

## DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2023 Interim 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 (I-23)

Report of Reference Committee J

Man-Kit Leung, MD, Chair

---

1 Your Reference Committee recommends the following consent calendar for acceptance:

2  
3 **RECOMMENDED FOR ADOPTION**

- 4  
5 1. Council on Medical Service Report 1 – ACO REACH  
6 2. Resolution 801 – Improving Pharmaceutical Access and Affordability  
7 3. Resolution 816 – Reducing Barriers to Gender-Affirming Care through Improved  
8 Payment and Reimbursement  
9

10 **RECOMMENDED FOR ADOPTION AS AMENDED**

- 11  
12 4. Council on Medical Service Report 2 – Health Insurers and Collection of Patient  
13 Cost-Sharing  
14 5. Council on Medical Service Report 3 – Strengthening Network Adequacy  
15 6. Council on Medical Service Report 5 – Medicaid Unwinding Update  
16 7. Council on Medical Service Report 6 – Rural Hospital Payment Models  
17 8. Resolution 804 – Required Clinical Qualifications in Determining Medical  
18 Diagnoses and Medical Necessity  
19 9. Resolution 805 - Medication Reconciliation Education  
20 10. Resolution 811 – Expanding Use of Medical Interpreters  
21 11. Resolution 812 – Indian Health Service Improvements  
22 12. Resolution 813 – Strengthening Efforts Against Horizontal & Vertical  
23 Consolidation  
24 13. Resolution 817 – Expanding AMA Payment Reform Work and Advocacy to  
25 Medicaid and Other Non-Medicare Payment Models for Pediatric Health Care  
26 and Specialty Populations  
27 14. Resolution 819 – Amend Virtual Credit Card Policy  
28

29 **RECOMMENDED FOR ADOPTION IN LIEU OF**

- 30  
31 15. Resolution 803 – Improving Medicaid and CHIP Access and Affordability  
32 16. Resolution 806 – Evidence-Based Anti-Obesity Medication as a Covered Benefit  
33 Resolution 820 – Affordability and Accessibility of Treatment of Overweight and  
34 Obesity  
35 17. Resolution 807 – Any Willing Provider  
36 18. Resolution 808 – Prosthodontic Coverage after Oncologic Reconstruction

- 1 19. Resolution 814 – Providing Parity for Medicare Facility Fees
- 2 20. Resolution 815 – Long-Term Care and Support Services for Seniors

3  
4 **RECOMMENDED FOR REFERRAL**

- 5
- 6 21. Council on Medical Service Report 7 – Sustainable Payment for Community
- 7 Practices
- 8 22. Resolution 802 – Improving Nonprofit Hospital Charity Care Policies
- 9 23. Resolution 818 – Amendment to AMA Policy on Health Care System Reform
- 10 Proposals
- 11 24. Resolution 821 – Modernizing the AMA/Specialty Society RVS Update
- 12 Committee (RUC) Processes

13  
14 **RECOMMENDED FOR REFERRAL FOR DECISION**

- 15 25. Resolution 809 – Outsourcing of Administrative and Clinical Work to Different
- 16 Time Zones – An Issue of Equity, Diversity, and Inclusion

17  
18 **Amendments**

19 **If you wish to propose an amendment to an item of business, click here: [SUBMIT](#)**  
20 **[NEW AMENDMENT](#)**

## RECOMMENDED FOR ADOPTION

1 (1) COUNCIL ON MEDICAL SERVICE REPORT 1 -- ACO  
2 REACH

3  
4 **RECOMMENDATION A:**

5  
6 **Your Reference Committee recommends that**  
7 **Recommendations in Council on Medical Service**  
8 **Report 1 be adopted and the remainder of the report be**  
9 **filed.**

10  
11 **HOD ACTION: Recommendation in the Report of the**  
12 **Council on Medical Service adopted and the remainder of**  
13 **the Report filed.**

14  
15 The Council on Medical Service recommends that the following be adopted in lieu of  
16 Resolution 822-I-22, and the remainder of the report be filed:

- 17 1. That our American Medical Association reaffirm the following policies:
- 18 a. Policy H-160.915, "Accountable Care Organization Principles"
  - 19 b. Policy H-373.998, "Patient Information and Choice"
  - 20 c. Policy H-160.892, "Effects of Hospital Integrated System Accountable
  - 21 Care Organizations"
  - 22 d. Policy D-385.963, "Health Care Reform Physician Payment Models"
  - 23 e. Policy H-180.944, "Plan for Continued Progress Toward Health Equity"
  - 24 f. Policy H-160.912, "The Structure and Function of Interprofessional Health
  - 25 Care Teams"
  - 26 g. Policy D-385.952, "Alternative Payment Models and Vulnerable
  - 27 Populations" (Reaffirm HOD Policy)
- 28

29 Your Reference Committee heard testimony in support of Council on Medical Service  
30 Report 1. Testimony from the authors of the resolution prompting this report thanked the  
31 Council for its work and stated that they believe the report adequately addressed the  
32 concerns of their resolution. Additional testimony online and in-person was supportive of  
33 the report. There was testimony provided to refer the report back and that asked for the  
34 Council to do more on this topic, but your Reference Committee feels that the Council  
35 explicitly stated in the report that it will continue to monitor this issue and update the House  
36 as necessary. We feel that is sufficient, especially considering that the ACO REACH  
37 model began at the beginning of 2023 and data is not yet available on the outcomes of  
38 the model. Therefore, your Reference Committee recommends that the recommendations  
39 in Council on Medical Service Report 1 be adopted, and the remainder of the report be  
40 filed.

1 (2) RESOLUTION 801 -- IMPROVING PHARMACEUTICAL  
2 ACCESS AND AFFORDABILITY  
3

4 **RECOMMENDATION A:**  
5

6 **Your Reference Committee recommends that Policy H-**  
7 **110.987 be reaffirmed in lieu of the first Resolve of**  
8 **Resolution 801.**  
9

10 **RECOMMENDATION B:**  
11

12 **Your Reference Committee recommends that the**  
13 **second Resolve of Resolution 801 be adopted.**  
14

15 **HOD ACTION: Resolution 801 adopted.**  
16

17 RESOLVED, that our American Medical Association supports lowering out-of-pocket  
18 maximums in insurance plans including but not limited to ERISA plans, other forms of  
19 employer-sponsored insurance, plans offered on the ACA marketplace, TRICARE, and  
20 any other public or private payers (New HOD Policy); and be it further  
21

22 RESOLVED, that our AMA oppose Direct Member Reimbursement plans, where  
23 patients pay the full retail costs of a prescription drug that they may then be reimbursed  
24 for, due to their potential to expose patients to significant out-of-pocket costs. (New HOD  
25 Policy)  
26

27 Testimony on Resolution 801 was mixed. Your Reference Committee heard testimony in  
28 support of the spirit of the resolution, indicating the importance of ensuring that  
29 prescription medications are affordable and accessible to patients. Testimony was largely  
30 supportive of the second resolved clause and split on the first resolved clause. Specifically,  
31 testimony indicated concern that the adoption of the first resolved clause could  
32 unintentionally cause costs to be shifted to increased patient deductibles, premiums, or  
33 copays. Additionally, testimony reflected that your AMA has extensive policy indicating  
34 support and efforts to lower the cost of prescription drugs to patients. Therefore, your  
35 Reference Committee recommends that Policy H-110.987 be reaffirmed in lieu of the first  
36 resolved clause and the second resolved clause be adopted.  
37

38 **PHARMACEUTICAL COSTS H-110.987**

- 39 1. Our AMA encourages Federal Trade Commission (FTC) actions to limit  
40 anticompetitive behavior by pharmaceutical companies attempting to reduce  
41 competition from generic manufacturers through manipulation of patent  
42 protections and abuse of regulatory exclusivity incentives.
- 43 2. Our AMA encourages Congress, the FTC and the Department of Health and  
44 Human Services to monitor and evaluate the utilization and impact of controlled  
45 distribution channels for prescription pharmaceuticals on patient access and  
46 market competition.
- 47 3. Our AMA will monitor the impact of mergers and acquisitions in the  
48 pharmaceutical industry.
- 49 4. Our AMA will continue to monitor and support an appropriate balance between  
50 incentives based on appropriate safeguards for innovation on the one hand and

