional reimbursement will be passed on to patients with mobility disabilities, consistent with Federal Law; (3) that primary and specialty medical providers be educated regarding the care of patients with severely impaired mobility to improve access to care; and (4) additional funding for payment for services provided to patients with mobility related impairments that is not through a budget neutral adjustment to the physician fee schedule.

Citation: Res. 814, I-17;

Community Mobility Devices H-90.978

The AMA urges physicians, who treat patients with impaired mobility outside the home, to work with state medical associations and appropriate medical specialty societies to identify state agencies and community service organizations that provide local transportation assistance to disabled individuals, and that such information be made readily accessible to disabled patients.

Citation: CMS Rep. 10, A-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: CMS Rep. 01, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 105
(A-23)

Introduced by: Medical Student Section

Subject: Studying Population-Based Payment Policy Disparities

Referred to: Reference Committee A

1 Whereas, Certain fields of medicine care for distinct patient populations, such as pediatrics,
2 obstetrics and gynecology (OBGYN), geriatrics, infectious disease, urology, addiction medicine,
3 sports medicine, etc.; and
4

5 Whereas, Procedures performed for specialized patient populations such as gynecology
6 patients have been shown to be reimbursed at lower rates than those for other specialized
7 patient populations such as urology patients, despite being similar in nature¹; and
8

9 Whereas, The Medicare fee schedule is a leading cause of reimbursement imbalance between
10 specialties due to documented factors, such as discrepancies in valuation of surgical
11 intraoperative time, and different valuation of procedural and physical effort to cognitive effort²;
12 and
13

14 Whereas, There is evidence to suggest that current work Relative Value Units (RVUs) are
15 misvalued as changes in work RVUs have not reflected changes in technology in some
16 specialties with undervaluation in cognitive effort, such as the management of complex
17 conditions by primary care providers^{3,4}; and
18

19 Whereas, In comparison to higher paid specialties, lower paid specialties with a single physician
20 serving Medicare recipients are more likely to be completely absent in a given county, such that
21 92% of counties lack an addiction medicine physician and 80% of counties lack an infectious
22 disease specialist⁵; and
23

24 Whereas, Access to care for mental health has persisted as an issue due to provider availability
25 and reimbursement incentives⁶; and
26

27 Whereas, Documented racial disparities in reimbursement rates demonstrate statistically
28 significant lower mean reimbursement per RVU for insured black patients within a tertiary
29 hospital Emergency Department compared to their white counterparts, after adjusting for
30 demographic and insurance factors⁷; and
31

32 Whereas, An analysis of RVUs reimbursed for gender-specific procedures revealed that
33 procedures predominantly done on men were associated with higher RVUs and compensated at
34 a rate 26.67% higher than procedures done predominantly on women¹; and
35

36 Whereas, Disparity in RVUs reimbursed for similar procedures performed predominantly on
37 women versus men has minimally decreased from 1997 to 2015, with a study reporting 42 of 50
38 (84%) male-based urologic procedures compensated at a higher rate than the paired female
39 urologic procedures¹; and

1 Whereas, OBGYN physicians work comparable hours and perform many surgical procedures
2 similar in number and complexity to other surgical specialties, yet their pay is the lowest
3 amongst all surgical specialties; leading to an estimated OBGYN physician shortage of 17% by
4 2030, 24% by 2040, and 31% by 2050^{8,9}; and

5
6 Whereas, Pediatric subspecialists are compensated at a significantly lower rate than that of
7 internal medicine subspecialists, contributing to a high percentage of vacant seats across
8 pediatric fellowship programs and a resulting shortage of pediatric subspecialists¹⁰⁻¹²; and

9
10 Whereas, The compensation of pediatric sub-specialists is lower than general pediatricians, de-
11 incentivizing trainees to pursue fellowships in that realm, with a study finding the salary of
12 pediatric endocrinologists to be 10% lower than that of general pediatricians¹³⁻¹⁵; and

13
14 Whereas, Pediatric infectious disease specialists experience the lowest compensation of all
15 physicians, earning \$191,735 compared to \$265,000 earned by adult infectious disease
16 specialists¹³⁻¹⁵; and

17
18 Whereas, Most pediatric subspecialty programs experience a significant fraction of unfilled
19 seats; for example, 40.6% of pediatric nephrologist fellowship seats were not filled in 2019,
20 indicating both trainee disinterest and a lack of provider availability, which can negatively impact
21 access to care and contribute to longer wait times^{10,16}; and

22
23 Whereas, Medicare and Medicaid often function as a safety net for hospitals by reimbursing
24 institutions for expenses of hospitalizations not paid by patients themselves, and often falls short
25 of covering the hospitals' care-delivery costs^{17,18}; and

26
27 Whereas, Lower reimbursements for specialties that care for certain underserved patient
28 populations may disincentivize physicians from entering those specialties and providing care for
29 the corresponding patient populations, or disincentivize hospitals to provide such care^{19,20}; and

30
31 Whereas, Not only is the ratio of specialists to primary care physicians (PCP) higher in the U.S.
32 than in other countries, it has been documented by studies as being due to U.S. ratio of
33 specialist to PCP compensation rates exceeding other countries' specialist to PCP
34 compensation rates²¹⁻²⁴; and

35
36 Whereas, An American College of Physicians position statement holds that "Medicare and other
37 payers should adopt population-based, prospective payment models for primary and
38 comprehensive care that are structured and sufficient to ensure access to needed care and
39 address the needs of individuals experiencing health care disparities and inequities based on
40 personal characteristics and/or are disproportionately affected by social drivers of health. Hybrid
41 models combining fee-for-service with prospective payment should be made available and
42 should prioritize the needs of such individuals"²⁵; and

43
44 Whereas, The Center for Medicare Services' most recent publication of the Medicare payment
45 schedule came with an official solicitation for comments on how the agency can advance health
46 equity for people with Medicare²⁶; and

47
48 Whereas, The National Academy of Medicine Committee for Medicare recommends a potential
49 policy remedy to use reimbursements to incentivize care for underserved populations: a per-
50 patient payment adjustment for patients' social risks, deliberately connected to the quality of
51 patient outcomes; an approach that requires separate reporting of quality measures for

1 hospitals in different categories related to distinct levels of social risk in the populations they
2 serve and includes an additional financial incentive for quality improvement^{27,28}; and

3
4 Whereas, Financial incentives can reward hospitals for incremental improvements in quality
5 measures against their own historical benchmarks, and promote closing gaps in the quality of
6 care that may be worse among institutions primarily serving disadvantaged populations^{27,28}; and

7
8 Whereas, Anchor institutions are (organizations that commit themselves to hiring, procuring,
9 and investing in disadvantaged communities) and would earn enriched reimbursement for the
10 patients they serve from those same or similarly disadvantaged communities²⁹; and

11
12 Whereas, Another policy alternative to use reimbursement to promote care for underserved
13 populations is to promote hospitals that achieve certain metrics in key domains to be qualified
14 as anchor institutions²⁹; and

15
16 Whereas, A study found that the choice of a higher-income specialty was associated with lower
17 burnout (OR = 0.56, 95% CI 0.32-0.98)³⁰; and

18
19 Whereas, Medical students have indicated difficulty in completing loan repayments due to
20 increasing tuition rates and lack of financial compensation as deterrents to entering certain
21 fields and caring for certain populations^{25, 31}; and

22
23 Whereas, Nearly half (48%) of graduating medical students cite income as a strong or moderate
24 influence on their decision to pursue a certain specialty, and only 20% stated that it has no
25 influence on their decision of which specialty to choose²⁰; and

26
27 Whereas, Current AMA Policy H-65.961 states that the AMA “declares that compensation
28 should be equitable and based on demonstrated competencies and expertise and not based on
29 personal characteristics,” which can include the type of population a physician serves or the
30 specialty they practice; therefore be it

31
32 RESOLVED, That our American Medical Association study opportunities to incentivize
33 physicians to select specialties and practice settings which involve delivery of health services to
34 populations experiencing a shortage of providers, such as women, LGBTQ+ patients, children,
35 elder adults, and patients with disabilities, including populations of such patients who do not live
36 in underserved geographic areas (Directive to Take Action); and be it further

37
38 RESOLVED, That our AMA study the effects of factors such as valuation and reimbursement
39 rates on physician choice of specialty, degree of institutional support, workforce shortages,
40 burnout, and attrition, especially in specialties and practice settings that primarily care for
41 underserved populations. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 3/27/23

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RELEVANT AMA POLICY

E9.5.5 Gender Discrimination in Medicine

Inequality of professional status **in medicine** among individuals based on **gender** can compromise patient care, undermine trust, and damage the working environment. Physician leaders **in** medical schools and medical institutions should advocate for increased leadership **in medicine** among individuals of underrepresented genders and equitable compensation for all physicians.

Collectively, physicians should actively advocate for and develop family-friendly policies that:

(a) Promote fairness **in** the workplace, including providing for:

(i) retraining or other programs that facilitate re-entry by physicians who take time away from their careers to have a family;

(ii) on-site child care services for dependent children;

(iii) job security for physicians who are temporarily not **in** practice due to pregnancy or family obligations.

(b) Promote fairness **in** academic medical settings by:

(i) ensuring that tenure decisions make allowance for family obligations by giving faculty members longer to achieve standards for promotion and tenure;

(ii) establish more reasonable guidelines regarding the quantity and timing of published material needed for promotion or tenure that emphasize quality over quantity and encourage the pursuit of careers based on individual talent rather than tenure standards that undervalue teaching ability and overvalue research;

(iii) fairly distribute teaching, clinical, research, administrative responsibilities, and access to tenure tracks;

(iv) structuring the mentoring process through a fair and visible system.

(c) Take steps to mitigate **gender** bias **in** research and publication.

Issued: 2016

Principles for Advancing Gender Equity in Medicine H-65.961

Principles for Advancing Gender Equity in Medicine:

Our AMA:

1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);

2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;

3. endorses the principle of equal opportunity of employment and practice in the medical field;

4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;

5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;

6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;

7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;

8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and

9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.

Citation: BOT Rep. 27, A-19;

Advancing Gender Equity in Medicine D-65.989

1. Our AMA will: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.
2. Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.
3. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.
4. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.
5. Our AMA will: (a) require all members elected and appointed to national and regional AMA leadership positions to complete AMA Code of Conduct and anti-harassment training, with continued evaluation of the training for effectiveness in reducing harassment within the AMA; and (b) work with the Women Physicians Section, American Medical Women's Association, GLMA: Health Professionals Advancing LGBTQ Equality, and other stakeholders to identify an appropriate, evidence-based anti-harassment and sexual harassment prevention training to administer to leadership.

