DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2023 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-23)

Report of Reference Committee A

Scott H. Pasichow, MD, MPH, Chair

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1 Your Reference Committee recommends the following consent calendar for acceptance:
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3 **RECOMMENDED FOR ADOPTION**
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5 1. Council on Medical Service Report 02 – Medicare Coverage of Dental, Vision,
6 and Hearing Services
7 2. Council on Medical Service Report 03 – Private Insurer Payment Integrity
8 *3.* Council on Medical Service Report 04 – Bundled Payments and Medically
9 Necessary Care
10 4. Council on Medical Service Report 07 – Reporting Multiple Services Performed
11 During a Single Patient Encounter
12 5. Resolution 117 – Payment for Physicians Who Practice Street Medicine
13
14 **RECOMMENDED FOR ADOPTION AS AMENDED**
15
16 6. Resolution 101 – Updating Physician Job Description for Disability Insurance
17 7. Resolution 105 – Studying Population-Based Payment Policy Disparities
18 8. Resolution 107 – Reducing the Cost of Centers for Medicare and Medicaid
19 Services Limited Data Sets for Academic Use
20 9. Resolution 109 – Improved Access to Care for Patients in Custody of Protective
21 Services
22 10. Resolution 110 – Long-Term Care Coverage for Dementia Patients
23 11. Resolution 116 – Medicare Coverage of OTC Nicotine Replacement Therapy
24 12. Resolution 118 – Advancing Acute Care at Home
25 Resolution 120 – Supporting Permanent Reimbursement of Acute Hospital Care
26 at Home
27 13. Resolution 119 – Rescinding the Medicare Three-Day Hospital Inpatient
28 Requirement for Nursing Home Admission
29
30 **RECOMMENDED FOR ADOPTION IN LIEU OF**
31
32 14. Resolution 104 – Support for Medicare Expansion to Wheelchair Accessibility
33 Home Modifications as Durable Medical Equipment
34 15. Resolution 112 – Removal of Barriers to Care for Lung Cancer Screening in
35 Medicaid Programs
36

RECOMMENDED FOR REFERRAL

16. Resolution 103 – Movement Away from Employer-Sponsored Health Insurance
17. Resolution 106 – Billing for Traditional Healing Services
18. Resolution 108 – Sustainable Reimbursement for Community Practices

RECOMMENDED FOR NOT ADOPTION

19. Resolution 102 – Reforming the Medicare Part B "Buy and Bill" Process to Encourage Biosimilar Use

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

20. Resolution 113 – Cost of Insulin

Amendments
If you wish to propose an amendment to an item of business, click here: SUBMIT NEW AMENDMENT

RECOMMENDED FOR ADOPTION

(1) COUNCIL ON MEDICAL SERVICE REPORT 02 -- MEDICARE COVERAGE OF DENTAL, VISION, AND HEARING SERVICES

RECOMMENDATION:

Recommendations in Council on Medical Service Report 02 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 02 adopted and the remainder of the report filed.

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 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. (Amend HOD Policy)

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

5. That our AMA reaffirm Policy H-330.872, which supports the American Medical Association's continued work with the ADA to improve access to dental care for Medicare beneficiaries and supports 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. (Reaffirm HOD Policy)

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

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

Testimony was generally supportive of Council on Medical Service Report 02. A member of the Council on Medical Service acknowledged that coverage for dental, vision, and hearing services is important to patients while also emphasizing that an expansion of Medicare to cover these services is not a viable option at this time. The Council member cited the current rate of inflation, the high costs projected to cover these services, and statutory budget neutrality requirements in explaining why the AMA must continue to be sensitive to the implications of adding such services to Medicare.

One commenter proffered amendments to the recommendations of the report to: 1) support new Medicare appropriations to cover periodic vision exams, prescription eyeglasses, hearing aids, and aural rehabilitation services; and 2) support federal and state financial assistance for senior patients to purchase dental care. Another amendment asked that the AMA support dental coverage under Medicare as long as physician reimbursements are increased to sustainable practice levels. A member of the Council on Medical Service stated that the Council discussed the option of supporting new Medicare appropriations for dental, vision, and hearing coverage but concluded the current climate would be unfavorable to the proposed coverage expansions. The Council member further stated that the coverage expansions are not currently feasible. Your Reference Committee concurs and recommends that the recommendations in Council on Medical Service Report 02 be adopted as written.

(2) COUNCIL ON MEDICAL SERVICE REPORT 03 --
PRIVATE INSURER PAYMENT INTEGRITY

RECOMMENDATION:

Recommendations in Council on Medical Service Report 03 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 03 adopted and the remainder of the report filed.