- 1 efforts to reduce regulatory and statutory barriers to competition as part of the
- 2 patent system.
- 3 5. Our AMA encourages prescription drug price and cost transparency among
- 4 pharmaceutical companies, pharmacy benefit managers and health insurance
- 5 companies.
- 6 6. Our AMA supports legislation to require generic drug manufacturers to pay an
- 7 additional rebate to state Medicaid programs if the price of a generic drug rises
- 8 faster than inflation.
- 9 7. Our AMA supports legislation to shorten the exclusivity period for biologics.
- 10 8. Our AMA will convene a task force of appropriate AMA Councils, state medical
- 11 societies and national medical specialty societies to develop principles to guide
- 12 advocacy and grassroots efforts aimed at addressing pharmaceutical costs and
- 13 improving patient access and adherence to medically necessary prescription drug
- 14 regimens.
- 15 9. Our AMA will generate an advocacy campaign to engage physicians and
- 16 patients in local and national advocacy initiatives that bring attention to the rising
- 17 price of prescription drugs and help to put forward solutions to make prescription
- 18 drugs more affordable for all patients.
- 19 10. Our AMA supports: (a) drug price transparency legislation that requires
- 20 pharmaceutical manufacturers to provide public notice before increasing the price
- 21 of any drug (generic, brand, or specialty) by 10% or more each year or per course
- 22 of treatment and provide justification for the price increase; (b) legislation that
- 23 authorizes the Attorney General and/or the Federal Trade Commission to take
- 24 legal action to address price gouging by pharmaceutical manufacturers and
- 25 increase access to affordable drugs for patients; and (c) the expedited review of
- 26 generic drug applications and prioritizing review of such applications when there is
- 27 a drug shortage, no available comparable generic drug, or a price increase of 10%
- 28 or more each year or per course of treatment.
- 29 11. Our AMA advocates for policies that prohibit price gouging on prescription
- 30 medications when there are no justifiable factors or data to support the price
- 31 increase.
- 32 12. Our AMA will provide assistance upon request to state medical associations in
- 33 support of state legislative and regulatory efforts addressing drug price and cost
- 34 transparency.
- 35 13. Our AMA supports legislation to shorten the exclusivity period for FDA
- 36 pharmaceutical products where manufacturers engage in anti-competitive
- 37 behaviors or unwarranted price escalations.
- 38 14. Our AMA supports legislation that limits Medicare annual drug price increases
- 39 to the rate of inflation. (CMS Rep. 2, I-15; Reaffirmation in lieu of: Res. 817, I-16;
- 40 Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified:
- 41 Speakers Rep. 01, A-17)

1 (3) RESOLUTION 816 -- REDUCING BARRIERS TO  
2 GENDER-AFFIRMING CARE THROUGH IMPROVED  
3 PAYMENT AND REIMBURSEMENT  
4

5 **RECOMMENDATION A:**

6  
7 **Your Reference Committee recommends that**  
8 **Resolution 816 be adopted.**  
9

10 **HOD ACTION: Resolution 816 adopted.**

11  
12 RESOLVED, that our American Medical Association appoint an ad hoc committee or  
13 task force, composed of physicians from specialties who routinely provide gender-  
14 affirming care, payers, community advocates, and state Medicaid directors and/or  
15 insurance commissioners, to identify issues with physician payment and reimbursement  
16 for gender-affirming care and recommend solutions to address these barriers to care.  
17 (Directive to Take Action)  
18

19 Testimony on Resolution 816 was unanimously supportive. Your Reference Committee  
20 heard testimony regarding the importance of ensuring that gender-affirming care is  
21 accessible to patients. Additionally, testimony made it clear that the ask of this resolution  
22 was specifically centered on the issues of payment for providing gender-affirming care.  
23 Due to the unanimous supportive testimony, your Reference Committee recommends the  
24 adoption of Resolution 816.

**RECOMMENDED FOR ADOPTION AS AMENDED**

1 (4) COUNCIL ON MEDICAL SERVICE REPORT 2 -- HEALTH  
2 INSURERS AND COLLECTION OF PATIENT COST-  
3 SHARING

4  
5 **RECOMMENDATION A:**

6  
7 **Your Reference Committee recommends that the first**  
8 **Recommendation of Council on Medical Service Report**  
9 **2 be amended by addition and deletion to read as**  
10 **follows:**

11  
12 **1. That our American Medical Association (AMA)**  
13 **support requiring health insurers to collect patient**  
14 **cost-sharing and pay physicians their full ~~contracted~~**  
15 **allowable amount for the health care services provided,**  
16 **unless the physicians opt-out to collect such cost-**  
17 **sharing on their own. (New HOD Policy)**

18  
19 **RECOMMENDATION B:**

20  
21 **Your Reference Committee recommends that Council**  
22 **on Medical Service Report 2 be amended by addition of**  
23 **a new third Recommendation to read as follows:**

24  
25 **3. That our AMA work with interested state medical**  
26 **associations and national medical specialty societies to**  
27 **support the adoption of policies requiring insurers to**  
28 **collect patient cost-sharing and pay physicians their**  
29 **full allowable amount for the health care services**  
30 **provided, unless the physician should opt out. (New**  
31 **HOD Policy)**

32  
33 **RECOMMENDATION C:**

34  
35 **Your Reference Committee recommends that**  
36 **Recommendations in Council on Medical Service**  
37 **Report 2 be adopted as amended and the remainder of**  
38 **the report be filed.**

39  
40 **HOD ACTION: Council on Medical Service Report 2**  
41 **adopted as amended and the remainder of the report filed.**

42  
43 The Council on Medical Service recommends that the following be adopted, and the  
44 remainder of the report be filed:

45  
46 1. That our American Medical Association (AMA) support requiring health insurers to  
47 collect patient cost-sharing and pay physicians their full contracted amount for the

1 health care services provided, unless the physicians opt-out to collect such cost-  
2 sharing on their own. (New HOD Policy)

3  
4 2. That our AMA reaffirm Policy H-165.838, which details the AMA's ongoing support  
5 for affordable and accessible insurance coverage. (Reaffirm HOD Policy)

6  
7 Your Reference Committee heard supportive testimony in favor of the adoption of CMS  
8 Report 2. Testimony noted that the current system of physician cost-sharing collection is  
9 unfair to physicians. Additionally, testimony indicated support for ensuring that the burden  
10 of collecting cost-sharing is shifted to insurers. Testimony explained the importance of  
11 ensuring that the adoption of policies encouraging this shift in cost-sharing collection be  
12 supported by our AMA's work with state and specialty societies. Therefore, your  
13 Reference Committee recommends that CMS Report 2 be adopted as amended and the  
14 remainder of the report be filed.



1 (5) COUNCIL ON MEDICAL SERVICE REPORT 3 --  
2 STRENGTHENING NETWORK ADEQUACY  
3

4 **RECOMMENDATION A:**

5  
6 Your Reference Committee recommends that  
7 Recommendation 1 in Council on Medical Service  
8 Report 3 be amended by addition and deletion to read  
9 as follows:

10  
11 1. That our American Medical Association (AMA)  
12 support establishment and enforcement of a minimum  
13 federal network adequacy standard requiring all health  
14 plans to contract with sufficient numbers and types of  
15 physicians and other providers, including for mental  
16 health and substance use disorder, such that both  
17 scheduled and unscheduled care may be provided  
18 without unreasonable travel or delay. (New HOD Policy)  
19

20 **RECOMMENDATION B:**

21  
22 Your Reference Committee recommends that  
23 Recommendation 2 in Council on Medical Service  
24 Report 3 be amended by addition and deletion to read  
25 as follows:

26  
27 2. That our AMA encourage the use of multiple criteria  
28 to evaluate the sufficiency of health plan ~~provider~~  
29 physician networks, including but not limited to:  
30 a. Minimum physician-to-enrollee ratios across  
31 specialties and subspecialties, including mental health  
32 and substance use disorder providers who are  
33 accepting new patients;  
34 b. Minimum percentages of non-emergency ~~providers~~  
35 physicians available on nights and weekends;  
36 c. Maximum time and distance standards, including for  
37 enrollees who rely on public transportation;  
38 d. Clear standard for network appointment wait times  
39 across specialties and subspecialties, developed in  
40 consultation with appropriate specialty societies, for  
41 both new patients and continuing care, that are  
42 appropriate to a patient’s urgent and non-urgent health  
43 care needs; and  
44 e. Sufficient ~~providers~~ physicians to meet the care  
45 needs of people experiencing economic or social  
46 marginalization, chronic or complex health conditions,  
47 disability, or limited English proficiency. (New HOD  
48 Policy)

1           **RECOMMENDATION C:**

2  
3           Your Reference Committee recommends that  
4           Recommendation 4 in Council on Medical Service  
5           Report 3 be amended by addition and deletion to read  
6           as follows:

7  
8           **4. That our AMA support requiring health plans to report**  
9           **to regulators annually and prominently display network**  
10           **adequacy information so that it is available to enrollees**  
11           **and consumers shopping for plans, including:**

12           **a. The breadth of a plan’s provider network, by county**  
13           **and geographic region or Metropolitan Statistical Area**  
14           **(MSA);**

15           **b. Average wait times for primary and behavioral health**  
16           **care appointments as well as common specialty and**  
17           **subspecialty referrals;**