Citation: Res. 010, A-18; Modified: BOT Rep. 27, A-19; Appended: Res. 615, A-22;

Medical Care of Persons with Disabilities H-90.968

1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with disabilities including but not limited to physical, sensory, developmental, intellectual, learning, and psychiatric disabilities and chronic illnesses; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) education of physicians on how to provide and/or advocate for developmentally appropriate and accessible medical, social and living support for patients with disabilities so as to improve health outcomes; (e) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound disabilities and multiple co-morbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with disabilities to implement priorities and quality improvements for the care of persons with disabilities.
2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with disabilities, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with disabilities.
3. Our AMA entreats health care professionals, parents, and others participating in decision-making to be

guided by the following principles: (a) All people with disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual's medical condition and welfare must be the basis of any medical decision.

Our AMA advocates for the highest quality medical care for persons with profound disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound disabilities, that there are resources available to them.

4. Our AMA will collaborate with appropriate stakeholders to create a model general curriculum/objective that (a) incorporates critical disability studies; and (b) includes people with disabilities as patient instructors in formal training sessions and preclinical and clinical instruction.

5. Our AMA recognizes the importance of managing the health of children and adults with developmental and intellectual disabilities as a part of overall patient care for the entire community.

6. Our AMA supports efforts to educate physicians on health management of children and adults with intellectual and developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with intellectual and developmental disabilities.

7. Our AMA encourages the Liaison Committee on Medical Education, Commission of Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement a curriculum on the care and treatment of people with a range of disabilities.

8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with a range of disabilities.

9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing programs that focus on the care and treatment of people with a range of disabilities.

10. Our AMA will advocate that the Health Resources and Services Administration include persons with disabilities as a medically underserved population.

11. Specific to people with developmental and intellectual disabilities, a uniquely underserved population, our AMA encourages: (a) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental and intellectual disabilities, to improve quality in clinical education; (b) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for individuals with developmental and intellectual disabilities; and (c) cooperation among physicians, health and human services professionals, and a wide variety of adults with intellectual and developmental disabilities to implement priorities and quality improvements for the care of persons with intellectual and developmental disabilities.

Citation: CCB/CLRPD Rep. 3, A-14; Appended: Res. 306, A-14; Appended: Res. 315, A-17; Appended: Res. 304, A-18; Reaffirmed in lieu of the 1st Resolved: Res. 304, A-18; Modified: Res. 428, A-22;

Principles of and Actions to Address Primary Care Workforce H-200.949

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.

2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).

3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.

4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to

reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.

18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.

19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.

20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.

21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.

22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.

23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.

24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.

25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

Citation: CME Rep. 04, I-18;

Reimbursement to Physicians and Hospitals for Government Mandated Services H-240.966

(1) It is the policy of the AMA that government mandated services imposed on physicians and hospitals that are peripheral to the direct medical care of patients be recognized as additional practice cost expense.

(2) Our AMA will accelerate its plans to develop quantitative information on the actual costs of regulations.

(3) Our AMA strongly urges Congress that the RBRVS and DRG formulas take into account these additional expenses incurred by physicians and hospitals when complying with governmentally mandated regulations and ensure that reimbursement increases are adequate to cover the costs of providing these services.

(4) Our AMA will advocate to the CMS and Congress that an equitable adjustment to the Medicare physician fee schedule (or another appropriate mechanism deemed appropriate by CMS or Congress) be developed to provide fair compensation to offset the additional professional and practice expenses required to comply with the Emergency Medical Treatment and Labor Act.

Citation: Sub. Res. 810, I-92; Appended by CMS 10, A-98; Reaffirmation I-98; Reaffirmation A-02; Reaffirmation I-07; Reaffirmed in lieu of Res. 126, A-09; Reaffirmed: CMS Rep. 01, A-19;

Adequate Physician Reimbursement for Long-Term Care H-280.979

Our AMA supports: (1) continuing discussion with CMS to improve Medicare reimbursement to physicians for primary care services, specifically including nursing home and home care medical services;

(2) continued efforts to work with the Federation to educate federal and state legislative bodies about the issues of quality from the perspective of attending physicians and medical directors and express AMA's commitment to quality care in the nursing home;

(3) efforts to work with legislative and administrative bodies to assure adequate payment for routine visits and visits for acute condition changes including the initial assessment and ongoing monitoring of care until the condition is resolved; and

(4) assisting attending physicians and medical directors in the development of quality assurance guidelines and methods appropriate to the nursing home setting.

Citation: Res. 110, I-88; Res. 94, A-89; Res. 152, A-91; CMS Rep. 11, I-95; Reaffirmed: Sunset Report, I-98; Reaffirmation A-02; Reaffirmation A-06; Reaffirmed: CMS Rep. 01, A-16;

Fair Physician Contracts H-285.946

Our AMA will develop national (state) standards and model legislation for fair managed care/physician contracts, thereby requiring full disclosure in plain English of important information, including but not limited to: (1) disclosure of reimbursement amounts, conversion factors for the RBRVS system or other formulas if applicable, global follow-up times, multiple procedure reimbursement policies, and all other payment policies;

(2) which proprietary "correct coding" CPT bundling program is employed;

(3) grievance and appeal mechanisms;

(4) conditions under which a contract can be terminated by a physician or health plan;

(5) patient confidentiality protections;

(6) policies on patient referrals and physician use of consultants;

(7) a current listing by name and specialty of the physicians participating in the plan; and

(8) a current listing by name of the ancillary service providers participating in the plan.

Citation: Res. 727, A-97; Amended by CMS Rep. 3, A-98; Reaffirmed: Res. 814, A-00; Reaffirmation A-06; Reaffirmation A-08; Reaffirmation I-08; Reaffirmed: CMS Rep. 01, A-18;

Cuts in Medicare and Medicaid Reimbursement H-330.932

Our AMA: (1) continues to oppose payment cuts in the Medicare and Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients; (2) supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the Medicare population, and the cost of new technology; (3) aggressively encourages CMS to affirm the patient's and the physician's constitutional right to privately contract for medical services; (4) if the reimbursement is not improved, the AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee; and (5) supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases.

Citation: Sub. Res. 101, A-97; Reaffirmation A-99 and Reaffirmed: Res. 127, A-99; Reaffirmation A-00;

Reaffirmation I-00; Reaffirmed: BOT Action in response to referred for decision Res. 215, I-00;

Reaffirmation A-01; Reaffirmation and Appended: Res. 113, A-02; Reaffirmation A-05; Reaffirmed in lieu of Res. 207, A-13; Reaffirmed: Res. 212, I-21;

Consultation Follow-Up and Concurrent Care of Referral for Principal Care H-390.917

(1) It is the policy of the AMA that: (a) the completion of a consultation may require multiple encounters after the initial consultative evaluation; and (b) after completion of the consultation, the consultant may be excused from responsibility of the care of the patient or may share with the primary care physician in concurrent care; he/she may also have the patient referred for care and thus become the principal care physician. (2) The AMA communicate the appropriate use of consultation, evaluation and management, and office medical services codes to third party payers and advocate the appropriate reimbursement for these services in order to encourage high quality, comprehensive and appropriate consultations for patients.

Citation: Sub. Res. 42, A-90; Amended: BOT Rep. P, I-92; CMS Rep. 3, A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation I-08; Modified: CMS Rep. 01, A-18;

Appropriate Reimbursement for Evaluation and Management Services for Patients with Severe Mobility-Related Impairments H-390.835

Our AMA supports: (1) additional reimbursement for evaluation and management services for patients who require additional time and specialized equipment during medical visits due to severe mobility-related impairments; (2) that no additional cost-sharing for the additional reimbursement will be passed on to patients with mobility disabilities, consistent with Federal Law; (3) that primary and specialty medical

providers be educated regarding the care of patients with severely impaired mobility to improve access to care; and (4) additional funding for payment for services provided to patients with mobility related impairments that is not through a budget neutral adjustment to the physician fee schedule.

Citation: Res. 814, I-17;

RVS Updating H-400.969

Status Report and Future Plans: The AMA/Specialty Society RVS Update Committee (RUC) represents an important opportunity for the medical profession to maintain professional control of the clinical practice of medicine. The AMA urges each and every organization represented in its House of Delegates to become an advocate for the RUC process in its interactions with the federal government and with its physician members. The AMA (1) will continue to urge CMS to adopt the recommendations of the AMA/Specialty Society RVS Update Committee for physician work relative values for new and revised CPT codes; (2) supports strongly use of this AMA/Specialty Society process as the principal method of refining and maintaining the Medicare RVS; (3) encourages CMS to rely upon this process as it considers new methodologies for addressing the practice expense components of the Medicare RVS and other RBRVS issues; and (4) opposes changes in Relative Value Units that are in excess of those recommended by the AMA/Specialty Society Relative Value Scale Update Committee (RUC).

Citation: (BOT Rep. O, I-92; Reaffirmed by BOT Rep. 8 - I-94; Reaffirmed by BOT Rep. 7, A-98; Reaffirmed: CMS Rep. 12, A-99; Reaffirmed: CMS Rep. 4, I-02; Reaffirmed: BOT Rep. 14, A-08; Reaffirmation I-10; Appended: Res. 822, I-12; Reaffirmation I-13; Reaffirmed: Sub. Res. 104, A-14; Reaffirmed in lieu of Res. 216, I-14; Reaffirmation A-15)

Guidelines for the Resource-Based Relative Value Scale H-400.991

(1) The AMA reaffirms its current policy in support of adoption of a fair and equitable Medicare indemnity payment schedule under which physicians would determine their own fees and Medicare would establish its payments for physician services using: (a) an appropriate RVS based on the resource costs of providing physician services; (b) an appropriate monetary conversion factor; and (c) an appropriate set of conversion factor multipliers.

(2) The AMA supports the position that the current Harvard RBRVS study and data, when sufficiently expanded, corrected and refined, would provide an acceptable basis for a Medicare indemnity payment system.

(3) The AMA reaffirms its strong support for physicians' right to decide on a claim-by-claim basis whether or not to accept Medicare assignment and its opposition to elimination of balance billing. (Reaffirmed: Sub. Res. 132, A-94)

(4) The AMA reaffirms its opposition to the continuation of the Medicare maximum allowable actual charge (MAAC) limits.

(5) The AMA promotes enhanced physician discussion of fees with patients as an explicit objective of a Medicare indemnity payment system.

(6) The AMA supports expanding its activities in support of state and county medical society-initiated voluntary assignment programs for low-income Medicare beneficiaries.

(7) The AMA reaffirms its current policy that payments under a Medicare indemnity payment system should reflect valid and demonstrable geographic differences in practice costs, including professional liability insurance premiums. In addition, as warranted and feasible, the costs of such premiums should be reflected in the payment system in a manner distinct from the treatment of other practice costs.

(8) The AMA believes that payment localities should be determined based on principles of reasonableness, flexibility and common sense (e.g., localities could consist of a combination of regions, states, and metropolitan and nonmetropolitan areas within states) based on the availability of high quality data.

(9) The AMA believes that, in addition to adjusting indemnity payments based on geographic practice cost differentials, a method of adjusting payments to effectively remedy demonstrable access problems in specific geographic areas should be developed and implemented.