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

1. That our American Medical Association (AMA) support the development of a comprehensive, evidence-based process to establish consistency in determinations of experimental/investigational status and transparency in coverage determinations from which insurers can develop benefit packages. (New HOD Policy)

2. That our AMA support voluntary programs that expedite review for coverage by private and governmental insurers when requested by either the manufacturer or third parties such as national medical specialty societies. (New HOD Policy)

3. That our AMA amend Policy D-185.986 by the addition of one new clause, as follows:

> 4. Our AMA will advocate that when clinical coverage protocols are more restrictive than governmental payers, that private insurers and benefit managers should include the clinical rationale substantiating their coverage policies. (Modify Current HOD Policy)

4. That our AMA reaffirm Policy H-185.964, which opposes new health benefit mandates unrelated to patient protections.(Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-165.856, which advocates for the minimization of benefit mandates. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-320.995, which 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. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy D-460.967, which calls for study of the implementation of expanded access programs, accelerated approval mechanisms, and payment reform models to increase access to investigational therapies. (Reaffirm HOD Policy)

In addition to testimony that was supportive of CMS Report 03 as written, amendments were proffered to the recommendations of the report to: 1) expand Recommendation 1 to include all medical necessity determinations in order to account for off-label drug use or

infrequently performed procedures; 2) replace the term “government payers” in Recommendation 3 to a more identifiable benchmark, such as “Medicare;” and 3) ensure that infrequently performed procedures are not automatically deemed experimental/investigational.

The Council on Medical Service commented that the amendments go beyond the purview of this report, as expanding the reach of medical necessity determinations to include off-label drug use or infrequently performed procedures may be premature given that a comprehensive, evidence-based process to establish consistency in those determinations has not yet been developed. The Council on Medical Service also noted that the term “government payers” was used purposefully in Recommendation 3 to avoid limiting the benchmark to a single public payer. Your Reference Committee agrees. Therefore, your Reference Committee recommends that the recommendations be adopted and the remainder of the report be filed.

(3) COUNCIL ON MEDICAL SERVICE REPORT 04 -- BUNDLED PAYMENTS AND MEDICALLY NECESSARY CARE

RECOMMENDATION:

Recommendations in Council on Medical Service Report 04 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 04 adopted and the remainder of the report filed.

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<u>, and functional improvements, if appropriate;</u> (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 <u>and safeguard patient access to medically necessary care, including institutional post-acute care.</u> (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)

Testimony was unanimously supportive of Council on Medical Service Report 04 and its approach to safeguarding medically necessary care under bundled payment models. A member of the Council on Medical Service stated that the concerns raised in the referred resolution were addressed through recommended amendments to AMA policy intended to protect access to medically necessary care under these models and ensure that functional improvements are measured when appropriate, as for orthopedic bundles. The authors of the referred resolution also testified in strong support of the report. Accordingly, your Reference Committee recommends adoption of the recommendations in Council on Medical Service Report 04.

(4) COUNCIL ON MEDICAL SERVICE REPORT 07 -- REPORTING MULTIPLE SERVICES DURING A SINGLE PATIENT ENCOUNTER

RECOMMENDATION:

Recommendations in Council on Medical Service Report 07 be <u>adopted</u> and the remainder of the report be <u>filed</u>.

HOD ACTION: Council on Medical Service Report 07 <u>adopted</u> and the remainder of the report <u>filed</u>.

1 The Council on Medical Service recommends that the following be adopted in lieu of
2 Resolution 824-I-22, and the remainder of the report be filed:
3
4 1. That our American Medical Association (AMA) support mechanisms to report
5 modifiers appropriately with the least administrative burden possible, including the
6 development of electronic health record tools to facilitate the reporting of multiple,
7 medically necessary services supported by modifier 25. (New HOD Policy)
8
9 2. That our AMA support comprehensive education for physicians and insurers on the
10 appropriate use of modifier 25. (New HOD Policy)
11
12 3. That our AMA reaffirm Policy D-70.971, which advocates for the acceptance of
13 Current Procedural Technology (CPT®) modifiers, particularly modifier 25, and the
14 appropriate alteration of payment based on CPT modifiers. (Reaffirm HOD Policy)
15
16 4. That our AMA reaffirm Policy D-385.956, which directs the AMA to aggressively and
17 immediately advocate through any legal means possible to ensure that when an
18 evaluation and management (E/M) code is reported with modifier 25, that both the
19 procedure and E/M codes are paid at the non-reduced, allowable payment rate.
20 (Reaffirm HOD Policy)
21
22 5. That our AMA reaffirm Policy H-385.944, which supports insurance company payment
23 for 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
26 representing a service or procedure that is covered and paid for separately should also
27 be paid for when performed at the same time as another service or procedure. (Reaffirm
28 HOD Policy)
29
30 Testimony was overwhelmingly supportive of CMS Report 07. A member of the Council
31 on Medical Service introduced the report, noting that it addresses the fact that while
32 *Current Procedural Terminology* (CPT®) offers a valid way to report multiple services,
33 there is a disconnect between physicians and payers regarding the feasibility of
34 providing, documenting, reporting, and paying for multiple services. Your Reference
35 Committee recommends the recommendations be adopted and the remainder of the
36 report be filed.
37
38 (5) RESOLUTION 117 -- PAYMENT FOR PHYSICIANS WHO
39 PRACTICE STREET MEDICINE
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41 **RECOMMENDATION:**
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43 **Resolution 117 be adopted.**
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45 **HOD ACTION: Resolution 117 adopted.**
46
47 RESOLVED, That our American Medical Association support the development of street
48 medicine programs to increase access to care for populations experiencing
49 homelessness and reduce long-term costs (New HOD Policy); and be it further
50

RESOLVED, That our AMA support the implementation of Medicare and Medicaid payment for street medicine initiatives by advocating for necessary legislative and/or regulatory changes, including submission of a recommendation to the Centers for Medicaid & Medicaid Services asking that it establish a new place-of-service code to support street medicine practices for people eligible for Medicare and/or Medicaid, with "street medicine" defined, in keeping with the Street Medicine Institute, as "the provision of health care directly to people where they are living and sleeping on the streets." (Directive to Take Action)