18           **c. The number of in-network physicians treating**  
19           **substance use disorder who are actively-accepting new**  
20           **patients in a timely manner, and the type of ~~opioid~~**  
21           **substance use disorder medications offered;**

22           **d. The number of in-network ~~mental health~~ physicians**  
23           **psychiatrists and other mental health providers actively**  
24           **accepting new patients in a timely manner; and**

25           **e. Instructions for consumers and physicians to easily**  
26           **contact regulators to report complaints about**  
27           **inadequate provider networks and other access**  
28           **problems-;**

29           **f. The number of physicians versus non-physician**  
30           **providers in the network overall and by**  
31           **specialty/practice focus; and**

32           **g. The number, geographic location, and medical**  
33           **specialty of any physician contracts terminated or**  
34           **added during the prior calendar year. (Modify HOD**  
35           **Policy)**

**RECOMMENDATION D:**

Your Reference Committee recommends that Recommendation 6 in Council on Medical Service Report 3 be amended by addition and deletion to read as follows:

6. That our AMA affirm that in-network physicians who provide both in-person and telehealth services may count towards health plan network adequacy requirements on a ~~very~~ limited basis when their physical practice does not meet time and distance standards, based on regulator discretion, such as when there is a shortage of physicians in the needed specialty or subspecialty within the community served by the health plan. The AMA does not support counting physicians who only offer telehealth services towards network adequacy requirements. (New HOD Policy)

**RECOMMENDATION E:**

Your Reference Committee recommends that Recommendations in Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

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

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) support establishment and enforcement of a minimum federal network adequacy standard requiring health plans to contract with sufficient numbers and types of physicians and other providers, including for mental health and substance use disorder, such that both scheduled and unscheduled care may be provided without unreasonable travel or delay. (New HOD Policy)
2. That our AMA encourage the use of multiple criteria to evaluate the sufficiency of health plan provider networks, including but not limited to:
  - a. Minimum physician-to-enrollee ratios across specialties, including mental health and substance use disorder providers who are accepting new patients;
  - b. Minimum percentages of non-emergency providers available on nights and weekends;
  - c. Maximum time and distance standards, including for enrollees who rely on public transportation;

- 1 d. Clear standard for network appointment wait times across specialties, for both  
2 new patients and continuing care, that are appropriate to a patient's urgent and  
3 non-urgent health care needs; and
- 4 e. Sufficient providers to meet the care needs of people experiencing economic or  
5 social marginalization, chronic or complex health conditions, disability, or limited  
6 English proficiency. (New HOD Policy)
- 7
- 8 3. That our AMA encourage the development and promulgation of network adequacy  
9 assessment tools that allow patients and employers to compare insurance plans and  
10 make informed decisions when enrolling in a plan. (New HOD Policy)
- 11 4. That our AMA support requiring health plans to report to regulators annually and  
12 prominently display network adequacy information so that it is available to enrollees  
13 and consumers shopping for plans, including:
  - 14 a. The breadth of a plan's provider network, by county and geographic region;
  - 15 b. Average wait times for primary and behavioral health care appointments as  
16 well as common specialty referrals;
  - 17 c. The number of in-network physicians treating substance use disorder who  
18 are actively accepting new patients, and the type of opioid use disorder  
19 medications offered;
  - 20 d. The number of in-network mental health physicians actively accepting new  
21 patients; and
  - 22 e. Instructions for consumers and physicians to easily contact regulators to  
23 report complaints about inadequate provider networks and other access  
24 problems. (New HOD Policy)
- 25
- 26 5. That our AMA encourage the use of claims data, audits, secret shopper programs,  
27 complaints, and enrollee surveys or interviews to monitor and validate in-network  
28 provider availability and wait times, network stability, and provider directory accuracy,  
29 and to identify other access or quality problems. (New HOD Policy)
- 30
- 31 6. That our AMA affirm that in-network physicians who provide both in-person and  
32 telehealth services may count towards health plan network adequacy requirements  
33 on a very limited basis when their physical practice does not meet time and distance  
34 standards, based on regulator discretion, such as when there is a shortage of  
35 physicians in the needed specialty within the community served by the health plan.  
36 The AMA does not support counting physicians who only offer telehealth services  
37 towards network adequacy requirements. (New HOD Policy)
- 38
- 39 7. That our AMA support regulation to hold health plans accountable for network  
40 inadequacies, including through use of corrective action plans and substantial  
41 financial penalties. (New HOD Policy)
- 42
- 43 8. That our AMA reaffirm Policy H-285.908, which supports state regulators as the  
44 primary enforcer of network adequacy requirements, sets parameters for out-of-  
45 network care and insurer termination of in-network providers, and advocates that  
46 plans be required to document to regulators that they have met requisite network  
47 adequacy standards including hospital-based physician specialties. (Reaffirm HOD  
48 Policy)
- 49

- 1 9. That our AMA reaffirm Policy H-285.904, which supports principles related to  
2 unanticipated out-of-network care and advocates that state regulators should enforce  
3 network adequacy standards through active regulation of health plans. (Reaffirm  
4 HOD Policy)  
5
- 6 10. That our AMA reaffirm Policy H-285.902, which urges the Centers for Medicare &  
7 Medicaid Services to take several steps to ensure network adequacy, enhance  
8 provider directory accuracy, measure network stability, and effectively communicate  
9 provider network information to patients. (Reaffirm HOD Policy)  
10
- 11 11. That our AMA reaffirm Policy H-285.911, which advocates that health insurance  
12 provider networks be sufficient to provide meaningful access to subscribers, for all  
13 medically necessary and emergency care, at the preferred, in-network benefit level  
14 on a timely and geographically accessible basis. (Reaffirm HOD Policy)  
15

16 Although several amendments were proffered, testimony was generally supportive of  
17 Council on Medical Service Report 3 and its approach to strengthening health plan  
18 network adequacy. The Council on Medical Service stated that the report  
19 recommendations support a multipronged approach by regulators that includes  
20 meaningful standards, transparency of network breadth, parameters for out-of-network  
21 care and effective monitoring and enforcement of existing standards. The Council on  
22 Medical Service also responded to several proffered amendments. The Council clarified  
23 that Recommendation 1 is intended to apply to *all* health plans and proposed the addition  
24 of “all” prior to “health plans” in this recommendation. Your Reference Committee concurs  
25 that, with this addition, a proposed amendment to add “including Medicaid managed care”  
26 to Recommendation 1 is not needed. Your Reference Committee also heard considerable  
27 testimony supportive of deleting “federal” before “network adequacy” in this  
28 recommendation. With this deletion, your Reference Committee believes proffered  
29 amendments to add “federally regulated” before health plans as well as the clause “and  
30 these standards be a guidance to state medical associations for state regulated plans” are  
31 no longer needed.  
32

33 After reviewing proffered amendments to Recommendation 2, the Council proposed  
34 changing “provider” to “physician” in the stem clause and subparts 2(b) and 2(e) to address  
35 scope of practice concerns raised in Online Member Forum testimony. However, an  
36 amendment to delete Recommendation 2(b) was opposed by the Council which stressed  
37 that night and weekend availability is an important aspect of network adequacy that is  
38 already being fulfilled by many physician practices.  
39

40 On Recommendation 4, testimony was mixed regarding use of the word “actively” before  
41 “accepting new patients” in subparts 4(c) and 4(d). A delegation suggested deletion of  
42 “actively,” while the Council on Medical Service asked that it be retained to address the  
43 problem of provider directories including physicians who may be open to taking patients  
44 but do not have any openings for patients. Your Reference Committee heard both sides  
45 and recommends adding “in a timely manner” to Recommendations 4(c) and 4(d) which  
46 addresses the Council’s concerns regarding the deletion of “actively.” Your Reference  
47 Committee also heard testimony requesting additional health plan reporting requirements  
48 in Recommendation 4(f) and (g).  
49

1 Your Reference Committee heard mixed testimony regarding deletion of “very limited  
2 basis” in Recommendation 6 with the Council on Medical Service arguing against deletion.  
3 As a compromise, your Reference Committee recommends deleting “very” before “limited  
4 basis.” Although one delegation testified against Recommendation 7, the Council testified  
5 that enforcement is the heart of this report and there are various ways these standards  
6 could be enforced when there are violations of network adequacy. Your Reference  
7 Committee agrees, and also incorporated a few minor amendments, including the addition  
8 of “metropolitan statistical area” to Recommendation 4(a), the addition of “and  
9 subspecialty/subspecialties” in Recommendations 2(a), 2(d), 4(b), and 6, and the use of  
10 “psychiatrists and other mental health providers” in Recommendation 4(d) instead of  
11 “mental health physicians.” Your Reference Committee recommends that Council on  
12 Medical Service Report 3 be adopted as amended.