(10) Where specialty differentials exist, criteria for specialty designation should avoid sole dependence on rigid criteria, such as board certification or completion of residency training. Instead, a variety of general national criteria should be utilized, with carriers having sufficient flexibility to respond to local conditions. In addition to board certification or completion of a residency, such criteria could include, but not be limited to: (a) partial completion of a residency plus time in practice; (b) local peer recognition; and (c) carrier analysis of practice patterns. A provision should also be implemented to protect the patients of physicians who have practiced as specialists for a number of years.

(11) The AMA strongly opposes any attempt to use the initial implementation or subsequent use of any new Medicare payment system to freeze or cut Medicare expenditures for physician services in order to produce federal budget savings.

(12) The AMA believes that whatever process is selected to update the RVS and conversion factor, only the AMA has the resources, experience and umbrella structure necessary to represent the collective interests of medicine, and that it seek to do so with appropriate mechanisms for full participation from all of organized medicine, especially taking advantage of the unique contributions of national medical specialty societies.

Citation: BOT Rep. AA, I-88; Reaffirmed: I-92; Reaffirmed and Modified: CMS Rep. 10, A-03; Reaffirmation A-06; Reaffirmed: CMS Rep. 01, A-16; Reaffirmed: Res. 212, I-21;

Non- Medicare Use of the RBRVS D-400.999

Our AMA will: (1) reaffirm Policy H-400.960 which advocates that annually updated and rigorously validated Resource Based Relative Value Scale (RBRVS) relative values could provide a basis for non-Medicare physician payment schedules, and that the AMA help to ensure that any potential non-Medicare use of an RBRVS reflects the most current and accurate data and implementation methods; (2) reaffirm Policy H-400.969 which supports the use of the AMA/Specialty Society process as the principal method of refining and maintaining the Medicare relative value scale; (3) continue to identify the extent to which third party payers and other public programs modify, adopt, and implement Medicare RBRVS payment policies; (4) strongly oppose and protests the Centers for Medicare & Medicaid Services Medicare multiple surgery reduction policy which reduces payment for additional surgical procedures after the first procedure by more than 50%; and (5) encourage third party payers and other public programs to utilize the most current CPT codes updated by the first quarter of the calendar year, modifiers, and relative values to ensure an accurate implementation of the RBRVS.

Citation: CMS Rep. 12, A-99; Reaffirmation I-03; Reaffirmation I-07; Modified: BOT Rep. 22, A-17;

Decreasing Sex and Gender Disparities in Health Outcomes H-410.946

Our AMA: (1) supports the use of decision support tools that aim to mitigate gender bias in diagnosis and treatment; and (2) encourages the use of guidelines, treatment protocols, and decision support tools specific to biological sex for conditions in which physiologic and pathophysiologic differences exist between sexes.

Citation: Res. 005, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 106
(A-23)

Introduced by: Medical Student Section

Subject: Billing for Traditional Healing Services

Referred to: Reference Committee A

1 Whereas, The Indian Health Service (IHS), an agency within the U.S. Department of Health
2 and Human Services, is responsible for providing health services to American Indians and
3 Alaska Natives (AI/AN), as a federal trust responsibility and treaty obligations to American
4 Indian and Alaska Native Tribes and Villages¹⁻²; and

5
6 Whereas, The IHS is underfunded relative to other federal health programs, IHS per capita
7 health care expenditures are \$4,078, while figures for Medicaid and Medicare are \$8,109 and
8 \$13,185, respectively³; and

9
10 Whereas, The IHS is considered the payor of last resort and is only utilized after other
11 federal, state, local, or private source of reimbursement for which the patient is eligible have
12 been exhausted⁴; and

13
14 Whereas, Reimbursement sources utilized before IHS payment include, but are not limited to,
15 Medicare Part A and B, State Medicaid, State or other federal health programs (e.g.,
16 Veterans Health Administration), private insurance, and funds from Tribal health programs⁴;
17 and

18
19 Whereas, Payments for IHS patients' medical care received from public programs such as
20 Medicaid and Medicare or from private insurers—increased from about \$943 million in fiscal
21 year 2015 to about \$1.15 billion in fiscal year 2019 at its federal facilities⁵; and

22
23 Whereas, Third-party collections are increasingly important, representing a significant portion
24 of IHS, Tribal, and Urban Indian Health Programs' health care delivery budget, and also used
25 to procure services, supplies, and pharmaceuticals⁵; and

26
27 Whereas, The IHS, through offerings of Western medicine and traditional healing services,
28 works to ensure that culturally-appropriate health care services are available and accessible
29 to AI/AN patients⁶; and

30
31 Whereas, Traditional medicine is the sum total of the knowledge, skills, and practices based
32 on the theories, beliefs, and experiences specific to different cultures, whether explicable or
33 not, used in the maintenance of health as well as in the prevention, diagnosis, improvement
34 or treatment of physical and mental illness⁷; and

35
36 Whereas, In a survey of 150 AI/AN patients at one Urban Indian Health Program, 38%
37 reported seeking medical care from both a physician and a traditional healer in their
38 community⁸; and

1 Whereas, In another rural, reservation-based setting of 2,595 AI/AN adolescents and adults,
2 41 to 60% sought biomedical services for physical health concerns; 8 to 23% sought
3 traditional healing services for physical health concerns; and 10-23% used Western and
4 traditional healing services, while 3 to 40% used only traditional healing⁹; and
5

6 Whereas, Among AI/AN patients who see both a physician and a traditional healer, more
7 than half (61.4%) trust the advice of their traditional healer(s) over their physician, and may
8 also limit disclosure of their medical history due to medical distrust and poor coordination of
9 care^{8,10}; and
10

11 Whereas, The American Medical Association recognizes the "medicine man" and other
12 traditional healing figures as an integral and culturally necessary part in delivering health care
13 to AI/AN patients (H-350.976); and
14

15 Whereas, A study evaluating the efficacy of many traditional Cherokee medicines found that
16 their use was efficient for treating intended illness, and was adopted by European settlers
17 following their introduction to them¹¹; and
18

19 Whereas, Connections to traditional culture, including food, has a positive impact on spiritual
20 and physical health and decreases rates of chronic disease within AI/AN populations^{12,13}; and
21

22 Whereas, The Alaska Native Medical Center, the major referral unit for AI/AN patients within
23 the state of Alaska, offers a Traditional Healing Clinic in conjunction with other health
24 services to provide whole-person care to patients¹⁴; and
25

26 Whereas, The IHS cannot bill private insurance and state Medicaid programs and Medicaid
27 managed care organizations for traditional healing services, limiting reimbursement for and
28 implementation of traditional healing services at IHS, Tribal, and Urban Indian health
29 facilities¹⁵; and
30

31 Whereas, Traditional healing practices and knowledge are widely considered sacred and not
32 shared with outside healthcare practitioners¹⁶; and
33

34 Whereas, The diversity of traditional healing practices between AI/AN Tribes and Villages
35 creates challenges for creating medical billing codes and reimbursement processes; and
36

37 Whereas, The state of Arizona, in consultation with Tribes, is seeking Section 1115
38 demonstration authority to cover traditional healing services furnished by the IHS to AI/AN
39 Medicaid enrollees¹⁷⁻¹⁸; and
40

41 Whereas, The proposed Arizona Section 1115 Medicaid waiver for traditional healing
42 services would (1) allow IHS, Tribal, and Urban Indian Health Programs and AI/AN Tribes
43 and Villages designate and contract with traditional healing providers; (2) coordinate medical
44 care and traditional healing delivery to prevent medical contraindications; and (3) require
45 patient evaluation of traditional healing services¹⁸; and
46

47 Whereas, While the IHS and Congress have long noted their acceptance and respect for
48 AI/AN traditional healing services, the Indian Health Care Improvement Act does not explicitly
49 define or authorize traditional healing services to be paid for by the IHS¹⁷⁻¹⁹; therefore be it

- 1 RESOLVED, That our American Medical Association study the impact of Medicaid waivers
- 2 for managed care demonstration projects regarding implementation and reimbursement for
- 3 traditional American Indian and Alaska Native healing practices provided in concert with
- 4 physician-led healthcare teams. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 3/31/23

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RELEVANT AMA POLICY

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

Citation: (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

Improving Health Care of American Indians H-350.976

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.

(2) The federal government provide sufficient funds to support needed health services for American Indians.

(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.

(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.

(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.

(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.

(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.

(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and

establish a liaison with the Association of American Indian Physicians.

(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.

(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.

(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

Citation: (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

Unconventional Medical Care in the United States H-480.973

Our AMA: (1) encourages the National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health (NIH) to determine by objective scientific evaluation the efficacy and safety of practices and procedures of unconventional medicine; and encourages its members to become better informed regarding the practices and techniques of such practices; and (2) utilizes the classification system of alternative medicine set forth by the NCCIH at the NIH, "Major Domains of Complementary and Alternative Medicine," in order to promote future discussion and research about the efficacy, safety, and use of alternative medicine.

Citation: BOT Rep. 15, A-94; Reaffirmed and Modified by Sub. Res. 514, I-95; Appended: Res. 505, A-00; Modified: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 01, A-20;

Physician-Focused Alternative Payment Models: Reducing Barriers H-385.908

1. Our AMA encourages physicians to engage in the development of Physician-Focused Payment Models by seeking guidance and refinement assistance from the Physician-Focused Payment Model Technical Advisory Committee (PTAC).

2. Our AMA will continue to urge CMS to limit financial risk requirements to costs that physicians participating in an APM have the ability to influence or control.

3. Our AMA will continue to advocate for innovative ways of defining financial risk, such as including start-up investments and ongoing costs of participation in the risk calculation that would alleviate the financial barrier to physician participation in APMs.

4. Our AMA will work with CMS, the Office of the National Coordinator for Health Information Technology (ONC), PTAC, interested medical societies, and other organizations to pursue the following to improve the availability and use of health information technology (IT):

a. Continue to expand technical assistance;

b. Develop IT systems that support and streamline clinical participation;

c. Enable health IT to support bi-directional data exchange to provide physicians with useful reports and analyses based on the data provided;

d. Identify methods to reduce the data collection burden; and

e. Begin implementing the 21st Century Cures Act.

5. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to design risk adjustment systems that:

a. Identify new 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;

b. Account for differences in patient needs, such as functional limitations, changes in medical conditions compared to historical data, and ability to access health care services; and

c. 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.

6. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve attribution methods through the following actions:

a. Develop methods to assign the costs of care among physicians in proportion to the amount of care they provided and/or controlled within the episode;

b. Distinguish between services ordered by a physician and those delivered by a physician;

- c. Develop methods to ensure a physician is not attributed costs they cannot control or costs for patients no longer in their care;
 - d. Explore implementing a voluntary approach wherein the physician and patient agree that the physician will be responsible for managing the care of a particular condition, potentially even having a contract that articulates the patients and physicians responsibility for managing the condition; and
 - e. Provide physicians with lists of attributed patients to improve care coordination.
7. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve performance target setting through the following actions:
- a. Analyze and disseminate data on how much is currently being spent on a given condition, how much of that spending is potentially avoidable through an APM, and the potential impact of an APM on costs and spending;
 - b. Account for costs that are not currently billable but that cost the practice to provide; and
 - c. Account for lost revenue for providing fewer or less expensive services.