Your Reference Committee heard strong support for Resolution 117, with multiple commenters reiterating that development of a new Place of Service (POS) code is essential to fulfilling the ask of the resolution. Lack of an appropriate POS code results in delay of payment and denial of payment – and that a new POS code is necessary for better epidemiological tracking. Additionally, it was noted that women and families are the fastest growing segment of the unhoused, with 20% of them becoming unhoused due to domestic violence. The current infrastructure limits physicians' ability to provide care and their ability to bill for care would increase access considerably. The Council on Medical Service agreed that increasing access to care for underserved populations will contribute to eradicating homelessness. Accordingly, your Reference Committee recommends that Resolution 117 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(6) RESOLUTION 101 -- UPDATING PHYSICIAN JOB DESCRIPTION FOR DISABILITY INSURANCE

RECOMMENDATION A:

Resolution 101 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support efforts ~~study the most effective approach~~ to develop~~ing~~ specialty-specific job descriptions that reflect the true physical and cognitive demands of each given specialty for use in the Occupational Information System under development by the Social Security Administration so as to ensure that physician disability policies are robust and protective if a coverage trigger occurs. (Directive to Take Action)

RECOMMENDATION B:

Resolution 101 be amended by addition of a new Resolved to read as follows:

RESOLVED, That our American Medical Association support removing the barriers to obtaining and claiming disability insurance for physicians on visas. (Directive to Take Action)

RECOMMENDATION C:

Resolution 101 be adopted as amended.

HOD ACTION: Resolution 101 adopted as amended.

RESOLVED, That our American Medical Association study the most effective approach to developing specialty-specific job descriptions that reflect the true physical and cognitive demands of each given specialty for use in the Occupational Information System under development by the Social Security Administration so as to ensure that physician disability policies are robust and protective if a coverage trigger occurs. (Directive to Take Action)

Your Reference Committee heard mostly supportive testimony for Resolution 101. Commenters noted physicians must be able to perform the duties required of their specific specialty in order to claim disability insurance and the current classification is based on outdated definitions, which places physicians at a significant disadvantage. Testimony supported amending the resolution rather than calling for a study and adding a second

resolved clause to support physicians on H-1 and J-1 visas who are typically not eligible for disability insurance.

Testimony from the Council on Medical Service agreed that while it is important that physician job descriptions accurately reflect the current physical, cognitive, and emotional demands of the position, the AMA does not possess the expertise to develop specialty-specific physician job descriptions. Therefore, the Council recommended amending the resolution to allow the AMA to support these efforts. Your Reference Committee agrees with this amendment and testimony that a second resolved clause on supporting International Medical Graduates is warranted. Accordingly, your Reference Committee recommends that Resolution 101 be adopted as amended.

(7) RESOLUTION 105 -- STUDYING POPULATION-BASED PAYMENT POLICY DISPARITIES

RECOMMENDATION A:

Resolution 105 be amended by addition and deletion to read as follows:

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

RESOLVED, That our AMA support the ongoing effort of members of the federation to analyze the ~~study the effects of factors such as~~ valuation of CPT codes describing similar services by gender to ensure equitable valuation. ~~toward equitable and reimbursement rates. on physician choice of specialty, degree of institutional support, workforce shortages, burnout, and attrition, especially in specialties and practice settings that primarily care for underserved populations.~~ (Directive to Take Action);and be it further

RESOLVED, That our AMA reaffirm Policy H-385.921 Health Care Access for Medicaid Patients and H-290.976 Enhanced SCHIP Enrollment, Outreach, and Reimbursement. (Reaffirm HOD Policy)

RECOMMENDATION B:

Resolution 105 be adopted as amended.

HOD ACTION: Resolution 105 adopted as amended.

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

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

Your Reference Committee heard supportive testimony on Resolution 105. The Chair of the AMA/Specialty Society Relative Value Scale Update Committee (RUC) spoke in favor of the spirit of the resolution, recognizing that the second resolved clause has been addressed via its Relativity Assessment Workgroup, which incorporated gender equity via the CPT coding and valuation process, working in collaboration with the American Urological Association and the American College of Obstetricians and Gynecologists.

The Council on Medical Service testified that the AMA has developed principles and actions to address the physician work force, as well as policy on supporting efforts to quantify the physician shortage in many specialties. The Council also noted that the AMA has key policies on the adequacy of Medicaid reimbursement which could be considered the underlying issue of this resolution. These key policies affirm the AMA commitment to advocating for reasonable Medicaid reimbursement for its medical providers, defined as at minimum 100% of RBRVS Medicare allowable. A third resolve clause was recommended to reaffirm H-385.921 Health Care Access for Medicaid Patients and H-290.976 Enhanced SCHIP Enrollment, Outreach, and Reimbursement.

The author of the resolution rose in support of the amended language. Therefore, your Reference Committee recommends that Resolution 105 be adopted as amended. An amendment was proffered that related to the Veterans Administration and the Indian Health Services fee schedules, but we believe that to be out of the scope of this resolution.