1 (6) COUNCIL ON MEDICAL SERVICE REPORT 5 --  
2 MEDICAID UNWINDING UPDATE  
3

4 **RECOMMENDATION A:**

5  
6 Your Reference Committee recommends that  
7 Recommendation 1 in Council on Medical Service  
8 Report 5 be amended by addition to read as follows:  
9

10 1. That our American Medical Association (AMA) amend  
11 Policy H-290.955 by addition to read:  
12

13 4. Our AMA encourages state Medicaid agencies to  
14 implement strategies to reduce inappropriate  
15 terminations from Medicaid/CHIP for procedural  
16 reasons, including automating renewal processes and  
17 following up with enrollees who have not responded to  
18 a renewal request, using multiple modalities, before  
19 terminating coverage.

20 5. Our AMA encourages states to provide continuity of  
21 care protections to patients transitioning from Medicaid  
22 or CHIP to a new health plan that does not include their  
23 treating physicians and other providers in network, and  
24 to recognize prior authorizations completed under the  
25 prior Medicaid/CHIP plan.

26 6. Our AMA encourages state Medicaid agencies to  
27 make Medicaid coverage status, including expiration of  
28 current coverage and information on pending renewals,  
29 accessible to physicians, clinics, and hospitals through  
30 the state’s portal or by other readily accessible means.

31 7. Our AMA supports additional strategies that respond  
32 to improper Medicaid disenrollments, such as requiring  
33 states to reinstate Medicaid coverage for individuals  
34 improperly terminated and encouraging states to pause  
35 disenrollments until the cause of the improper  
36 terminations has been mitigated.

37 8. Our AMA supports the establishment of special  
38 enrollment periods that allow those disenrolled from  
39 Medicaid to enroll in Affordable Care Act marketplace  
40 plans outside of annual open enrollment dates, and  
41 increased funding for health insurance navigators,  
42 when significant Medicaid/CHIP disenrollments occur.

43 9. Our AMA supports strategies to prevent states from  
44 improperly disenrolling physicians from  
45 Medicaid/CHIP. (Modify HOD Policy)

**RECOMMENDATION B:**

**Your Reference Committee recommends that Recommendations in Council on Medical Service Report 5 be adopted as amended and the remainder of the report be filed.**

**HOD ACTION: Recommendations in Council on Medical Service Report 5 adopted as amended and the remainder of the report filed.**

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

- 1. That our American Medical Association (AMA) amend Policy H-290.955 by addition to read:
  - 4. Our AMA encourages state Medicaid agencies to implement strategies to reduce inappropriate terminations from Medicaid/CHIP for procedural reasons, including automating renewal processes and following up with enrollees who have not responded to a renewal request, using multiple modalities, before terminating coverage.
  - 5. Our AMA encourages states to provide continuity of care protections to patients transitioning from Medicaid or CHIP to a new health plan that does not include their treating physicians and other providers in network, and to recognize prior authorizations completed under the prior Medicaid/CHIP plan.
  - 6. Our AMA encourages state Medicaid agencies to make Medicaid coverage status, including expiration of current coverage and information on pending renewals, accessible to physicians, clinics, and hospitals through the state's portal or by other readily accessible means. (Modify HOD Policy)
- 2. That our AMA reaffirm Policy H-165.855, which calls for adoption of 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans and supports allowing for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care. (Reaffirm HOD Policy)
- 3. That our AMA reaffirm Policy H-165.823, which supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets certain standards related to consent, cost, ability to opt out, and other guardrails. (Reaffirm HOD Policy)

Testimony was very supportive of Council on Medical Service Report 5 as timely and appropriately focused on keeping patients covered during Medicaid unwinding. The Council on Medical Service introduced the report, noting that disenrollment rates in some states have been far too high and almost three out of every four disenrollments have been for procedural reasons. The Council also explained that little to no data on coverage transitions has been reported for individuals disenrolled from Medicaid and CHIP and the impact of the unwinding on coverage and uninsurance rates may not be fully understood until well after the unwinding period ends next summer.



1 To address the addition of two new clauses to Recommendation 1 proffered in the Online  
2 Member Forum, the Council proposed language capturing the intent of these amendments  
3 without calling on states and the Centers for Medicare & Medicaid Services (CMS) to take  
4 actions that have already been taken. The Council affirmed that any new policy  
5 established at this meeting will be cited in AMA advocacy with CMS. The Council said that  
6 a proffered amendment to Recommendation 1, subpart 4, which would encourage CMS  
7 and state medical associations to work with state Medicaid agencies, was unnecessary  
8 since this is already occurring and asked that Recommendation 1, subpart 4 be adopted  
9 as written. Your Reference Committee recommends adoption of the Council's proffered  
10 language as well as a third clause reflective of testimony heard regarding physicians in  
11 one state being improperly disenrolled from Medicaid during the unwinding period. Your  
12 Reference Committee recommends that Council on Medical Service Report 5 be adopted  
13 as amended.

14  
15 (7) COUNCIL ON MEDICAL SERVICE REPORT 6 -- RURAL  
16 HOSPITAL PAYMENT MODELS

17  
18 **RECOMMENDATION A:**

19  
20 **Your Reference Committee recommends that Council**  
21 **on Medical Service Report 6 be amended by addition of**  
22 **a fifth Recommendation to read as follows:**

23  
24 **5. That our AMA support data analysis and appropriate**  
25 **recommendations for improved rural hospital**  
26 **payments based on innovative payment models such**  
27 **as the Pennsylvania Rural Health Model (PARHM). (New**  
28 **HOD Policy)**

29  
30 **RECOMMENDATION B:**

31  
32 **Your Reference Committee recommends that**  
33 **Recommendations in Council on Medical Service**  
34 **Report 6 be adopted as amended and the remainder of**  
35 **the report be filed.**

36  
37 **HOD ACTION: That Resolve 5 of CMS Report 6**  
38 **adopted as amended to read as follows and the**  
39 **remainder of the report filed:**

40  
41 **5. That our AMA ~~support~~ report back no later**  
42 **than A-26 on data analysis and appropriate**  
43 **recommendations for improved rural hospital**  
44 **payments based on innovative payment models**  
45 **such as the Pennsylvania Rural Health Model**  
46 **(PARHM). (New HOD Policy Directive for action)**  
47  
48

1  
2 The Council on Medical Service recommends that the following be adopted and that the  
3 remainder of the report be filed:

- 4  
5 1. That our American Medical Association (AMA) support and encourage efforts to  
6 develop and implement proposals for improving payment models to rural  
7 hospitals. (New HOD Policy)  
8  
9 2. That our AMA reaffirm Policy H-465.978, which recognizes the payment bias  
10 toward rural hospitals as a factor in rural health disparities and encourages  
11 solutions to help solve this bias. (Reaffirm HOD Policy)  
12  
13 3. That our AMA reaffirm Policy D-465.998, which advocates for improvements to  
14 the payment and health care service delivery in rural hospitals. (Reaffirm HOD  
15 Policy)  
16  
17 4. That our AMA rescind Policy D-465.996 as having been accomplished with this  
18 report. (Rescind HOD Policy)  
19

20 Your Reference Committee heard supportive testimony regarding Council on Medical  
21 Service Report 6. One amendment suggested the addition of a fifth recommendation.  
22 The testimony indicated the importance of ensuring that rural hospitals are able to  
23 remain viable and provide care to the vulnerable communities they serve. Testimony  
24 indicated that future studies and reports should include discussions on maternal health  
25 in rural settings. Finally, testimony indicated a desire for ongoing support of both data  
26 collection and innovative payment models by your AMA. Therefore, your Reference  
27 Committee recommends that CMS Report 6 be adopted as amended and the  
28 remainder of the report be filed.  
29

1 (8) RESOLUTION 804 -- REQUIRED CLINICAL  
2 QUALIFICATIONS IN DETERMINING MEDICAL  
3 DIAGNOSES AND MEDICAL NECESSITY  
4

5 **RECOMMENDATION A:**

6  
7 **Your Reference Committee recommends that**  
8 **Resolution 804 be amended by addition and deletion**  
9 **to read as follows:**

10  
11 **RESOLVED, that our American Medical Association**  
12 **(AMA) advocate for change to existing public and**  
13 **private processes including Utilization Management,**  
14 **Prior Authorization, Medicare and Medicaid audits,**  
15 **Medicare and State Public Health surveys of clinical**  
16 **care settings, to only allow physicians ~~clinicians~~ with**  
17 **adequate and commensurate training, scope of**  
18 **practice, and licensure to determine accuracy of**  
19 **medical diagnoses and assess medical necessity.**  
20 **(Directive to Take Action)**

21  
22 **RECOMMENDATION B:**

23  
24 **Your Reference Committee recommends that**  
25 **Resolution 804 be amended by addition of a new**  
26 **Resolve to read as follows:**

27  
28 **RESOLVED, that to prevent a delay in care, our AMA**  
29 **support favoring the treating physician’s judgment if**  
30 **the reviewing physician is not available. (New HOD**  
31 **Policy)**