Citation: CMS Rep. 10, A-17; Reaffirmed: CMS Rep. 03, I-18; Reaffirmed: CMS Rep. 10, A-19;
Reaffirmed: CMS Rep. 3, I-19; Reaffirmed: BOT Rep. 13, I-20;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 107
(A-23)

Introduced by: Medical Student Section

Subject: Reducing the Cost of Centers for Medicare and Medicaid Services Limited
Data Sets for Academic Use

Referred to: Reference Committee A

1 Whereas, Free and affordable sharing of research data among scientists has been shown to
2 confer numerous benefits in the advancement of scientific progress¹⁻³; and
3

4 Whereas, Limited data sets are defined as those registries and databases that adhere to the
5 Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and are
6 stripped of all direct patient identifiers and protected health information (PHI)^{4,5}; and
7

8 Whereas, The Centers for Medicare and Medicaid Services (CMS) currently maintains de-
9 identified limited data sets that contain outcome, demographic, comorbidity, and cost data for
10 millions of patients across the United States, which have been instrumental in conducting high-
11 quality, population-wide research⁶⁻⁸; and
12

13 Whereas, Many of these data files, which are already subsidized by taxpayer dollars, can cost
14 tens of thousands of dollars per year of data to acquire, an expense that poses a significant
15 financial barrier to academic and non-profit organizations^{6,9}; and
16

17 Whereas, There is currently no written justification for these prices on the CMS website^{6,10,11};
18 and
19

20 Whereas, Increasing academic and non-profit access to larger datasets for scholarly purposes
21 would greatly increase the sample size, relevance, and power of future studies; and
22

23 Whereas, Lowering the cost of this data for academic and non-profit users, and offsetting the
24 resulting loss in revenue with increased prices for for-profit and corporate entities, would aid in
25 increasing access to this data for research purposes⁹; and
26

27 Whereas, A tiered pricing scheme (i.e. higher prices for commercial users and lower prices for
28 non-commercial users) has already been implemented in other countries such as the United
29 Kingdom^{12,13}; therefore be it
30

31 RESOLVED, That our American Medical Association encourage the Centers for Medicare and
32 Medicaid Services to adjust the pricing of limited data sets in order to increase access for
33 academic use. (New HOD Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 4/3/23

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RELEVANT AMA POLICY**Medicare Claims Data Release D-406.993**

Our AMA will: (1) continue to work with the Centers for Medicare & Medicaid Services to identify appropriate modifications to improve the usefulness and accuracy of any existing or future provider-specific data released by that agency; (2) engage with data experts and other stakeholders to develop guiding principles on the data and transparency efforts that should be pursued in order to assist physicians to improve the quality of care and reduce costs; (3) petition the Centers for Medicare & Medicaid Services and the Office of Health & Human Services to remove practice expense and malpractice expense from reimbursements reported to the public; and (4) in an effort to advance the feasibility of population health research to fulfill the promise of value based care, will request that CMS eliminate the prohibitions on sharing data outside of any CMS model including Accountable Care Organizations that are contained in the CMS Data Use Agreement and allow sharing of that data: (a) in the form of de-identified data sets as permitted by federal, state, and local privacy laws; and (b) for purposes of research as permitted by federal, state, and local privacy laws.

Citation: Sub. Res. 204, A-14; Appended: Res. 226, A-17; Appended: Res. 241, A-19;

Work of the Task Force on the Release of Physician Data H-406.990**Release of Claims and Payment Data from Governmental Programs**

The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The AMA supports this use of physician data only when it preserves access to health care and is used to provide accurate physician performance assessments.

Raw claims data used in isolation have significant limitations. The release of such data from government programs must be subject to safeguards to ensure that neither false nor misleading conclusions are derived that could undermine the delivery of appropriate and quality care. If not addressed, the limitations of such data are significant. The foregoing limitations may include, but are not limited to, failure to consider factors that impact care such as specialty, geographic location, patient mix and demographics, plan design, patient compliance, drug and supply costs, hospital and service costs, professional liability coverage, support staff and other practice costs as well as the potential for mistakes and errors in the data or its attribution.

Raw claims and payment data resulting from government health care programs, including, but not limited to, the Medicare and Medicaid programs should only be released:

1. when appropriate patient privacy is preserved via de-identified data aggregation or if written authorization for release of individually identifiable patient data has been obtained from such patient in accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and applicable regulations;
2. upon request of physicians [or their practice entities] to the extent the data involve services that they have provided;
3. to law enforcement and other regulatory agencies when there is reasonable and credible reason to believe that a specific physician [or practice entity] may have violated a law or regulation, and the data is relevant to the agency's investigation or prosecution of a possible violation;
4. to researchers/policy analysts for bona fide research/policy analysis purposes, provided the data do not identify specific physicians [or their practice entities] unless the researcher or policy analyst has (a) made a specific showing as to why the disclosure of specific identities is essential; and, (b) executed a written agreement to maintain the confidentiality of any data identifying specific physicians [or their practice entities];
5. to other entities only if the data do not identify specific physicians [or their practice entities]; or
6. if a law is enacted that permits the government to release raw physician-specific Medicare and/or Medicaid claims data, or allows the use of such data to construct profiles of identified physicians or physician practices. Such disclosures must meet the following criteria:
 - (a) the publication or release of this information is deemed imperative to safeguard the public welfare;
 - (b) the raw data regarding physician claims from governmental healthcare programs is:
 - (i) published in conjunction with appropriate disclosures and/or explanatory statements as to the limitations of the data that raise the potential for specific misinterpretation of such data. These statements should include disclosure or explanation of factors that influence the provision of care including geographic location, specialty, patient mix and demographics, health plan design, patient compliance, drug and supply costs, hospital and service costs, professional liability coverage, support staff and other practice costs as well as the potential for mistakes and errors in the data or its attribution, in addition to other relevant factors.
 - (ii) safeguarded to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data.
 - (c) any physician profiling which draws upon this raw data acknowledges that the data set is not representative of the physicians' entire patient population and uses a methodology that ensures the following:
 - (i) the data are used to profile physicians based on quality of care provided - never on utilization of resources alone - and the degree to which profiling is based on utilization of resources is clearly identified.
 - (ii) data are measured against evidence-based quality of care measures, created by physicians across appropriate specialties.
 - (iii) the data and methodologies used in profiling physicians, including the use of representative and statistically valid sample sizes, statistically valid risk-adjustment methodologies and statistically valid attribution rules produce verifiably accurate results that reflect the quality and cost of care provided by the physicians.
 - (d) any governmental healthcare data shall be protected and shared with physicians before it is released or used, to ensure that physicians are provided with an adequate and timely opportunity to review, respond and appeal the accuracy of the raw data (and its attribution to individual physicians) and any physician profiling results derived from the analysis of physician-specific medical practice data to ensure accuracy prior to their use, publication or release.

Citation: BOT Rep. 18, A-09; Reaffirmed: BOT Rep. 09, A-19; Modified: Speakers Rep., A-19;

Medical Information and Its Uses H-406.987

DATA TRANSPARENCY PRINCIPLES TO PROMOTE IMPROVEMENTS IN QUALITY AND CARE DELIVERY

Our AMA seeks to help physicians improve the quality reporting of patient care data and adapt to new payment and delivery models to transform our health care system. One means of accomplishing this goal is to increase the transparency of health care data. The principles outlined below ensure that physicians, practices, care systems, physician-led organizations, patients and other relevant stakeholders can access and proactively use meaningful, actionable health care information to achieve care improvements and innovations. These principles do not replace but build upon existing AMA policies H-406.990, H-406.989, H-406.991, and H-406.996 that address safeguards for the release of physician data and physician

profiles, expanding these guidelines to reflect the new opportunities and potential uses of this information.

Transparency Objectives and Goals

Engaging Physicians - Our AMA encourages greater physician engagement in transparency efforts, including the development of physician-led quality measures to ensure that gaps in measures are minimized and that analyses reflect the knowledge and expertise of physicians.

Promoting New Payment and Delivery Models - Our AMA supports appropriate funding and other support to ensure that the data that are used to inform new payment and delivery models are readily available and do not impose a new cost or additional burden on model participants.

Improving Care Choices and Decisions - Our AMA promotes efforts to present data appropriately depending on the objective and the relevant end-user, including transparently identifying what information is being provided, for what purpose, and how the information can or cannot be used to influence care choices.

Informing Physicians - Our AMA encourages the development of user interfaces that allow physicians or their staff to structure simple queries to obtain and track actionable reports related to specific patients, peer comparisons, provider-level resource use, practice patterns, and other relevant information.

Informing Patients - Our AMA encourages patients to consult with physicians to understand and navigate health care transparency and data efforts.

Informing Other Consumers - Our AMA seeks opportunities to engage with other stakeholders to facilitate physician involvement and more proactive use of health care data.

Data Transparency Resources

Data Availability - Our AMA supports removing barriers to accessing additional information from other payers and care settings, focusing on data that is valid, reliable, and complete.

Access to Timely Data - While some datasets will require more frequent updates than others, our AMA encourages use of the most current information and that governmental reports are made available, at a minimum, from the previous quarter.

Accurate Data - Our AMA supports proper oversight of entities accessing and using health care data, and more stringent safeguards for public reporting, so that information is accurate, transparent, and appropriately used.

Use of Quality Data - Our AMA supports definitions of quality based on evidence-based guidelines, measures developed and supported by specialty societies, and physician-developed metrics that focus on patient outcomes and engagement.

Increasing Data Utility - Our AMA promotes efforts by clinical data registries, regional collaborations, Qualified Entities, and specialty societies to develop reliable and valid performance measures, increase data utility and reduce barriers that currently limit access to and use of the health care data.

Challenges to Transparency

Standardization - Our AMA supports improvements in electronic health records (EHRs) and other technology to capture and access data in uniform formats.

Mitigating Administrative Burden - To reduce burdens, data reporting requirements imposed on physicians should be limited to the information proven to improve clinical practice. Collection, reporting, and review of all other data and information should be voluntary.

Data Attribution - Our AMA seeks to ensure that those compiling and using the data avoid attribution

errors by working to correctly assign services and patients to the appropriate provider(s) as well as allowing entities to verify who or where procedures, services, and items were performed, ordered, or otherwise provided. Until problems with the current state of episode of care and attribution methodologies are resolved, our AMA encourages public data and analyses primarily focused at the system-level instead of on individual physicians or providers.