Health Care Access for Medicaid Patients H-385.921
It is AMA policy that to increase and maintain access to health care for all, payment for physician providers for Medicaid, TRICARE, and any other publicly funded insurance plan must be at minimum 100% of the RBRVS Medicare allowable. (Res. 103, A-07; Reaffirmed: CMS Rep. 2 I-08; Reaffirmation A-12; Reaffirmed: Res 132, A-14; Reaffirmed in lieu of Res. 808, I-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 807, I-18)

Enhanced SCHIP Enrollment, Outreach, and Reimbursement H-290.976
1. It is the policy of our AMA that prior to or concomitant with states' expansion of State Children's Health Insurance Programs (SCHIP) to adult coverage, our AMA

urge all states to maximize their efforts at outreach and enrollment of SCHIP eligible children, using all available state and federal funds.
2. Our AMA affirms its commitment to advocating for reasonable SCHIP and Medicaid reimbursement for its medical providers, defined as at minimum 100% of RBRVS Medicare allowable.
(Res. 103, I-01; Reaffirmation A-07; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, I-14; Reaffirmation A-15; Reaffirmed: CMS Rep. 3, A-15; Reaffirmation: A-17; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 9, A-21; Reaffirmed: CMS Rep. 3, I-21; Reaffirmed: CMS Rep. 1, I-22)

(8) RESOLUTION 107 -- REDUCING THE COST OF CENTERS FOR MEDICARE AND MEDICAID SERVICES LIMITED DATA SETS FOR ACADEMIC USE

RECOMMENDATION A:

Resolution 107 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~encourage the Centers for Medicare and Medicaid Services to adjust the~~ support reduced pricing of limited data sets ~~in order to increase access~~ for academic, nonprofit, and government researchers use. (New HOD Policy)

RECOMMENDATION B:

Resolution 107 be adopted as amended.

RECOMMENDATION C:

Title of Resolution 107 be changed to read as follows:

REDUCING THE COST OF LIMITED DATA SETS

HOD ACTION: Resolution 107 adopted as amended with new Resolve and change in title.

RESOLVED, That our AMA advocate that Centers for Medicare and Medicaid Services fully comply with Section 105(b) of the Medicare and CHIP Reauthorization Act of 2015 (MACRA), in order to grant Qualified Clinical Data Registries (QCDRs) timely and cost-effective access to Medicare claims data for research to support quality improvement and patient safety, and further advocate for additional federal funding if necessary to implement this statutory requirement. (Directive to Take Action)

REDUCING THE COST OF LIMITED DATA SETS

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

Testimony was generally supportive of Resolution 107. Some speakers suggested amending the resolution to expand the types of organizations and researchers who could benefit from reduced pricing of data sets. Additionally, a member of the Council on Medical Service noted that Centers for Medicare and Medicaid Services (CMS) data sets can be cheaper than non-governmental data sets and suggested amending the Resolved clause so that it is not limited to CMS limited data sets. Your Reference Committee believes the amended Resolved clause is sufficiently broad to allow the AMA to take the action proposed in proffered alternate language, which asked the AMA to advocate that CMS comply with Section 105(b) of the Medicare and CHIP Reauthorization Act of 2015 (MACRA) on expanding access to Medicare data by qualified clinical data registries for quality improvement. Accordingly, your Reference Committee recommends that Resolution 107 be adopted as amended and that the title be changed to reflect the amended Resolved clause.

(9) RESOLUTION 109 -- IMPROVED ACCESS TO CARE FOR PATIENTS IN CUSTODY OF PROTECTIVE SERVICES

RECOMMENDATION A:

Resolution 109 be amended by addition and deletion to read as follows:

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

RECOMMENDATION B:

Resolution 109 be adopted as amended.

HOD ACTION: Resolution 109 adopted as amended.

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

Your Reference Committee heard testimony in favor of Resolution 109 that emphasized the importance of valuing the additional work involved in providing care to the vulnerable patient population under protective services custody. Testimony clarified that anyone can bring a coding proposal to the CPT Editorial Panel. It was also acknowledged that each state may approach this differently as they have their own local codes used by Medicaid plans. The Council on Medical Service was supportive and recognized that a study is not

necessary as the AMA has substantial policy on ensuring adequate Medicaid payment rates and recognizing the additional resources required to appropriately care for patients taking into account their social determinants of health. Therefore, your Reference Committee recommends that Resolution 109 be adopted as amended.

(10) RESOLUTION 110 -- LONG-TERM CARE COVERAGE FOR DEMENTIA PATIENTS

RECOMMENDATION A:

Resolution 110 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with Centers for Medicare & Medicaid Services and other relevant stakeholders to formulate appropriate medical insurance plans to provide long-term care coverage for patients with Alzheimer's and other forms of dementia ~~cover this ever-growing disenfranchised population~~. (Directive to Take Action)

RECOMMENDATION B:

Title of Resolution 110 be changed to read as follows:

LONG-TERM CARE COVERAGE FOR PATIENTS WITH DEMENTIA

HOD ACTION: Resolution 110 adopted as amended with change in title.

LONG-TERM CARE COVERAGE FOR PATIENTS WITH DEMENTIA

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

Testimony was very supportive of the intent of Resolution 110 to address the long-term care needs of dementia patients. Clarifying amendments were proffered that suggested replacing "ever-growing disenfranchised population" with language more specific to patients with dementia. Although some speakers supported reaffirmation of AMA policy on long-term care and long-term services and supports, a preponderance of the testimony favored adoption of Resolution 110. Accordingly, your Reference Committee recommends that the resolution be adopted as amended.