32  
33 **RECOMMENDATION C:**

34  
35 **Your Reference Committee recommends that**  
36 **Resolution 804 be adopted as amended.**

37  
38 **HOD ACTION: Resolution 804 adopted as amended.**

39  
40 **RESOLVED, that our American Medical Association advocate for a change to existing**  
41 **public and private processes including Utilization Management, Prior Authorization,**  
42 **Medicare and Medicaid audits, Medicare and State Public Health surveys of clinical care**  
43 **settings, to only allow clinicians with adequate and commensurate training, scope of**  
44 **practice, and licensure to determine accuracy of medical diagnoses and assess medical**  
45 **necessity. (Directive to Take Action)**

46  
47 **Your Reference Committee heard supportive testimony for Resolution 804, which pointed**  
48 **out that prior authorization was created to reduce the use of low-value treatments, but has**  
49 **instead become a tool to prevent patients in need from getting treatments recommended**  
50 **by qualified and dedicated physicians. The authors testified that the intent of the resolution**

1 was not necessarily prior authorization but, rather, reducing or even eliminating situations  
2 where nurses in facilities make determinations regarding physicians' medical diagnoses  
3 and assessment of medical necessity. The Council on Medical Service agreed that  
4 physicians should only be audited or surveyed by peers with adequate and commensurate  
5 training, scope of practice, and licensure to determine accuracy of medical diagnoses and  
6 assess medical necessity, and offered amendments equivalent to the language outlined  
7 in Section V of our *AMA Ensuring Transparency in Prior Authorization Act* model bill.  
8 Another amendment was proffered to require that if the reviewing party with equivalent  
9 expertise is not available, the decision should favor the treating physician. Therefore, your  
10 Reference Committee recommends that Resolution 804 be adopted as amended.

11  
12 (9) RESOLUTION 805 -- MEDICATION RECONCILIATION  
13 EDUCATION

14  
15 **RECOMMENDATION A:**

16  
17 **Your Reference Committee recommends that the first**  
18 **Resolve of Resolution 805 be amended by addition and**  
19 **deletion to read as follows:**

20  
21 **RESOLVED, that our American Medical Association**  
22 **~~work with Centers for Medicare and Medicaid Services~~**  
23 **~~and other appropriate organizations to encourage the~~**  
24 **study of current medication reconciliation practices**  
25 **across transitions of care ~~with dissimilar electronic~~**  
26 **~~health records~~ to evaluate the impact on patient safety**  
27 **and quality of care, including when there are dissimilar**  
28 **electronic health records, and to develop strategies,**  
29 **including ~~determine~~ the potential need for additional**  
30 **training, to reduce medical errors and ensure patient**  
31 **safety and quality of care (Directive to Take Action); and**  
32 **be it further**

33  
34 **RECOMMENDATION B:**

35  
36 **Your Reference Committee recommends that the**  
37 **second Resolve of Resolution 805 be amended by**  
38 **addition and deletion to read as follows:**

39  
40 **RESOLVED, that our American Medical Association**  
41 **~~work with other appropriate organizations to determine~~**  
42 **~~whether support~~ education for relevant health care**  
43 **providers ~~physicians-in-training is sufficient to attain~~**  
44 **the medication reconciliation core competencies**  
45 **necessary to reduce medical errors and ensure patient**  
46 **safety and quality of care and ~~provide~~**  
47 **~~recommendations for action as applicable.~~ (Directive to**  
48 **Take Action)**  
49

1           **RECOMMENDATION C:**

2  
3           **Your Reference Committee recommends that**  
4           **Resolution 805 be adopted as amended.**

5  
6                   **HOD ACTION: Resolve two of Resolution 805 referred and**  
7                   **the remainder of the resolution adopted as amended.**

8  
9           RESOLVED, that our American Medical Association work with Centers for Medicare &  
10          Medicaid Services and other appropriate organizations to study current medication-  
11          reconciliation practices across transitions of care with dissimilar electronic health records  
12          to evaluate the impact on patient safety and quality of care, and to determine the  
13          potential need for additional training to reduce medical errors and ensure patient safety  
14          and quality of care (Directive to Take Action); and be it further

15  
16          RESOLVED, that our American Medical Association work with other appropriate  
17          organizations to determine whether education for physicians-in-training is sufficient to  
18          attain the medication reconciliation core competencies necessary to reduce medical  
19          errors and ensure patient safety and quality of care and provide recommendations for  
20          action as applicable. (Directive to Take Action)

21  
22          Your Reference Committee heard mixed testimony on Resolution 805. Testimony  
23          indicated the importance of the spirit of the resolution and emphasized how vital  
24          appropriate medication reconciliation is to patient safety. Additionally, testimony indicated  
25          that this is not an issue around the education of physicians, but rather the challenges that  
26          can occur for physicians working toward medication reconciliation. Testimony indicated  
27          that these challenges are especially burdensome when electronic health records are  
28          dissimilar. Therefore, your Reference Committee recommends the adoption of Resolution  
29          805 as amended.

1 (10) RESOLUTION 811 -- EXPANDING THE USE OF  
2 MEDICAL INTERPRETERS

3  
4 **RECOMMENDATION A:**

5  
6 Your Reference Committee recommends that  
7 Resolution 811 be amended by addition and deletion to  
8 read as follows:

9  
10 **RESOLVED**, that our American Medical Association  
11 amend H-160.924, "Use of Language Interpreters in the  
12 Context of the Patient-Physician Relationship," by  
13 addition and deletion as follows:

14  
15 Use of Language Interpreters in the Context of the  
16 Patient-Physician Relationship H-160.924 27

17 1. AMA policy is that:

18 (1a) further research is necessary on how the use of  
19 interpreters--both those who are trained and those who  
20 are not--impacts patient care;

21 (b) treating physicians shall respect and assist the  
22 patients' choices whether to involve capable family  
23 members or friends to provide language assistance that  
24 is culturally sensitive and competent, with or without an  
25 interpreter who is competent and culturally sensitive;

26 (c) physicians continue to be resourceful in their use of  
27 other appropriate means that can help facilitate  
28 communication--including print materials, digital and  
29 other electronic or telecommunication services with the  
30 understanding, however, of these tools' limitations--to  
31 aid Limited English Proficiency (LEP) patients'  
32 involvement in meaningful decisions about their care;

33 ~~(d) patients have expanded should have access to~~  
34 ~~documentation and communications available in their~~  
35 ~~preferred language, when feasible and in a manner that~~  
36 ~~requires all payers to directly pay for such services;~~  
37 ~~including appointment reminder calls/messages, post-~~  
38 ~~appointment summaries, and electronic medical~~  
39 ~~records, through access to trained interpreter and~~  
40 ~~translator services; and~~

41 (de) physicians cannot be expected to provide and fund  
42 these translation services for their patients, as the  
43 Department of Health and Human Services' policy  
44 guidance currently requires; when trained medical  
45 interpreters are needed, the costs of their services shall  
46 be paid directly to the interpreters by patients and/or  
47 third party payers and physicians shall not be required  
48 to participate in payment arrangements.

1           **2. Our AMA recognizes the importance of using medical**  
2           **interpreters as a means of improving quality of care**  
3           **provided to patients with LEP including patients with**  
4           **sensory impairments.**

5  
6           **3. Our AMA encourage hospital systems, clinics,**  
7           **residency programs, and medical schools to promote**  
8           **and incentivize pursue opportunities for physicians,**  
9           **staff, and trainees to voluntarily receive medical**  
10           **interpreter training and certification should they desire.**  
11           **(Modify Current HOD Policy)**

12  
13           **RECOMMENDATION B:**

14  
15           **Your Reference Committee recommends that**  
16           **Resolution 811 be adopted as amended.**

17  
18           **HOD ACTION: Resolution 811 adopted as amended.**

19  
20           RESOLVED, that our American Medical Association amend H-160.924, "Use of  
21           Language Interpreters in the Context of the Patient-Physician Relationship," by addition  
22           as follows:

23  
24           Use of Language Interpreters in the Context of the Patient-Physician Relationship  
25           H-160.924

26           1. AMA policy is that: (1) further research is necessary on how the use of  
27           interpreters--both those who are trained and those who are not--impacts patient  
28           care; (b) treating physicians shall respect and assist the patients' choices whether to  
29           involve capable family members or friends to provide language assistance that is  
30           culturally sensitive and competent, with or without an interpreter who is competent  
31           and culturally sensitive; (c) physicians continue to be resourceful in their use of  
32           other appropriate means that can help facilitate communication--including print  
33           materials, digital and other electronic or telecommunication services with the  
34           understanding, however, of these tools' limitations--to aid Limited English  
35           Proficiency (LEP) patients' involvement in meaningful decisions about their care; d)  
36           patients have expanded access to documentation and communications available in  
37           their preferred language, including appointment reminder calls/messages, post-  
38           appointment summaries, and electronic medical records, through access to trained  
39           interpreter and translator services; and (de) physicians cannot be expected to  
40           provide and fund these translation services for their patients, as the Department of  
41           Health and Human Services' policy guidance currently requires; when trained  
42           medical interpreters are needed, the costs of their services shall be paid directly to  
43           the interpreters by patients and/or third party payers and physicians shall not be  
44           required to participate in payment arrangements.