Citation: BOT Rep. 6, A-15; Reaffirmation: I-18; Reaffirmed: CSAPH Rep. 2, I-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 108
(A-23)

Introduced by: District of Columbia

Subject: Sustainable Reimbursement for Community Practices

Referred to: Reference Committee A

1 Whereas, Community-based private practices accept insurance reimbursement to provide
2 access to affordable service for people in need; and
3

4 Whereas, Small private practices provide neighborhood-based care, often in communities facing
5 health disparities, that may not be readily available elsewhere; and
6

7 Whereas, Medicare rates are collaboratively (by AMA, government agencies, and industry)
8 based on the resource-based relative value scale, created by Harvard University in 1985 and
9 published in the *Journal of the American Medical Association* in 1988¹, which incorporates
10 physician work, practice expense, professional liability costs, and geographic variations, with
11 extensive input from physicians and specialty societies; and
12

13 Whereas, Reimbursement from private insurers to small practices is often well below Medicare
14 rates and below the level required to cover fixed costs and accompanied by a dramatic increase
15 in required reporting by physician offices; and
16

17 Whereas, There are currently no lower limits regarding the reimbursement rates insurers pay to
18 medical practices and no legal requirements that insurers negotiate with practices, provide fair
19 reimbursement, or consider the needs of patients served by community practices; and
20

21 Whereas, Payers may refuse to negotiate appropriate reimbursement rates with small private
22 practices; and
23

24 Whereas, Private practices are rapidly disappearing, either going out of business or being
25 absorbed by large institutional practices that are able to negotiate with payers (as of January
26 2021, nearly 70 percent of U.S. physicians reportedly worked for hospitals or corporate
27 entities²); and
28

29 Whereas, AMA policy supports a pluralistic approach to health care utilization to include small,
30 solo, and medium-sized practices. Despite the well documented outcome-based evidence of the
31 benefit of these treatment options, third-party insurers are forcing market consolidation with
32 unsustainable reimbursement models that are below Medicare reimbursement rates; and
33

34 Whereas, Private practices are prohibited from collaborating with each other to request fair
35 reimbursement due to prior anti-trust legal interpretations; and
36

37 Whereas, The future of health care is trending towards the concepts of population health
38 management, outcome evidence-based care, and value-based purchasing of health care.
39 These models favor large groups and hospitals, once again excluding private practice
40 physicians in small and medium-sized groups. The AMA should take steps now to establish

1 both access to patients and appropriate floors for reimbursement which will address these
 2 health care models and their potentially deleterious effects on private practice physicians in
 3 small and medium-sized groups going forward; and
 4

5 Whereas, In the same way as the U.S. Government has protected individuals through the Fair
 6 Labor Standards Act of 1938 (29 U.S.C. § 203), which set a minimum wage, and states and
 7 municipalities have enacted similar measures, governments have the authority to establish
 8 minimum levels of reimbursement for medical practices; therefore be it
 9

10 RESOLVED, That our American Medical Association study small medical practices to assess
 11 the prevalence of insurance payments to these practices that are below Medicare rates and to
 12 assess the effects of these payment levels on practices' ability to provide care, and report back
 13 by the 2024 Annual Meeting (Directive to Take Action); and be it further
 14

15 RESOLVED, That our AMA study and report back on remedies for such reimbursement rates
 16 for physician practices (Directive to Take Action); and be it further
 17

18 RESOLVED, That our AMA study the impact on small and medium-sized physician practices of
 19 being excluded from population health management, outcome evidence-based care, and value-
 20 based purchasing arrangements (Directive to Take Action); and be it further
 21

22 RESOLVED, That our AMA study and report back to the HOD options for model legislation for
 23 states and municipalities seeking to correct reimbursement rates for medical practices that are
 24 below those required to meet fixed costs. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 4/27/23

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RELEVANT AMA POLICY

Insurance Industry Behaviors D-385.949

Our AMA will: (1) step up its ongoing review of the proper use of the AMA CPT Codes in medical billing claims payments and its misuse by the US Health Insurance Industry; (2) undertake as soon as practical a formal, legal review of ongoing grievous behaviors of the health insurance industry, including a search for potential litigation partners across the medical federation; and (3) communicate with AMA members outcomes in litigating egregious behaviors of the health insurance industry.

Citation: Res. 614, I-21; Reaffirmation: A-22;

Health System Reform Legislation H-165.838

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:

- a. Health insurance coverage for all Americans
- b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps

- c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
- d. Investments and incentives for quality improvement and prevention and wellness initiatives
- e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
- f. Implementation of medical liability reforms to reduce the cost of defensive medicine
- g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens
- 2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
- 3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.
- 4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.
- 5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.
- 6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
- 7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.
- 8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
 - a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
 - b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
 - c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
 - d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
 - e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
 - f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest
- 9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.
- 10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.
- 11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.
- 12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.
- 13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.

Citation: Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep.

9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17;

Consultation Codes and Private Payers D-385.955

1. Our AMA will proactively engage and advocate with any commercial insurance company that discontinues payment for consultation codes or that is proposing to or considering eliminating payment for such codes, requesting that the company reconsider the policy change.
 2. Where a reason given by an insurance company for policy change to discontinue payment of consultation codes includes purported coding errors or abuses, our AMA will request the company carry out coding education and outreach to physicians on consultation codes rather than discontinue payment for the codes, and call for release of de-identified data from the company related to purported coding issues in order to help facilitate potential education by physician societies.
 Citation: Res. 819, I-17; Reaffirmed in lieu of: Res. 808, I-22;

Uncoupling Commercial Fee Schedules from Medicare Conversion Factors D-400.990

Our AMA: (1) shall use every means available to convince health insurance companies and managed care organizations to immediately uncouple fee schedules from Medicare conversion factors and to maintain a fair and appropriate level of reimbursement; and (2) will seek legislation and/or regulation to prevent managed care companies from utilizing a physician payment schedule below the updated Medicare professional fee schedule.

Citation: Res. 137, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12; Appended: Res. 103, A-13;
 Reaffirmation: A-19;

National Mandatory Fee Schedule H-385.986

The AMA opposes any type of national mandatory fee schedule.

Citation: (Res. 27, A-85; Reaffirmed: BOT Rep. UU, A-93; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed in lieu of Res. 127, A-10; Reaffirmation A-15)

Definition of "Usual, Customary and Reasonable" (UCR) H-385.923

1. Our AMA adopts as policy the following definitions:

(a) "usual; fee means that fee usually charged, for a given service, by an individual physician to his private patient (i.e., his own usual fee);
 (b) a fee is 'customary' when it is within the range of usual fees currently charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area; and
 (c) a fee is 'reasonable' when it meets the above two criteria and is justifiable, considering the special circumstances of the particular case in question, without regard to payments that have been discounted under governmental or private plans.

2. Our AMA takes the position that there is no relationship between the Medicare fee schedule and Usual, Customary and Reasonable Fees.

Citation: (Res. 109, A-07; Appended: Res. 107, A-13)

Physician Choice of Practice H-385.926

Our AMA: (1) encourages the growth and development of the physician/patient contract; (2) supports the freedom of physicians to choose their method of earning a living (fee-for-service, salary, capitation, etc.); (3) supports the right of physicians to charge their patients their usual fee that is fair, irrespective of insurance/coverage arrangements between the patient and the insurers. (This right may be limited by contractual agreement.) An accompanying responsibility of the physician is to provide to the patient adequate fee information prior to the provision of the service. In circumstances where it is not feasible to provide fee information ahead of time, fairness in application of market-based principles demands such fees be subject, upon complaint, to expedited professional review as to appropriateness; and (4) encourages physicians when setting their fees to take into consideration the out-of-pocket expenses paid by patients under a system of individually selected and owned health insurance.

Citation: BOT Rep. QQ, I-91; Reaffirmed: BOT Rep. TT, I-92; Reaffirmed: Ref. Cmte. A, A-93; Reaffirmed: BOT Rep. UU, A-93; Reaffirmed: CMS Rep. G, A-93; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: Sub. Res. 701, A-93; Reaffirmation A-93; Reaffirmed: BOT Rep. 25, I-93; Reaffirmed: CMS Rep. 5, I-93; Reaffirmed: CMS Rep. 10, I-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: Sub. Res. 107,

I-93; Res. 124, I-93; Reaffirmed: Sub. Res. 127, A-94; Reaffirmed: BOT Rep. 46, A-94; Reaffirmed: Sub. Res. 132, A-94; Reaffirmed: BOT Rep. 16, I-94; Reaffirmed: CMS Rep. 8, A-95; Reaffirmed: Sub. Res. 109, A-95; Reaffirmed: Sub. Res. 125, A-95; Reaffirmed: Sub. Res. 109, I-95; Reaffirmation A-96; Reaffirmation I-96; Reaffirmation A-97; Reaffirmation I-98; Reaffirmation A-99; Appended by Res. 127, A-98; Reaffirmed: CMS Rep. 6, A-99; Reaffirmation A-00; Reaffirmation A-00; Sub. Res. 116, I-00; Reaffirmation & Reaffirmed: Res. 217, A-01; Reaffirmation A-04; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed in lieu of Res. 127, A-10; Reaffirmation I-13; Reaffirmation A-15; Reaffirmed: CMS Rep. 5, I-15; Reaffirmed: CMS Rep. 09, A-16; Reaffirmed: CMS Rep. 07, A-17; Reaffirmed: CMS Rep. 6, A-21; Reaffirmed: CMS Rep. 2, A-22;

Payment for Physicians Services H-385.989

Our AMA: (1) supports a pluralistic approach to third party payment methodology under fee-for-service, and does not support a preference for "usual and customary or reasonable" (UCR) or any other specific payment methodology; (2) affirms the following four principles: (a) Physicians have the right to establish their fees at a level which they believe fairly reflects the costs of providing a service and the value of their professional judgment. (b) Physicians should continue to volunteer fee information to patients, to discuss fees in advance of service where feasible, to expand the practice of accepting any third party allowances as payment in full in cases of financial hardship, and to communicate voluntarily to their patients their willingness to make appropriate arrangements in cases of financial need. (c) Physicians should have the right to choose the basic mechanism of payment for their services, and specifically to choose whether or not to participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service. (d) All methods of physician payment should incorporate mechanisms to foster increased cost-awareness by both providers and recipients of service; and (3) supports modification of current legal restrictions, so as to allow meaningful involvement by physician groups in: (a) negotiations on behalf of those physicians who do not choose to accept third party allowances as full payment, so that the amount of such allowances can be more equitably determined; (b) establishing additional limits on the amount or the rate of increase in charge-related payment levels when appropriate; and (c) professional fee review for the protection of the public.