(11) RESOLUTION 116 -- MEDICARE COVERAGE OF OTC NICOTINE REPLACEMENT THERAPY

RECOMMENDATION A:

Resolution 116 be amended by addition to read as follows:

RESOLVED, That our American Medical Association advocate for over-the-counter (OTC) nicotine replacement therapies, that have been approved or cleared by the U.S. Food and Drug Administration, excluding e-cigarette product device types and 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.

RECOMMENDATION B:

Resolution 116 be adopted as amended.

HOD ACTION: Resolution 116 adopted as amended.

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)

Your Reference Committee heard testimony supportive of Resolution 116. It was noted that nicotine replacement therapy is covered through Medicaid in 15 states and online testimony noted that Medicaid allows over-the-counter (OTC) coverage as an optional benefit and the ACA includes technical carve-outs for OTC therapies, both of which establish a federal precedent. Your Reference Committee agreed that the amended language offered by the Centers for Disease Control and Prevention is consistent with existing policy on the potential harms of e-cigarette use, specifically Policy H-495.972 Electronic Cigarettes, Vaping, and Health. The resolution is also consistent with Policy H-490.916 Health Insurance and Reimbursement for Tobacco Cessation and Counseling that supports the ready availability of health insurance coverage and reimbursement for pharmacologic and behavioral treatment of nicotine dependence and smoking cessation efforts. Therefore, your Reference Committee recommends that Resolution 116 be adopted as amended.

(12) RESOLUTION 118 -- ADVANCING ACUTE CARE AT HOME
RESOLUTION 120 – SUPPORTING PERMANENT REIMBURSEMENT OF ACUTE CARE AT HOME

RECOMMENDATION A:

Resolution 118 be amended by addition and deletion to read as follows:

RESOLVED, That the AMA advocate for passage of federal legislation that provides permanence to the Centers for Medicare and Medicaid Services acute care at home model (Directive to Take Action); and be it further

RESOLVED, That the AMA work with interested state medical associations to identify state-level barriers to implementing and sustainably funding acute care at home~~, to include but not be limited to: health and safety regulation applicability to services in the home, union opposition to acute care at home, and Mobile Integrated Health/Community Paramedicine limitations in states~~ (Directive to Take Action); and be it further

RESOLVED, That the AMA, in coordination with other acute care at home advocacy groups, ~~advocate that the federal government work with states to address the concerns of current state regulators~~ identify avenues for addressing state regulatory concerns (Directive to Take Action); and be it further

RESOLVED, That the AMA engage with allied health professional ~~nursing~~ organizations to share perspectives and address concerns about the benefits and challenges of acute care at home (Directive to Take Action).

RECOMMENDATION B:

Resolution 118 be adopted as amended in lieu of Resolution 120.

HOD ACTION: Resolution 118 adopted as amended in lieu of Resolution 120.

RESOLUTION 118

RESOLVED, that the AMA advocate for passage of federal legislation that provides permanence to the Centers for Medicare and Medicaid Services acute care at home model (Directive to Take Action); and be it further

RESOLVED, that the AMA work with interested state medical associations to identify state-level barriers to implementing acute care at home, to include but not be limited to: health and safety regulation applicability to services in the home, union opposition to acute care at home, and Mobile Integrated Health/Community Paramedicine limitations in states (Directive to Take Action); and be it further

RESOLVED, That the AMA, in coordination with other acute care at home advocacy groups, advocate that the federal government work with states to address the concerns of current state regulators (Directive to Take Action); and be it further

RESOLVED, That the AMA engage with nursing organizations to share perspectives and address concerns about the benefits and challenges of acute care at home. (Directive to Take Action)

RESOLUTION 120

RESOLVED, That our AMA advocate for policy making the reimbursement of Home Hospital permanent as currently enabled through the temporary Centers for Medicare & Medicaid Services Acute Hospital Care at Home waiver (Directive to Take Action); and be it further

RESOLVED, That our AMA support legislation that promotes parity between the reimbursement for Home Hospital care and traditional inpatient care amongst all payors (Directive to Take Action); and be it further

RESOLVED, That our AMA support efforts to promote the sustainability and growth of Home Hospital, including those encouraging research and innovation in the home-based acute care space. (Directive to Take Action)

Your Reference Committee heard robust testimony on Resolution 118 and Resolution 120 attesting that acute hospital care at home is a valid health care delivery model and emphasizing the need to provide permanence to the Centers for Medicare and Medicaid Services' acute care at home model, beyond its current December 31, 2024, extension. The Council on Medical Service offered amended language for Resolution 120 that your Reference Committee agreed addresses the intent of the two resolutions. The amendments to the second and third resolve clauses appropriately make them broader and more flexible. The authors of Resolution 120 testified to the importance of ensuring that physicians are adequately compensated for the care they are providing in the home hospital, thus your Reference Committee amended the second resolve clause to include sustainably funding these efforts. In the fourth resolve clause, your Reference Committee acknowledges that other allied health professional organizations in addition to nursing will be involved with the acute care at home physician-led multi-disciplinary team.