45           2. Our AMA recognizes the importance of using medical interpreters as a means of  
46           improving quality of care provided to patients with LEP including patients with  
47           sensory impairments.

48           3. Our AMA encourage hospital systems, clinics, residency programs, and medical  
49           schools to promote and incentivize opportunities for physicians, staff, and trainees  
50           to receive medical interpreter training and certification. (Modify Current HOD Policy)

1 Testimony on Resolution 811 was largely supportive of the intent of the resolution to  
2 ensure that patients have access to communications and care in their preferred language.  
3 However, testimony did indicate concerns around the burden that these services may  
4 place on physicians and their practices and around the feasibility of accessing certified  
5 medical interpreters of uncommonly spoken languages. Testimony indicated particular  
6 concern around the financial burden that could result should practices be required to  
7 implement these translation changes. Additionally, testimony outlined the vital nature of  
8 quality interpreters in health care. Testimony indicated that patients who have access to  
9 quality interpreters have better outcomes. Finally, concern was voiced that relying upon  
10 physicians, staff, and trainees could amount to an increased burden. Therefore, your  
11 Reference Committee recommends Resolution 811 be adopted as amended.



1 (11) RESOLUTION 812 -- INDIAN HEALTH SERVICE  
2 IMPROVEMENTS

3  
4 **RECOMMENDATION A:**

5  
6 **Your Reference Committee recommends that the first**  
7 **Resolve of Resolution 812 be amended by addition and**  
8 **deletion to read as follows:**

9  
10 **RESOLVED, that our American Medical Association**  
11 **support ~~advocate to permanently an~~ increase to the**  
12 **Federal Medical Assistance Percentage (FMAP) to 100%**  
13 **for medical services which are received at or through**  
14 **an Urban Indian Organization that has a grant or**  
15 **contract with the Indian Health Service (IHS) and**  
16 **encourage state and federal governments to reinvest**  
17 **Medicaid savings from 100% FMAP into tribally-driven**  
18 **health improvement programs; and be it further**

19  
20 **RECOMMENDATION B:**

21  
22 **Your Reference Committee recommends that the**  
23 **second Resolve of Resolution 812 be deleted.**

24  
25 **~~RESOLVED, that our AMA encourage state and federal~~**  
26 **~~governments to reinvest Medicaid savings from 100%~~**  
27 **~~FMAP into tribally-driven health improvement~~**  
28 **~~programs; and be it further~~**

29  
30 **RECOMMENDATION C:**

31  
32 **Your Reference Committee recommends that the third**  
33 **Resolve of Resolution 812 be amended by addition and**  
34 **deletion to read as follows:**

35  
36 **RESOLVED, that our AMA support ~~advocate for~~ greater**  
37 **physician and federal oversight of the IHS National Core**  
38 **Formulary, ensuring that the pharmacy benefit for**  
39 **American Indian and Alaska Native patients represents**  
40 **the standard-of-care for prevalent diseases and medical**  
41 **conditions in this population and includes at least two**  
42 **standard-of-care drugs proven to be equally effective in**  
43 **each therapeutic category or pharmacologic class, if**  
44 **available, to be available for use by physicians in**  
45 **deciding the best treatment options for their patients;**  
46 **and be it further**

1           **RECOMMENDATION D:**

2  
3           Your Reference Committee recommends that the fourth  
4           Resolve of Resolution 812 be deleted.

5  
6           ~~RESOLVED, that our AMA work with IHS and~~  
7           ~~appropriate agencies and organizations to ensure that~~  
8           ~~their National Core Formulary includes at least two~~  
9           ~~standard-of-care drugs proven to be equally effective in~~  
10           ~~each therapeutic category or pharmacologic class, if~~  
11           ~~available, to be used by the physician in deciding the~~  
12           ~~best treatment options for their patients; and be it~~  
13           ~~further~~

14  
15           **RECOMMENDATION E:**

16  
17           Your Reference Committee recommends that the fifth  
18           Resolve of Resolution 812 be amended by addition and  
19           deletion to read as follows:

20  
21           **RESOLVED, that our AMA support permanent**  
22           **reauthorization of the Special Diabetes Program for**  
23           **Indians and the Special Diabetes Program for Type 1**  
24           **Diabetes Research along with inflationary increases for**  
25           **public health and health profession grants for**  
26           **physicians sponsored by IHS; and be it further**

27  
28           **RECOMMENDATION F:**

29  
30           Your Reference Committee recommends that the sixth  
31           Resolve of Resolution 812 be deleted.

32  
33           ~~RESOLVED, that our AMA support biannual inflationary~~  
34           ~~increases for public health and health profession~~  
35           ~~grants sponsored by IHS.~~

36  
37           **RECOMMENDATION G:**

38  
39           Your Reference Committee recommends that  
40           Resolution 812 be adopted as amended.

41  
42           **HOD ACTION: Resolution 812 adopted as amended.**

43  
44           RESOLVED, that our American Medical Association advocate to permanently increase  
45           the Federal Medical Assistance Percentage (FMAP) to 100% for medical services which  
46           are received at or through an Urban Indian Organization that has a grant or contract with  
47           the Indian Health Service (IHS) (Directive to Take Action); and be it further  
48

1 RESOLVED, that our AMA encourage state and federal governments to reinvest  
2 Medicaid savings from 100% FMAP into tribally-driven health improvement programs  
3 (New HOD Policy); and be it further  
4

5 RESOLVED, that our AMA advocate for greater physician and federal oversight of the  
6 IHS National Core Formulary, ensuring that the pharmacy benefit for American Indian  
7 and Alaska Native patients represents the standard-of-care for prevalent diseases and  
8 medical conditions in this population (Directive to Take Action); and be it further  
9

10 RESOLVED, that our AMA work with IHS and appropriate agencies and organizations to  
11 ensure that their National Core Formulary includes at least two standard-of-care drugs  
12 proven to be equally effective in each therapeutic category or pharmacologic class, if  
13 available, to be used by the physician in deciding the best treatment options for their  
14 patients (Directive to Take Action); and be it further  
15

16 RESOLVED, that our AMA support permanent reauthorization of the Special Diabetes  
17 Program for Indians (New HOD Policy); and be it further  
18

19 RESOLVED, that our AMA support biannual inflationary increases for public health and  
20 health profession grants sponsored by IHS. (New HOD Policy)  
21

22 Your Reference Committee heard unanimously supportive testimony on Resolution 812.  
23 Commenters noted that the COVID-19 pandemic has highlighted the disparities and  
24 shortcomings of the Indian Health Service (IHS), largely due to chronic underfunding of  
25 the agency. The three main tenets of the resolution (i.e., 100% of FMAP for IHS, oversight  
26 of the National Core Formulary, and permanent authorization of the Special Diabetes  
27 Program for Indians) will lead to enhanced and directed advocacy of priorities as identified  
28 by American Indian/Alaska Native-serving health organizations and other important  
29 stakeholders. The Council on Medical Service recognized the importance of the IHS, as it  
30 provides a comprehensive health service delivery system for approximately 2.6 million  
31 American Indians and Alaska Natives who belong to 574 federally recognized Tribes.  
32 While the IHS was previously the only federal health program without advance  
33 appropriations, the Department of Health and Human Services successfully secured  
34 advance appropriations for IHS for Fiscal Year 2024. Therefore, starting in 2024, the  
35 majority of IHS-funded programs, including Tribal Health Programs and Urban Indian  
36 Organizations, will remain funded and operational in the event of a lapse of appropriation.  
37 The Council proffered amendments to streamline the resolution's asks, which several  
38 commenters supported. Your Reference Committee recommends that Resolution 812 be  
39 adopted as amended.