Citation: (CMS Rep. A, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: Sub. Res. 716, A-00; Reaffirmation A-02; Reaffirmation A-07; Reaffirmed in lieu of Res. 127, A-10; Reaffirmation I-13; Reaffirmation A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 109
(A-23)

Introduced by: American Academy of Pediatrics

Subject: Improved Access to Care For Patients in Custody of Protective Services

Referred to: Reference Committee A

1 Whereas, In 2020 over 600,000 children were confirmed victims of child abuse of varying types
2 including physical, sexual, neglect, and medical neglect; and
3

4 Whereas, In 2020 over 600,000 children were placed into the child protective system; and
5

6 Whereas, There were over 1.3 million reports of adult abuse and neglect in 2020; and
7

8 Whereas, In most instances children placed into the custody of child protective services are also
9 entered into the Medicaid program for health insurance coverage; and
10

11 Whereas, In the majority of states Medicaid payment to physicians is less than that of Medicare
12 payment to physicians; and
13

14 Whereas, Children and adults placed into protective services often have complex medical and
15 mental health conditions in addition to the risk of removal from their homes; and
16

17 Whereas, Many state protective services require physician visits within a limited number of days
18 of placement to ensure the safety of the protectee; and
19

20 Whereas, The American Academy of Pediatrics recent report on children removed from family
21 care delineates the best care for children within the protective services system as including
22 three medical visits within the first three months of placement as a best practice for these
23 complicated patients; and
24

25 Whereas, Low Medicaid payment rates are a significant barrier to healthcare often preventing
26 these severely at risk children and adults from receiving timely appropriate care within a medical
27 home; and
28

29 Whereas, The amount of work physicians perform when caring for patients under the custody of
30 protective services far outweighs work performed on patients not within this system; and
31

32 Whereas, Increased private insurance and Medicaid payment rates for patients placed within
33 the protective services system, such as enhanced Federal Medical Assistance Percentage
34 (FMAP), modifiers to signify additional work required and other mechanisms, would improve
35 access to timely appropriate care for these at-risk patients; therefore be it
36

37 RESOLVED, That our American Medical Association study and report back mechanisms to
38 improve payment for physician services provided to patients under protective services custody.
39 (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 5/2/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 110
(A-23)

Introduced by: Mississippi

Subject: Long-Term Care Coverage for Dementia Patients

Referred to: Reference Committee A

1 Whereas, More than 6 million patients are living with Alzheimer's disease and by 2050 the
2 number will rise to nearly 13 million; and
3

4 Whereas, 1 in 3 seniors die with Alzheimer's or other dementias; and
5

6 Whereas, In 2023 Alzheimer's disease and other dementias will cost the US \$345 billion and by
7 2050 nearly \$1 trillion; and
8

9 Whereas, Over 11 million Americans provide unpaid care for patients with Alzheimer's disease
10 and other dementias; and
11

12 Whereas, In 2022 unpaid caregivers provided approximately 18 billion hours of care valued at
13 almost \$340 billion; and
14

15 Whereas, 6.7 million Americans age 65 or older are living with Alzheimer's disease. 73% of
16 them are 75 or older; and
17

18 Whereas, 1 in 9 of the population (10.7%) age 65 and older have Alzheimer's disease; and
19

20 Whereas, Almost 2/3 of Americans with Alzheimer's disease are women; and
21

22 Whereas, Between 2020 to 2030 an additional 1.2 million direct care workers will be needed to
23 care for the growing dementia population which is the largest worker gap in the United States;
24 and
25

26 Whereas, Long-term care is a range of services and support for personal care needs; and
27

28 Whereas, Medicare and most health insurance plans including Medicare supplement insurance
29 (Medigap) do not pay for long-term care; and
30

31 Whereas, Private insurance plans covering long-term care are scarce and very expensive; and
32

33 Whereas, Long-term Medicaid is the only plan The Centers for Medicare and Medicaid Services
34 provide for long-term care; and
35

36 Whereas, To qualify for long-term Medicaid patients have to satisfy draconian financial
37 guidelines; therefore be it

- 1 RESOLVED, That our American Medical Association work with Centers for Medicare &
- 2 Medicaid Services and other relevant stakeholders to formulate appropriate medical insurance
- 3 plans to cover this ever-growing disenfranchised population. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 5/2/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 111
(A-23)

Introduced by: American Academy of Dermatology, Pennsylvania, The American Society of Dermatopathology, Society for Investigative Dermatology, American Contact Dermatitis Society, American Society for Dermatologic Surgery

Subject: Potential Negative Consequences of Accountable Care Organizations (ACOs)

Referred to: Reference Committee A

Whereas, Centers for Medicare and Medicaid Services (CMS) has stated that one of its goals is that all patients covered by traditional Medicare are to be in Accountable Care Organizations (ACOs) by 2030¹; and

Whereas, ACOs may cause financial risk for the physicians directly and/or indirectly; and

Whereas, The structure of ACOs demands that financial penalties to physicians be incurred if the costs attributable to patient care exceed federally determined benchmarks. Without more granular risk adjustment methodologies, there remains a risk of disincentivizing physicians from taking care of patients with more complicated medical care needs; and

Whereas, ACO participation is logistically difficult or impossible for independent small or solo practices; and

Whereas, ACOs create another expensive layer of bureaucratic burden contributing to burnout and possibly impacting the patient-physician relationship; therefore be it

RESOLVED, That our American Medical Association advocate for the provision of health care and reimbursement models that are in the best interest of patients and offer risk adjustment methodologies to prevent financial penalty to the physician and other healthcare team members who provide care for the sickest patients (Directive to Take Action); and be it further

RESOLVED, That our AMA oppose capitation care healthcare systems, such as ACOs, when such systems place physicians and other healthcare team members at financial risk for the overall healthcare costs of their patients, including costs attributable to care provided by other entities (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for flexible pathways for small practice participation in ACOs that greatly mitigate ACO participation-related bureaucratic burdens and help protect small practices from large financial penalties otherwise assigned to large health systems for cost overages (Directive to Take Action); and be it further

RESOLVED, That our AMA oppose CMS mandates that require Medicare beneficiaries to enroll in ACOs (New HOD Policy); and be it further

RESOLVED, That our AMA oppose the expansion of capitation care systems, such as ACOs, as a means of providing coverage and services for all Medicare enrollees. (New HOD Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 5/10/23

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2. Medicare Payment Advisory Commission (MedPAC) Meeting pg 39-40 April 4, 2013. (MedPAC is an independent congressional agency established by the Balance Budget Act of 1997 to advise the US Congress on issues affecting the Medicare program)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 112
(A-23)

Introduced by: American College of Chest Physicians

Subject: Removal of Barriers to Care for Lung Cancer Screening in Medicaid Programs

Referred to: Reference Committee A

1 Whereas, Lung cancer is the leading cause of cancer deaths in the United States, accounting
2 for approximately 22% of all cancer deaths¹; and
3

4 Whereas, Detecting lung cancer in its early stages is crucial for effective treatment, but only
5 22% of lung cancer cases are diagnosed early; and
6

7 Whereas, Low-dose computed tomography (LDCT) screening has been shown to reduce lung
8 cancer mortality by up to 20% among high-risk populations²; and
9

10 Whereas, The U.S. Preventive Services Task Force has recommended LDCT screening for
11 high-risk populations; and
12

13 Whereas, Studies have shown that uptake of screening is highly dependent on coverage
14 eligibility and no-cost access to preventative measures, screening-eligible Black adults are
15 nearly twice as likely to rely on Medicaid, which may not cover LDCT screening, exacerbating
16 long-standing inequities in lung cancer outcomes³; and
17

18 Whereas, The American Medical Association has policy recommending coverage of LDCT
19 scans for patients at high risk for lung cancer by Medicare, Medicaid, and private insurance be a
20 required covered benefit (AMA policy H-185.936); and
21

22 Whereas, The AMA also encourages state medical associations to provide ongoing feedback
23 regarding barriers to access to their state's Medicaid access monitoring review plan (AMA policy
24 H-290.965); and
25

26 Whereas, Many states, including those with Medicaid expansion and traditional Medicaid
27 programs, have created barriers to lung cancer screening such as pre-authorization and co-
28 pays; therefore be it
29

30 RESOLVED, That our American Medical Association urge the Centers for Medicare & Medicaid
31 Services (CMS) to encourage and insist that all states, both Medicaid expansion and traditional
32 Medicaid, remove barriers to care for lung cancer screening, including but not limited to pre-
33 authorization and co-pay requirements (Directive to Take Action); and be it further
34

35 RESOLVED, That our AMA, and their state medical associations, work with the Centers for
36 Medicare & Medicaid Services (CMS) and State Medicaid Managed Care Organizations to
37 develop and implement strategies to improve access to LDCT screening for high-risk
38 populations in Medicaid programs (Directive to Take Action); and be it further

1 RESOLVED, That our AMA advocate for increased funding for research and education to
2 further increase awareness and uptake of LDCT screening for lung cancer among high-risk
3 populations (Directive to Take Action); and be it further
4

5 RESOLVED, That our AMA urge state medical associations to work with their respective
6 Medicaid programs to ensure that these programs comply with the AMA's policy on LDCT
7 screening for high-risk populations. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 5/10/23

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3. Lozier JW, Fedewa SA, Smith RA, Silvestri GA. Lung Cancer Screening Eligibility and Screening Patterns Among Black and White Adults in the United States. JAMA Netw Open. 2021 Oct 1;4(10):e2130350.

RELEVANT AMA POLICY

Lung Cancer Screening to be Considered Standard Care H-185.936

Our AMA: (1) recommends that coverage of screening low-dose CT (LDCT) scans for patients at high risk for lung cancer by Medicare, Medicaid, and private insurance be a required covered benefit; and (2) will empower the American public with knowledge through an education campaign to raise awareness of lung cancer screening with low-dose CT scans in high-risk patients to improve screening rates and decrease the leading cause of cancer death in the United States.

Citation: Sub. Res. 114, A-14; Appended: Res. 418, A-22;

Affordable Care Act Medicaid Expansion H-290.965

1. Our AMA encourages state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.
2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.
3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries.
4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents.
5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.
6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs.
7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care.
8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.
9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS.
10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.
11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.

12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches.

13. Our AMA supports the use of emergency department (ED) best practices that are evidenced-based to reduce avoidable ED visits.

Citation: CMS Rep. 02, A-16; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 807, I-18; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 3, I-21; Reaffirmed: Res. 122, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 113
(A-23)

Introduced by: Georgia

Subject: Cost of Insulin

Referred to: Reference Committee A

1 Whereas, There are approximately 30.3 million people in the United States with diabetes and
2 about 1.5 million of those require insulin to survive; and
3

4 Whereas, Between 2012 and 2016 the price of insulin almost doubled with the average cost of
5 insulin per patient in 2012 at \$2,864 per year and in 2016 at \$5,705; and
6

7 Whereas, The retail price for a 10ml vial of insulin is approximately \$330 and some patients
8 need six vials per month; and
9

10 Whereas, Americans pay ten times more on average for insulin than people in other developed
11 countries; and
12

13 Whereas, A 2018 study found that a vial of insulin could be made for between \$3 to \$8; and
14

15 Whereas, 90% of insulin produced comes from three companies: Eli Lilly, Novo Nordisk, and
16 Sanofi; and
17

18 Whereas, The three producers have patient assistance programs to help the uninsured but
19 require a process that can take up to 60 days for review and approval, during which an insulin-
20 dependent-diabetic could die; and
21

22 Whereas, The insured are at the mercy of the pharmacy benefit managers (PBMs) who require
23 rebates to have their brand of insulin included in the insurance formulary thus driving up the cost
24 of insulin and all other drugs; and
25

26 Whereas, Americans have been skipping doses of insulin, traveling across borders to Canada
27 to purchase affordable insulin, even dying when they could not purchase it, and have medical
28 expenditures 2.3 times higher because of the diagnosis; and
29

30 Whereas, COVID-19 is now triggering diabetes in patients who did not previously have it, and in
31 one study COVID-19 survivors were 39% more likely to have a new diabetes diagnosis in the
32 six months after infection; and
33

34 Whereas, In 2021 Novo Nordisk made \$52 Billion in revenue and in 2020 Eli Lilly made \$24
35 Billion, and Sanofi made \$46 Billion; and
36

37 Whereas, On April 2, 2022, the House of Representatives passed the Affordable Insulin Now
38 Act that would limit the cost of insulin to \$35 a month for insured patients, but even \$35 a vial
39 times up to six or more vials of insulin a month could be unaffordable to the most fragile; and

1 Whereas, The estimated total economic cost of diabetes yearly is in excess of \$300 billion;
2 therefore be it

3
4 RESOLVED, That our American Medical Association urge Congress to mandate complete
5 coverage of any insulin approved by the FDA (at \$0 cost) for any patient, insured or uninsured,
6 who presents to the pharmacy and bypassing all PBMs and disallowing any rebates. (Directive
7 to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 5/9/23

RELEVANT AMA POLICY

Insulin Affordability H-110.984

Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to investigate insulin pricing and market competition and take enforcement actions as appropriate; (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies; and (3) support state and national efforts to limit the ultimate expenses incurred by insured patients for prescribed insulin.