(13) RESOLUTION 119 -- RESCINDING THE MEDICARE THREE-DAY HOSPITAL INPATIENT REQUIREMENT FOR NURSING HOME ADMISSION

RECOMMENDATION A:

Resolution 119 be <u>amended by deletion</u> to read as follows:

RESOLVED, That our American Medical Association ~~request a stakeholdersmeeting with the Centers for Medicare and Medicaid Services to~~ advocate that the Medicare three-day hospital inpatient requirement for skilled nursing facility admissions be immediately rescinded for uniformity and safety for all Medicare recipients (Directive to Take Action).

RECOMMENDATION B:

Resolution 119 be <u>adopted as amended</u>.

HOD ACTION: Resolution 119 <u>adopted as amended</u>.

RESOLVED, That our American Medical Association request a stakeholders meeting with the Centers for Medicare and Medicaid Services to advocate that the Medicare three-day hospital inpatient requirement for skilled nursing facility admissions be immediately rescinded for uniformity and safety for all Medicare recipients. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 119, with commenters noting that the three-day rule is based on an antiquated law created in an era when the average hospital stay was 13 days. During the COVID-19 public health emergency, the three-day policy was temporarily rescinded but patient care was vastly improved.

Testimony outlined the discriminatory nature of the recent Center for Medicare and Medicaid Services decision to lift the three-day requirement for some Medicare beneficiaries but not others, highlighting the inequity inherent in the three-day policy. The Council on Medical Service noted that while they are supportive of a permanent ban of the three-day rule, only Congress has the ability to rescind it. Therefore, the Council suggested that the resolution be amended accordingly. Your Reference Committee appreciates the clarification provided by the Council and recommends that Resolution 119 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(14) RESOLUTION 104 -- SUPPORT FOR MEDICARE EXPANSION TO WHEELCHAIR ACCESIBILITY HOME MODIFICATIONS AS DURABLE MEDICAL EQUIPMENT

RECOMMENDATION:

Alternate Resolution 104 be adopted in lieu of Resolution 104.

RESOLVED, That our American Medical Association (AMA) recognize that for individuals for whom use of a wheelchair at home has been deemed medically necessary, home modifications, including wheelchair ramps, are also medically necessary (New HOD Policy); and be it further

RESOLVED, That our AMA help to educate patients, physicians, and other health care providers regarding available sources of funding, including but not limited to Medicaid waivers, nonprofits, loans through the U.S. Department of Housing and Urban Development, and volunteer organizations, for home modifications. (New HOD Policy)

HOD ACTION: Alternate Resolution 104 adopted in lieu of Resolution 104.

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)

Testimony on Resolution 104 was mixed, with commenters highlighting both the importance of ramps to wheelchair users and the potentially high costs of home modifications. Testimony further conveyed that home modification expenses should not be added to the budget-neutral Medicare Part B program.

An amendment was offered to support “new funding” for Medicare Part B to cover wheelchair ramps and associated home installation. Alternate Resolved clauses were also proffered asking the AMA to recognize that home modifications, such as ramps, are medically necessary only for individuals for whom using a wheelchair at home is medically necessary. Testimony was supportive of the proffered alternate language but new funding seems unlikely in the current political climate. Therefore, your Reference Committee recommends that Alternate Resolution 104 be adopted in lieu of Resolution 104.

(15) RESOLUTION 112 -- REMOVAL OF BARRIERS TO CARE FOR LUNG CANCER SCREENING IN MEDICAID PROGRAMS

RECOMMENDATION:

Alternate Resolution 112 be adopted in lieu of Resolution 112.

RESOLVED, That our American Medical Association work with interested national medical specialty societies and state medical associations to urge the Centers for Medicare & Medicaid Services and state Medicaid programs to increase access to low-dose CT screening for Medicaid patients at high risk for lung cancer by including it as a covered benefit, without cost-sharing or prior authorization requirements, and increasing funding for research and education to improve awareness and utilization of the screening among eligible enrollees. (New HOD Policy)

HOD ACTION: Alternate Resolution 112 adopted in lieu of Resolution 112.

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

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

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

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

Testimony was very supportive of Resolution 112. Speakers highlighted the variability across state Medicaid programs in coverage of low-dose CT screening for eligible enrollees and affirmed the need to reduce barriers to screening such as patient cost-sharing and prior authorization. Testimony highlighted the need to increase access to low-dose CT screening for Medicaid enrollees at high risk for lung cancer to improve screening rates so the disease can be detected at earlier stages. A Council on Medical Service

1 member testified that AMA advocacy for Medicaid improvements at the state level is
2 generally carried out at the invitation of a state medical association, and offered alternate
3 language that is consistent with AMA policy and advocacy efforts regarding Medicaid and
4 lung cancer screening. Your Reference Committee added language to the suggested
5 alternate Resolved clause to support increased funding for research and education and,
6 therefore, recommends adoption of Alternate Resolution 112 in lieu of Resolution 112.

RECOMMENDED FOR REFERRAL

(16) RESOLUTION 103 -- MOVEMENT AWAY FROM EMPLOYER-SPONSORED HEALTH INSURANCE

RECOMMENDATION:

Resolution 103 be referred.

HOD ACTION: Resolution 103 referred.