1 (12) RESOLUTION 813 -- STRENGTHENING EFFORTS  
2 AGAINST HORIZONTAL & VERTICAL CONSOLIDATION  
3

4 **RECOMMENDATION A:**

5  
6 Your Reference Committee recommends that the  
7 second Resolve of Resolution 813 be amended by  
8 deletion to read as follows:  
9

10 **RESOLVED**, that our AMA oppose not-for-profit firm  
11 immunity from FTC competition policy enforcement in  
12 the health care sector, ~~which represent the majority of~~  
13 ~~U.S. hospitals~~ (New HOD Policy); and be it further  
14

15 **RECOMMENDATION B:**

16  
17 Your Reference Committee recommends that the third  
18 Resolve of Resolution 813 be amended by addition and  
19 deletion to read as follows:  
20

21 **RESOLVED**, that our AMA support appropriate lowering  
22 the transaction value thresholds, including cumulative  
23 transaction values, for merger reporting in health care  
24 sectors to ensure that vertical acquisitions in health  
25 care do not evade antitrust scrutiny (New HOD Policy);  
26 and be it further  
27

28 **RECOMMENDATION C:**

29  
30 Your Reference Committee recommends that the fourth  
31 Resolve of Resolution 813 be amended by deletion to  
32 read as follows:  
33

34 **RESOLVED**, that our AMA support health care-specific  
35 advocacy efforts that will strengthen antitrust  
36 enforcement in the health care sector through multiple  
37 mechanisms, ~~including but not limited to a) simplifying~~  
38 ~~the evidentiary burden on plaintiffs and shifting the~~  
39 ~~evidentiary burden to defendants and b) encouraging~~  
40 ~~the FTC to leverage its authority to increase the~~  
41 ~~frequency of challenges in consolidated health care~~  
42 ~~markets.~~ (New HOD Policy)  
43

44 **RECOMMENDATION D:**

45  
46 Your Reference Committee recommends that  
47 Resolution 813 be adopted as amended.  
48

49 **HOD ACTION:** Resolution 813 adopted as amended.

1 RESOLVED, that our American Medical Association advocate to adequately resource  
2 competition policy authorities such as the Federal Trade Commission (FTC) and  
3 Department of Justice Antitrust Division to perform oversight of health care markets  
4 (Directive to Take Action); and be it further

5  
6 RESOLVED, that our AMA oppose not-for-profit firm immunity from FTC competition  
7 policy enforcement in the health care sector, which represent the majority of U.S.  
8 hospitals (New HOD Policy); and be it further

9  
10 RESOLVED, that our AMA support lowering the transaction value threshold for merger  
11 reporting in health care sectors to ensure that vertical acquisitions in health care do not  
12 evade antitrust scrutiny (New HOD Policy); and be it further

13  
14 RESOLVED, that our AMA support health care-specific advocacy efforts which will  
15 strengthen antitrust enforcement in the health care sector through multiple mechanisms,  
16 including but not limited to a) simplifying the evidentiary burden on plaintiffs and shifting  
17 the evidentiary burden to defendants and b) encouraging the FTC to leverage its  
18 authority to increase the frequency of challenges in consolidated health care markets.  
19 (New HOD Policy)

20  
21 Testimony was mixed on Resolution 813. Testimony in support of Resolution 813 stated  
22 that countless studies have documented the problems associated with health care  
23 consolidation, including increasing costs while limiting access to care.

24  
25 There was concern that as written, resolved clauses 3 and 4 could lead to unintended  
26 consequences, specifically that lowering the threshold for merger review and reporting  
27 could increase the burden on small- and medium-sized physician practices that may wish  
28 to merge and remain small- or medium-sized practices. Lowering the threshold could lead  
29 to costs and administrative burdens that these practices would not be able to afford.

30  
31 The Council on Medical Service shared the concerns raised in previous testimony and  
32 proposed several amendments to the resolved clauses to address these and prevent the  
33 unintended consequence of putting the burden on small- and medium-sized physician  
34 practices if the transaction value threshold is lowered. The Council recommended striking  
35 “which represent the majority of U.S. hospitals” from the second resolved clause, which  
36 was deemed unnecessary. The Council recommended amending the third resolved clause  
37 to support a continuous, cumulative lookback period to address the concern that if a  
38 hospital or a private equity firm acquires one physician practice, the value may fall below  
39 the threshold, but if it acquires many practices over time, eventually the value of all these  
40 transactions will reach the threshold set by the FTC. The Council amendment removed  
41 support for broadly lowering the threshold and put safeguards in place to protect small-  
42 and medium-sized private physician practices. Finally, the Council recommended striking  
43 “through multiple mechanisms, including but not limited to a) simplifying the evidentiary  
44 burden on plaintiffs and shifting the evidentiary burden to defendants and b) encouraging  
45 the FTC to leverage its authority to increase the frequency of challenges in consolidated  
46 health care markets.” This streamlines the fourth resolved clause by removing  
47 unnecessary language.  
48

1 The original authors of the resolution did not support striking the text in the fourth resolved  
2 clause, stating that simplifying the evidentiary burden is an essential part of this resolution.  
3 However, your Reference Committee agreed with previous testimony that shifting the  
4 evidentiary burden to defendants still has the potential to harm physicians, especially  
5 those in small- and medium-sized practices.

6  
7 Your Reference Committee agreed with the amendments proposed by the Council.  
8 Therefore, your Reference Committee recommends that Resolution 813 be adopted as  
9 amended.

1 (13) RESOLUTION 817 -- EXPANDING AMA PAYMENT  
2 REFORM WORK AND ADVOCACY TO MEDICAID AND  
3 OTHER NON-MEDICARE PAYMENT MODELS FOR  
4 PEDIATRIC HEALTH CARE AND SPECIALTY  
5 POPULATIONS

6  
7 **RECOMMENDATION A:**

8  
9 **Your Reference Committee recommends that the first**  
10 **Resolve of Resolution 817 be amended by addition and**  
11 **deletion to read as follows:**

12  
13 **RESOLVED, that our American Medical Association**  
14 **~~examine and report back on support~~ demonstration**  
15 **projects, carve outs, and adjustments for pediatric**  
16 **patients and services provided to pediatric patients**  
17 **within the payment reform arena (Directive to Take**  
18 **Action)**

19  
20 **RECOMMENDATION B:**

21  
22 **Your Reference Committee recommends that the third**  
23 **Resolve of Resolution 817 be amended by addition and**  
24 **deletion to read as follows:**

25  
26 **RESOLVED, that our AMA support and work with**  
27 **national medical specialty societies that are developing**  
28 **alternative payment models for specific conditions or**  
29 **episodes, target patient populations, such as pediatric**  
30 **populations, health care and medical and surgical**  
31 **specialties and continue to advocate that the Center for**  
32 **Medicare and Medicaid Innovation implement**  
33 **physician-developed payment models; (New HOD**  
34 **Policy)**

35  
36 **RECOMMENDATION C:**

37  
38 **Your Reference Committee recommends that**  
39 **Resolution 817 be adopted as amended.**

40  
41 **HOD ACTION: Resolution 817 adopted as amended to read**  
42 **as follows:**  
43

1           **RESOLVED, that our American Medical Association**  
2 ~~**examine and report back on support**~~ **appropriate**  
3 **demonstration projects, carve outs, and adjustments**  
4 **for pediatric patients and services provided to pediatric**  
5 **patients within the payment reform arena (Directive to**  
6 **Take Action); and be it further**

7  
8           **RESOLVED, that our AMA extend ongoing payment**  
9 **reform research, education, and advocacy to address**  
10 **the needs of specialties and patient populations not**  
11 **served by current CMMI models or other Medicare-**  
12 **focused payment reform efforts (Directive to Take**  
13 **Action); and be it further**

14  
15           **RESOLVED, that our AMA support and work with**  
16 **national medical specialty societies that are developing**  
17 **alternative payment models for specific conditions or**  
18 **episodes, target patient populations, such as including**  
19 **pediatric populations, health care and medical and**  
20 **surgical specialties and continue to advocate that the**  
21 **Centers for Medicare and Medicaid Services, including**  
22 **the Center for Medicare and Medicaid Innovation, state**  
23 **Medicaid agencies, and other payers implement**  
24 **physician-developed payment models** (New HOD  
25 **Policy); and be it further**

26  
27           **RESOLVED, that our AMA consider improved Medicaid**  
28 **payment rates to be a priority given the critical impact**  
29 **these payment rates have on patient care and patient**  
30 **access to care (New HOD Policy); and be it further**

31  
32           **RESOLVED, that our AMA support and collaborate with**  
33 **state and national medical specialty societies and other**  
34 **interested parties on the development and adoption of**  
35 **physician-developed alternative payment models for**  
36 **pediatric health care that address the distinct**  
37 **prevention and health needs of children and take long-**  
38 **term, life-course impact into account.** (New HOD Policy)  
39

40 **RESOLVED, That our American Medical Association examine and report back on**  
41 **demonstration projects, carve outs, and adjustments for pediatric patients and services**  
42 **provided to pediatric patients within the payment reform arena (Directive to Take Action);**  
43 **and be it further**

44  
45 **RESOLVED, That our AMA extend ongoing payment reform research, education, and**  
46 **advocacy to address the needs of specialties and patient populations not served by**  
47 **current CMMI models or other Medicare-focused payment reform efforts (Directive to**  
48 **Take Action); and be it further**  
49



1 RESOLVED, That our AMA support and work with medical specialty societies who are  
2 developing alternative payment models for pediatric health care (New HOD Policy); and  
3 be it further

4  
5 RESOLVED, That our AMA consider improved Medicaid payment rates to be a priority  
6 given the critical impact these payment rates have on patient care and patient access to  
7 care. (New HOD Policy)

8  
9 Testimony strongly supported Resolution 817 and the need to prioritize increasing  
10 Medicaid payment rates, which will in turn improve Medicaid enrollees' access to care and  
11 help maintain the solvency of physicians who care for these patients. Testimony also  
12 noted that pediatric patients are often after-thoughts in discussions of alternative payment  
13 models (APMs) and that APMs designed for adults should not be applied to children.  
14 Speakers were adamant that our AMA should help with both Medicaid payment and APMs  
15 for populations served by the Medicaid program.