Citation: CMS Rep. 07, A-18; Modified: Res. 118, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 114
(A-23)

Introduced by: Illinois

Subject: Physician and Trainee Literacy of Healthcare Costs

Referred to: Reference Committee A

1 Whereas, The cost of medical care continues to increase, now 18% of U.S. GDP^{1,2}; and

2
3 Whereas, Meta-analyses estimate extraneous healthcare spending between \$706-935 billion
4 USD, about 25% of total healthcare spending³; and

5
6 Whereas, Price transparency is an important aspect of a functioning market⁴; and

7
8 Whereas, Federal mandates to publish hospital chargemasters have largely been ignored⁵; and

9
10 Whereas, Federal mandates to publish health insurer billing data have yet to show market
11 adoption⁶; and

12
13 Whereas, Many physicians believe they have an obligation to address rising healthcare costs⁷;
14 and

15
16 Whereas, Physician literacy on healthcare costs is an important component of informed
17 decision-making which may have a significant impact on future discussions of health system
18 reform; and

19
20 Whereas, Medical school accreditation does not require medical schools to teach healthcare
21 financing and the costs associated with care⁸; and

22
23 Whereas, Medical students are more price sensitive than their senior colleagues and interested
24 in considering a patient's financial health if given the appropriate information^{9,10}; and

25
26 Whereas, Residency accreditation requires institutions to cover healthcare finance but not the
27 billing practices of local or any other healthcare organization¹¹; and

28
29 Whereas, U.S. physicians are bad estimators of health costs^{12,13}; and

30
31 Whereas, Physicians often guide patients to the best medical decision without accurate
32 estimations for cost¹⁴; and

33
34 Whereas, Patient decisions and health are impacted by whether they can afford the care
35 decided within the physician-patient relationship^{15,16}; and

36
37 Whereas, Patients who have concerns about the affordability of their prescriptions may skip
38 doses, decrease doses, or not fill their prescription altogether¹⁷; and

1 Whereas, The physician-patient relationship is the ideal place for conversations regarding the
2 cost of care and potential affordable alternatives; and
3

4 Whereas, New healthcare companies are being created to provide clarity in a variety of health
5 services using information readily available^{18,19}; and
6

7 Whereas, A northwestern Wisconsin medical group has called for radical healthcare reform
8 through a series of recommendations, including suggesting that healthcare facilities should be
9 required to list their prices²⁰; and
10

11 Whereas, The Wisconsin Medical Society supports the promotion of healthcare cost
12 transparency, including prices, true costs, Medicare and Medicaid payments for services, drugs,
13 and treatments²¹; and
14

15 Whereas, The Australian Medical Association has developed a process for Informed Financial
16 Consent between doctors and patients to encourage shared decision-making about the costs of
17 medical treatment, physicians' fees, and healthcare benefits²²; therefore be it
18

19 RESOLVED, That our American Medical Association endorse price transparency within all
20 sectors of the healthcare market (New HOD Policy); and be it further
21

22 RESOLVED, That our AMA encourage all physician employers, including hospitals, to allow
23 their healthcare professionals access to accurate and easily understandable costs of any
24 laboratory test, procedure, medication, medical supply, or any other cost related to medical care
25 within and outside their organization (New HOD Policy); and be it further
26

27 RESOLVED, That our AMA advocate for all physician employers, including hospitals, to
28 empower their healthcare professionals to incorporate discussions on healthcare costs during
29 patient counseling (Directive to Take Action); and be it further
30

31 RESOLVED, That our AMA advocate for medical education inclusive of price transparency,
32 financial literacy, and the economics and financing of healthcare delivery (Directive to Take
33 Action); and be it further
34

35 RESOLVED, That our AMA work with the Commission of Osteopathic College Accreditation
36 (COCA), the Liaison Committee on Medical Education (LCME), the Accreditation Council on
37 Graduate Medical Education (ACGME), and other relevant stakeholders, to include price
38 transparency and healthcare financing in medical education as components of program
39 accreditation (Directive to Take Action); and be it further
40

41 RESOLVED, That our AMA study the issues around price transparency, including the feasibility
42 of providing accurate and easily understandable costs of tests, procedures, medications, and
43 other costs related to medical care. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 5/5/23

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RELEVANT AMA POLICY

Voluntary Health Care Cost Containment H-155.998

(1) All physicians, including physicians in training, should become knowledgeable in all aspects of patient-related medical expenses, including hospital charges of both a service and professional nature. (2) Physicians should be cost conscious and should exercise discretion, consistent with good medical care, in determining the medical necessity for hospitalization and the specific treatment, tests and ancillary medical services to be provided a patient. (3) Medical staffs, in cooperation with hospital administrators, should embark now upon a concerted effort to educate physicians, including house staff officers, on all aspects of hospital charges, including specific medical tests, procedures, and all ancillary services. (4) Medical educators should be urged to include similar education for future physicians in the required medical school curriculum. (5) All physicians and medical staffs should join with hospital administrators and hospital governing boards nationwide in a conjoint and across-the-board effort to voluntarily contain and control the escalation of health care costs, individually and collectively, to the greatest extent possible consistent with good medical care. (6) All physicians, practicing solo or in groups, independently or in

professional association, should review their professional charges and operating overhead with the objective of providing quality medical care at optimum reasonable patient cost through appropriateness of fees and efficient office management, thus favorably moderating the rate of escalation of health care costs. (7) The AMA should widely publicize and disseminate information on activities of the AMA and state, county and national medical specialty societies which are designed to control or reduce the costs of health care.

Citation: Res. 34, A-78; Reaffirmed: CLRPD Rep. C, A-89; Res. 100, I-89; Res. 822, A-93; Reaffirmed: BOT Rep. 40, I-93; CMS Rep. 12, A-95; Reaffirmed: Res. 808, I-02; Modified: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 1, A-22;

Controlling Cost of Medical Care H-155.966

The AMA urges the American Hospital Association and all hospitals to encourage the administrators and medical directors to provide to the members of the medical staffs, housestaff and medical students the charges for tests, procedures, medications and durable medical equipment in such a fashion as to emphasize cost and quality consciousness and to maximize the education of those who order these items as to their costs to the patient, to the hospital and to society in general.

Citation: Sub. Res. 75, I-81; Reaffirmed: CLRPD Rep. F, I-91; Res. 801, A-93; CMS Rep. 12, A-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 5, A-12; Reaffirmed: CMS Rep. 1, A-22;

Value-Based Decision-Making in the Health Care System D-155.994

1. Our AMA will advocate for third-party payers and purchasers to make cost data available to physicians in a useable form at the point of service and decision-making, including the cost of each alternate intervention, and the insurance coverage and cost-sharing requirements of the respective patient.
2. Our AMA encourages efforts by the Congressional Budget Office to more comprehensively measure the long-term as well as short-term budget deficit reductions and costs associated with legislation related to the prevention of health conditions and effects as a key step in improving and promoting value-based decision-making by Congress.

Citation: (CMS Rep. 7, A-08; Reaffirmed in lieu of Res. 230, I-14; Reaffirmation I-15)

Price of Medicine H-110.991

Our AMA: (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications; (2) will pursue legislation requiring pharmacies, pharmacy benefit managers and health plans to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication; (3) opposes provisions in pharmacies' contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient's co-pay is higher than the drug's cash price; (4) will disseminate model state legislation to promote drug price and cost transparency and to prohibit "clawbacks"; (5) supports physician education regarding drug price and cost transparency, manufacturers' pricing practices, and challenges patients may encounter at the pharmacy point-of-sale; and (6) work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare's drug-pricing dashboard.

Citation: CMS Rep. 6, A-03; Appended: Res. 107, A-07; Reaffirmed in lieu of: Res. 207, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Reaffirmation: A-19; Appended: Res. 126, A-19;

Price Transparency D-155.987

1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.
2. Our AMA advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.
3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy

and relevance of the information they provide.

4. Our AMA will work with states and the federal government to support and strengthen the development of all-payer claims databases.

5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.

6. Our AMA encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving.

7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.

Citation: CMS Rep. 4, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed in lieu of: Res. 213, I-17; Reaffirmed: BOT Rep. 14, A-18; Reaffirmed in lieu of: Res. 112, A-19; Modified: Res. 213, I-19;

Management and Leadership for Physicians D-295.316

1. Our AMA will study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options.

2. Our AMA will work with key stakeholders to advocate for collaborative programs among medical schools, residency programs, and related schools of business and management to better prepare physicians for administrative, financial and leadership responsibilities in medical management.

3. Our AMA: (a) will advocate for and support the creation of leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills and management techniques integral to achieving personal and professional financial literacy and leading interprofessional team care, in the spirit of the AMA's Accelerating Change in Medical Education initiative; and (b) will advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early in medical training to promote the development of leadership and personal and professional financial literacy capabilities.

4. Our AMA will: (a) study the extent of the impact of AMA Policy D-295.316, "Management and Leadership for Physicians," on elective curriculum; and (b) expand efforts to promote the tenets of health systems science to prepare trainees for leadership roles and address prevalent challenges in the practice of medicine and public health.

Citation: Sub. Res. 918, I-14; Appended: Res. 306, I-16; Reaffirmed in lieu of: Res. 307, A-17; Modified: Res. 313, A-18; Appended: Res. 327, A-22;

Strategies to Address Rising Health Care Costs H-155.960

Our AMA:

(1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government;

(2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease;

(b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and

(d) promote "value-based decision-making" at all levels;

(3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and medical education and training;

(4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers;

(5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols;

relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors;

(6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings;

(7) encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment.

Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and

(8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care.

(9) Our AMA will, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system.