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.~~
b~~c~~. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
c~~d~~. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
d~~e~~. The public option is financially self-sustaining and has uniform solvency requirements.
e~~f~~. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
f~~g~~. 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 auto-enrollment would, therefore,

include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero premium marketplace coverage.
c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto enrollment.
e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost sharing advantages of enrolling in silver plans.
h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.
4. Our AMA: (a) will advocate that any federal approach to cover 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 credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status. (Modify Current HOD Policy)

Your Reference Committee heard mixed testimony regarding Resolution 103, with one commenter proffering alternate Resolved clauses to: (1) recognize inefficiencies and complexities in all health insurance systems and support models that better align incentives to facilitate access to high quality health care; (2) support movement toward a health care system that enables universal access to high quality health care; and (3) reaffirm Policy H-165.828 Health Insurance Affordability.

Some commenters who opposed Resolution 103 believed that its Resolved clauses support a government sponsored single payer health care system, with lower payments to providers and/or decreased access for patients. They noted that inefficiencies and complexities occur in all types of health care coverage, not just employer-sponsored health insurance (ESHI). There were also questions on the accuracy of the statistics provided in the whereas clauses regarding the percentage of patients dissatisfied with

their ESHI plans, and one commenter presented contrasting data that the typical individual is happy with their ESHI plans. The vast majority of commenters who opposed Resolution 103 recommended referral given the complexity of the issue.

Commenters who supported Resolution 103 believed that its Resolved clauses allow additional insurance options, thereby reinforcing plurality of coverage. They also noted that Resolution 103 does not advocate against employer sponsored health insurance but allows additional insurance options for persons whose work-based insurance does not provide adequate coverage for said person or families. Commenters indicated support for resolved clause 3 but referral for resolved clauses 1 and 2.

The Council on Medical Service pointed out that the resolution does not consider many unintended consequences of the proposal, including the potential cost shift from employers to taxpayers and adverse selection. It was noted that employers may be motivated to restructure their plans to maximize the benefits of both premium tax credits and the tax exclusion since they would have less incentive to keep premiums low for low-income workers (as long as they could avoid the penalty) since those workers could just go to the marketplace. Beyond further increasing federal costs, that could also mean that some middle-income individuals would see higher employee premiums. Therefore, the Council suggested referral to allow consideration consistent with AMA policy. Accordingly, your Reference Committee recommends referral of Resolution 103.

(17) RESOLUTION 106 -- BILLING FOR TRADITIONAL HEALING SERVICES

RECOMMENDATION:

Resolution 106 be referred.

HOD ACTION: Resolution 106 referred.

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

Testimony on Resolution 106 was mixed. An individual proposed alternate language asking the AMA to support Medicaid payment for traditional healing services when provided in concert with physician-led health care teams. The proffered alternate Resolved clauses further asked the AMA to encourage communities and health care systems offering such services to adhere to a series of principles addressing traditional provider/facility arrangements, covered services, and qualified providers. Several individuals, and one state delegation, testified in support of the proffered substitute language.

There was also support for Resolution 106 as written, with some speakers concerned that the AMA should not support Medicaid payment for traditional American Indian and Alaska Native healing practices without further study. A Council on Medical Service member testified in favor of referral, expressing support for being inclusive of culturally relevant

care while also wanting to ensure patient safety. Your Reference Committee agrees that further study is warranted and recommends that Resolution 106 be referred.

(18) RESOLUTION 108 -- SUSTAINABLE REIMBURSEMENT FOR COMMUNITY PRACTICES

RECOMMENDATION:

Resolution 108 be referred.

HOD ACTION: Resolution 108 referred.

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

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

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

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

Your Reference Committee heard mostly supportive testimony on Resolution 108, with commenters acknowledging the need to address the effects of low payment on small and rural practices, including unfair advantages granted to competitors such as federally qualified health centers. Testimony outlined that AMA policy has gaps and does not address subpar payment by private payers or state and local governments. Commenters noted that private practices are critical to serve the breadth of patient needs but are closing due to lack of negotiating power.

In addition to one other commenter, the Council on Medical Service recommended referral, as the AMA has substantial policy on protecting and supporting small group medical practices and advocating for adequate payment for private practicing physicians and the AMA's broader goals of advocating for fair payment and ensuring access to health care for all patients. The Council agreed that a study is essential to uncover the extent of the problem and identify how smaller practices can unify to negotiate with the power of larger groups. Referral will achieve the intended goal while allowing the creation of one unified report instead of a series of disparate reports linked to each individual resolved clause as requested by the resolution. Accordingly, your Reference Committee recommends that Resolution 108 be referred.

RECOMMENDED FOR NOT ADOPTION

(19) RESOLUTION 102 -- REFORMING THE MEDICARE PART B "BUY AND BILL" PROCESS TO ENCOURAGE BIOSIMILAR USE

RECOMMENDATION:

Resolution 102 not be adopted.

HOD ACTION: Resolution 102 not adopted.

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)

Your Reference Committee heard predominantly negative testimony for Resolution 102, with one recommendation for referral. Supporters noted that Resolution 102 mirrors Medicare's existing small-molecule/generic payment policy, by reimbursing a brand-name biologic at the same price as its clinically equivalent biosimilar alternatives and will encourage direct price competition, resulting in savings and gains for physicians.