Citation: CMS Rep. 8, A-07; Reaffirmed: CMS Rep. 7, A-08; Reaffirmed in lieu of Res. 828, I-08;

Reaffirmation A-09; Reaffirmation I-09; Reaffirmation A-11; Reaffirmation I-11; Appended: Res. 239, A-

12; Reaffirmed in lieu of Res. 706, A-12; Reaffirmed: CMS Rep. 1, I-12; Modified: CMS Rep. 2, A-13;

Reaffirmed in lieu of Res. 122, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed: CMS Rep. 05, I-

16; Reaffirmation I-16; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed:

Joint CMS CSAPH Rep. 01, I-18; Reaffirmation: A-22;

Value-Based Decision-Making in the Health Care System H-450.938

PRINCIPLES TO GUIDE PHYSICIAN VALUE-BASED DECISION-MAKING

1. Physicians should encourage their patients to participate in making value-based health care decisions.

2. Physicians should have easy access to and consider the best available evidence at the point of decision-making, to ensure that the chosen intervention is maximally effective in reducing morbidity and mortality.

3. Physicians should have easy access to and review the best available data associated with costs at the point of decision-making. This necessitates cost data to be delivered in a reasonable and useable manner by third-party payers and purchasers. The cost of each alternate intervention, in addition to patient insurance coverage and cost-sharing requirements, should be evaluated.

4. Physicians can enhance value by balancing the potential benefits and costs in their decision-making related to maximizing health outcomes and quality of care for patients.

5. Physicians should seek opportunities to improve their information technology infrastructures to include new and innovative technologies, such as personal health records and other health information technology initiatives, to facilitate increased access to needed and useable evidence and information at the point of decision-making.

6. Physicians should seek opportunities to integrate prevention, including screening, testing and lifestyle counseling, into office visits by patients who may be at risk of developing a preventable chronic disease later in life.

Citation: CMS Rep. 7, A-08; Reaffirmed in lieu of Res. 5, A-12; Reaffirmation I-14; Reaffirmation: I-17;

Reaffirmed: CMS Rep. 06, A-19; Reaffirmed: CMS Rep. 2, I-21;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 115
(A-23)

Introduced by: Illinois

Subject: Advocating for All Payer Coverage of Wigs for Patients Undergoing
Treatment for Cancer

Referred to: Reference Committee A

1 Whereas, In 2019, 1,752,735 new cancer cases were reported in the United States¹; and

2
3 Whereas, Cancer treatments may lead to alopecia²; and

4
5 Whereas, Alopecia affects approximately 65% of patients undergoing chemotherapy, 75- 100%
6 of patients undergoing head and neck radiation, and a variable number of patients undergoing
7 targeted therapies, immunotherapies, stem cell transplants, and endocrine therapies³; and

8
9 Whereas, Hair loss as a result of cancer treatment may have a variety of manifestations such as
10 patchy hair loss in areas of high friction, diffuse hair loss on the scalp, hair loss accompanied by
11 dermatitis and cutaneous ulceration, and scarring alopecia²; and

12
13 Whereas, In a cross-sectional survey of breast cancer patients, 55.3% of patients reported
14 higher stress levels due to alopecia which resulted in decreased body image, emotional and
15 social functioning, and depression⁴; and

16
17 Whereas, Many female cancer patients associated the experience of hair loss with a loss of
18 femininity and sense of self identity⁵; and

19
20 Whereas, For many female cancer patients, hair loss served as a visible sign of their cancer
21 diagnosis and affected their social and personal relationships, with many women expressing
22 concern about the impact alopecia had on their children⁵; and

23
24 Whereas, Many patients report feeling poorly prepared for the psychologically distressing nature
25 of hair loss and change of appearance⁶; and

26
27 Whereas, A prior study found that participants who were shown photos of individuals with
28 alopecia were less comfortable with having physical contact with or hiring individuals with
29 alopecia compared to those without hair loss⁷; and

30
31 Whereas, Many patients with cancer wear wigs to cope with the psychological and societal
32 effects of hair loss⁸; and

33
34 Whereas, Wigs are either made from synthetic fiber, human hair, or a mixture of synthetic fiber
35 and human hair; and

36
37 Whereas, The best-quality, most natural-appearing wigs are often composed of human hair and
38 cost \$800-\$3000⁹; and

Whereas, Payers such as Medicare do not deem wigs to be medically necessary¹⁰; and

Whereas, Medicare (Part A and Part B) and many private insurers do not cover the cost for wigs for patients who experience alopecia as a result of cancer treatment¹¹; and

Whereas, While charities may assist with wig donations, many patients pay out of pocket for their wigs; and

Whereas, Wigs help alleviate the psychological effects of hair loss and improve the integration of patients into social contexts during their illness journey¹²; therefore be it

RESOLVED, That our American Medical Association urge all payers to consider that wigs, cold caps, and medically necessary cranial prosthetics may have significant benefits to improve the quality of life for patients with cancer (New HOD Policy); and be it further

RESOLVED, That our AMA work with relevant stakeholders such as the Centers for Medicare and Medicaid Services to encourage payers to cover costs associated with wigs, cold caps, and medically necessary cranial prosthetics for patients with alopecia secondary to cancer treatments (Directive to Take Action); and be it further

RESOLVED, That our AMA work with all relevant medical specialty societies, third party payers, including The Centers for Medicare & Medicaid Services (CMS), and other national stakeholders as deemed appropriate to require third party payers to include reimbursement for wigs, cold caps, and medically necessary cranial prosthetics for patients with alopecia secondary to cancer treatment. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 5/5/23

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RELEVANT AMA POLICY

Definitions of "Cosmetic" and "Reconstructive" Surgery H-475.992

(1) Our AMA supports the following definitions of "cosmetic" and "reconstructive" surgery: Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance. (2) Our AMA encourages third party payers to use these definitions in determining services eligible for coverage under the plans they offer or administer.

Citation: (CMS Rep. F, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed, A-03; Reaffirmed: CMS Rep. 4, A-13)

Symptomatic and Supportive Care for Patients with Cancer H-55.999

Our AMA recognizes the need to ensure the highest standards of symptomatic, rehabilitative, and supportive care for patients with both cured and advanced cancer. The Association supports clinical research in evaluation of rehabilitative and palliative care procedures for the cancer patient, this to include such areas as pain control, relief of nausea and vomiting, management of complications of surgery, radiation and chemotherapy, appropriate hemotherapy, nutritional support, emotional support, rehabilitation, and the hospice concept. Our AMA actively encourages the implementation of continuing education of the practicing American physician regarding the most effective methodology for meeting the symptomatic, rehabilitative, supportive, and other human needs of the cancer patient.

Citation: CSA Rep. H, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 514, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Prescription Drug Diversion, Misuse and Addiction H-95.945

Our AMA: (1) supports permanent authorization of and adequate funding for the National All Schedules Prescription Electronic Reporting (NASPER) program so that every state, district and territory of the US can have an operational Prescription Drug Monitoring Program (PDMP) for use of clinicians in all jurisdictions; (2) considers PDMP data to be protected health information, and thus protected from release outside the healthcare system unless there is a HIPAA exception or specific authorization from the individual patient to release personal health information, and recommends that others recognize that PDMP data is health information; (3) recommends that PDMP's be designed such that data is immediately available when clinicians query the database and are considering a decision to prescribe a controlled substance; (4) recommends that individual PDMP databases be designed with connectivity among each other so that clinicians can have access to PDMP controlled substances dispensing data across state boundaries; and (5) will promote medical school and postgraduate training that incorporates curriculum topics focusing on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education regarding safe medication storage and disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths.

Citation: Res. 223, A-12; Reaffirmed: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmation A-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 116
(A-23)

Introduced by: New York

Subject: Medicare Coverage of OTC Nicotine Replacement Therapy

Referred to: Reference Committee A

Whereas, Nicotine dependence causes patients to continue smoking despite well-known harms;
and

Whereas, Nicotine replacement therapy (NRT), especially dual therapy which is now the evidence-based standard of care is effective at helping smokers to stop smoking essentially doubling or tripling successful quit rates; and

Whereas, Medicare Part D prescription medication plans, by law, do not cover over the counter (OTC) products, Medicare Parts A and B do not cover OTC products, and Medicare Part C (Medicare disadvantage plans) do not cover OTC products or do so in very limited ways; and

Whereas, Many persons who only have Medicare insurance coverage have very limited incomes, and may have limited fixed budgets, yet may have chronic mental illness, both social determinants of health associated with double or triple the national average rate of smoking, and people with psychiatric illnesses have much more difficulties trying to quit smoking; and

Whereas, OTC NRT can be prohibitively expensive to members of lower sociodemographic groups thereby presenting a barrier to facilitating treatment of nicotine dependence; and

Whereas, The expense and harm from tobacco related illnesses is so vast: chronic smoking damages nearly every organ of the body, remains the leading cause of preventable disease, disability, and death in the United States and costs the United States hundreds of billions of dollars each year therefore it is worth carving out; therefore be it

RESOLVED, That our American Medical Association advocate for over the counter (OTC) nicotine replacement therapies, excluding vaping products, to be carved out from the non-coverage by Medicare of OTC products and be specifically covered when prescribed by physicians who care for patients with Medicare, Medicare Part D, or Medicare Part C coverage. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 5/10/23

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3. https://www.cdc.gov/tobacco/data_statistics/sgr/2020-smoking-cessation/pdfs/2020-cessation-sgr-chapter-6-508c.pdf

RELEVANT AMA POLICY

Electronic Cigarettes, Vaping, and Health H-495.972

1. Our AMA urges physicians to: (a) educate themselves about electronic nicotine delivery systems (ENDS), including e-cigarettes, be prepared to counsel patients about the use of these products and the potential for nicotine addiction and the potential hazards of dual use with conventional cigarettes, and be sensitive to the possibility that when patients ask about e-cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical interviews to inquire about "vaping" or the use of e-cigarettes; (c) promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers; and (d) advise patients who use e-cigarettes to take measures to assure the safety of children in the home who could be exposed to risks of nicotine overdose via ingestion of replacement e-cigarette liquid that is capped or stored improperly.

2. Our AMA: (a) encourages further clinical and epidemiological research on e-cigarettes; (b) supports education of the public on the health effects, including toxins and carcinogens of electronic nicotine delivery systems (ENDS) including e-cigarettes; and (c) recognizes that the use of products containing nicotine in any form among youth, including e-cigarettes, is unsafe and can cause addiction.

3. Our AMA supports legislation and associated initiatives and will work in coordination with the Surgeon General to prevent e-cigarettes from reaching youth and young adults through various means, including, but not limited to, CDC research, education and a campaign for preventing and reducing use by youth, young adults and others of e-cigarettes, and combustible and emerging tobacco products.

Citation: CSAPH Rep. 2, I-14; Modified in lieu of Res. 412, A-15; Modified in lieu of Res. 419, A-15;

Reaffirmed: Res. 421, A-15; Modified: CSAPH Rep. 05, A-18; Reaffirmed: CSAPH Rep. 03, A-19;

Appended: Res. 428, A-19;