Commenters who opposed Resolution 102 were concerned about lowering payment to incentivize selection of less expensive physician-administered drugs, which runs counter to patient care and physician choice. Several commenters who were high volume prescribers stated that Resolution 102 misstates the problem, as the current system works and fixed pricing would inhibit competition. The real issue lies in the pharmacy benefit manager system, which is not "buy and bill." A unifying price would allow the insurance company to pick the lowest price and then penalize the physician for using the higher priced drug, even if it is the one more appropriate for the patient.

Testimony from the Council on Medical Service noted that biosimilars do not always come with significant discounts as most assume; therefore, this reform will not solve the problem. The Council indicated that this proposal places the onus of fixing drug prices on physicians and patients while not addressing the root problem, which is the high list price of the drugs. Accordingly, your Reference Committee recommends that Resolution not be adopted.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(20) RESOLUTION 113 -- COST OF INSULIN

RECOMMENDATION:

Policies H-110.984, H-110.986, and H-110.990 be reaffirmed in lieu of Resolution 113.

HOD ACTION: Policies H-110.984, H-110.986, and H-110.990 reaffirmed in lieu of Resolution 113.

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

Testimony on Resolution 113 was mixed. Some commenters were supportive of the concept of reducing cost-sharing for insulin to zero, while others favored reaffirmation of existing AMA policy on insulin affordability and value-based prescription drug pricing. A Council on Medical Service member noted that the Council presented a report in 2018 on insulin affordability as well as a 2016 report that established policy supporting value-based pricing for pharmaceuticals. Further, existing policy encourages payers to determine patient cost-sharing based on the clinical value of a health care service or treatment, stipulating that consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance.

A Council on Legislation member also testified in support of reaffirmation, highlighting a new $35 cap on Medicare patients' out-of-pocket spending for insulin, enacted by the Inflation Reduction Act, and a similar $35 cap announced by a manufacturer. The Council member stated that the AMA can monitor the new caps' impact over time and then evaluate the need for further action. Additional testimony questioned why the resolution focused solely on insulin and not on supplies and other treatments for patients with diabetes. Although some speakers recommended referral, your Reference Committee believes existing AMA policy should be reaffirmed and therefore recommends reaffirmation of Policies H-110.984, H-110.986, and H-110.990 in lieu of Resolution 113.

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

Incorporating Value into Pharmaceutical Pricing H-110.986
1. Our AMA supports value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by the following principles: (a) value-based

1 prices of pharmaceuticals should be determined by objective, independent entities;
2 (b) value-based prices of pharmaceuticals should be evidence-based and be the
3 result of valid and reliable inputs and data that incorporate rigorous scientific
4 methods, including clinical trials, clinical data registries, comparative effectiveness
5 research, and robust outcome measures that capture short- and long-term clinical
6 outcomes; (c) processes to determine value-based prices of pharmaceuticals must
7 be transparent, easily accessible to physicians and patients, and provide practicing
8 physicians and researchers a central and significant role; (d) processes to
9 determine value-based prices of pharmaceuticals should limit administrative
10 burdens on physicians and patients; (e) processes to determine value-based
11 prices of pharmaceuticals should incorporate affordability criteria to help assure
12 patient affordability as well as limit system-wide budgetary impact; and (f) value-
13 based pricing of pharmaceuticals should allow for patient variation and physician
14 discretion. 2. Our AMA supports the inclusion of the cost of alternatives and cost-
15 effectiveness analysis in comparative effectiveness research. 3. Our AMA
16 supports direct purchasing of pharmaceuticals used to treat or cure diseases that
17 pose unique public health threats, including hepatitis C, in which lower drug prices
18 are assured in exchange for a guaranteed market size. (CMS Rep. 05, I-16;
19 Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: CMS-CSAPH Rep. 01, A-17;
20 Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: CSAPH Rep. 2, I-19; Reaffirmed:
21 CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 6, I-20)
22
23 Cost Sharing Arrangements for Prescription Drugs H-110.990
24 Our AMA: 1. believes that cost-sharing arrangements for prescription drugs should
25 be designed to encourage the judicious use of health care resources, rather than
26 simply shifting costs to patients;
27 2. believes that cost-sharing requirements should be based on considerations such
28 as: unit cost of medication; availability of therapeutic alternatives; medical
29 condition being treated; personal income; and other factors known to affect patient
30 compliance and health outcomes; 3. supports the development and use of tools
31 and technology that enable physicians and patients to determine the actual price
32 and patient-specific out-of-pocket costs of individual prescription drugs, taking into
33 account insurance status or payer type, prior to making prescribing decisions, so
34 that physicians and patients can work together to determine the most efficient and
35 effective treatment for the patient’s medical condition; and 4. supports public and
36 private prescription drug plans in offering patient-friendly tools and technology that
37 allow patients to directly and securely access their individualized prescription
38 benefit and prescription drug cost information. (CMS Rep. 1, I-07; Reaffirmation A-
39 08; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed in lieu of Res. 105, A-13; Reaffirmed
40 in lieu of: Res. 205, A-17; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: CMS
41 Rep. 07, A-18; Appended: CMS Rep. 2, I-21)
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1 This concludes the report of Reference Committee A. I would like to thank Mark A.
2 Dobbertien, DO, Haidn Foster, MD, Courtland Keteyian, MD, Sudeep Kukreja, MD, Lynn
3 Parry, MD, Jayesh B. Shah, MD, and all those who testified before the Committee.
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5

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