16  
17 The Council on Medical Service suggested that the first resolved could be amended to  
18 "support" demonstration projects and adjustments for pediatric patients and services  
19 provided to pediatric patients within the payment reform arena and that "examination and  
20 report back" are not needed. The Council also noted that, at every opportunity and in every  
21 comment letter to CMS in response to proposed Medicaid/CHIP rulemaking, our AMA  
22 advocates for improved Medicaid payment rates that are at a minimum equal to Medicare  
23 rates.

24  
25 The Council on Legislation offered amendments to the third and fourth resolved clauses,  
26 noting that, since Medicaid payment decisions are generally made at the state level, the  
27 best way for our AMA to help AAP achieve its payment reform goals is by supporting multi-  
28 payer models and specialty society-developed APMs. Testimony by the Council  
29 highlighted several examples of our AMA working with and providing support to medical  
30 specialty societies on APMs, including support for APM proposals developed by the  
31 American Academy of Family Physicians and the American College of Physicians on  
32 advanced primary care and medical neighborhoods and improving the Primary Care First  
33 model. According to the Council's testimony, our AMA has also worked closely with  
34 allergists on a payment model for patients with asthma, with the American Society of  
35 Addiction Medicine on a payment model for opioid use disorder treatment, and with the  
36 American College of Emergency Physicians to advocate for a model to support emergency  
37 physicians in preventing inpatient admissions and improving safe patient discharges back  
38 to their communities. The amendment to the third resolved clause proffered by the Council  
39 reflects this ongoing work. The Council suggested amending the fourth resolved clause to  
40 reflect AMA federal and state advocacy efforts that continually highlight access problems  
41 that stem from inadequate Medicaid payment rates while urging the establishment of a  
42 payment floor that is at a minimum 100% of Medicare rates.

43  
44 Your Reference Committee supports the second and fourth resolved clauses as written  
45 and believes amendments to the first and third resolved clauses are consistent with the  
46 intent of Resolution 817. Your Reference Committee recommends that Resolution 817 be  
47 adopted as amended.

1 (14) RESOLUTION 819 -- AMEND VIRTUAL CREDIT CARD  
2 POLICY

3  
4 **RECOMMENDATION A:**

5  
6 Your Reference Committee recommends that the first  
7 Resolve of Resolution 819 be amended by deletion  
8 to read as follows:

9  
10 ~~RESOLVED, that our American Medical Association~~  
11 ~~make no further statements regarding the “legality” of~~  
12 ~~Virtual Credit Cards (VCCs) (New HOD Policy); and be it~~  
13 ~~further~~

14  
15 **RECOMMENDATION B:**

16  
17 Your Reference Committee recommends that the third  
18 Resolve of Resolution 819 be amended by addition and  
19 deletion to read as follows:

20  
21 **RESOLVED**, that our AMA advocate on behalf of  
22 physicians and plainly state that ~~in no circumstance is~~  
23 ~~it is not~~ advisable or beneficial for medical practices to  
24 get paid by VCCs; and be it further-

25  
26 **RECOMMENDATION C:**

27  
28 Your Reference Committee recommends that  
29 Resolution 819 be amended by addition of a new  
30 Resolve to read as follows:

31  
32 RESOLVED, that our AMA engage in legislative and  
33 regulatory advocacy efforts to address the growing and  
34 excessive electronic funds transfer (EFT) add-on  
35 service fees charged by payers when paying  
36 physicians, including advocacy efforts directed at: (1)  
37 the issuance of Centers for Medicare & Medicaid  
38 Services (CMS) regulatory guidance affirming  
39 physicians’ right to choose and receive timely basic  
40 EFT payments without paying for additional services,  
41 (2) CMS enforcement activities related to this issue, and  
42 (3) physician access to a timely no fee EFT option as an  
43 alternative to virtual credit cards (VCCs).

**RECOMMENDATION D:**

**Your Reference Committee recommends that Resolution 819 be adopted as amended.**

**RECOMMENDATION E:**

**Your Reference Committee recommends that the title of Resolution 819 be changed to read as follows:**

**AMEND VIRTUAL CREDIT CARD AND ELECTRONIC FUNDS TRANSFER FEE POLICY**

**HOD ACTION: Resolution 819 adopted as amended with a change in title.**

RESOLVED, that our American Medical Association (AMA) make no further statements regarding the “legality” of Virtual Credit Cards (VCCs) (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for legislation or regulation that would prohibit the use of VCCs for electronic health care payments (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate on behalf of physicians and plainly state that in no circumstance is it advisable or beneficial for medical practices to get paid by VCCs (Directive to Take Action).

Your Reference Committee heard robust testimony on Resolution 819, with several commenters recommending amendments. One concern was raised pertaining to the possible antitrust implications of the third resolved clause. Several commenters stated that physicians should have the freedom to accept these payments if they desire, but it should be voluntary (i.e., a requirement for a voluntary opt-in, not a need for an opt out). The author of the resolution and several additional commenters supported alternative language focused more directly on advocacy to the Department of Health & Human Services and the Centers for Medicare & Medicaid Services (CMS). Those in support of alternative language indicated that the only solution may be to sue CMS for violations of the Administrative Procedure Act, including the need to overturn illegal regulations that allow these practices, while another provided a 2016 example where Maryland was able to pass a law to make VCCs an opt-in for physicians. Yet another referenced a 2014 Interim Meeting adopted resolution (225-I-14), which has not resulted in any significant change in VCC payments in their practice. One commenter noted that VCCs are loopholes that insurance companies have used to exploit physicians in private practice and that many physicians are not even aware that they are being charged "credit card processing fees" to receive their payments.

The Council on Medical Service testified that it wholeheartedly agrees that virtual credit cards have a significant negative impact on physician practices, both in terms of finances and administrative burdens. Our AMA has strongly advocated for increased guidance and transparency, along with fair business practices, regarding virtual credit card payments

1 over the past 10 years. The Council clarified that virtual credit cards are not currently  
2 illegal. A 2012 Interim Final Rule on electronic funds transfer (EFT) issued by the Centers  
3 for Medicare & Medicaid Services (CMS) allows payment by virtual credit cards, and CMS  
4 reiterated in guidance released last year that “adopted HIPAA EFT and ERA standards  
5 permit health plans to pay claims by VCC.” Therefore, the issue at hand is what would be  
6 the most impactful policy for our AMA to adopt to address this issue. Creating policy stating  
7 that our AMA shall refer to virtual credit cards as illegal will not change the current reality  
8 or protect practices from the financial harms imposed by this payment method.  
9 Accordingly, the Council supported the amendments proffered in the Online Member  
10 Forum, that would establish new policy calling on our AMA to advocate for legislation or  
11 regulation that would prohibit the use of VCCs for electronic health care payments. In  
12 addition, the proffered amendment addresses a separate but related issue of add-on  
13 service fees for standard EFT payments. By advocating for legislation or regulation to  
14 address fees with standard EFT payments, our AMA would be taking action to ensure that  
15 physicians have access to free and timely standard electronic payments – which was the  
16 initial intent of the HIPAA EFT standard. Therefore, your Reference Committee  
17 recommends that Resolution 819 be adopted as amended.

**RECOMMENDED FOR ADOPTION IN LIEU OF**

1 (15) RESOLUTION 803 -- IMPROVING MEDICAID AND CHIP  
2 ACCESS AND AFFORDABILITY

3  
4 **RECOMMENDATION A:**

5  
6 **Your Reference Committee recommends that Alternate**  
7 **Resolution 803 be adopted in lieu of Resolution 803.**

8  
9 **RESOLVED, That our American Medical Association**  
10 **amend Policy H-290.982[10], “Transforming Medicaid**  
11 **and Long-Term Care and Improving Access to Care for**  
12 **the Uninsured,” by addition and deletion to read as**  
13 **follows:**

14  
15 **AMA policy is that our AMA ... (10) supports ~~modest co-~~**  
16 **~~pays or income-adjusted premium shares for continued~~**  
17 **~~state flexibility to waive copayments or impose minimal~~**  
18 **~~copayment amounts that are based on income and in~~**  
19 **~~limited circumstances including non-emergent, non-~~**  
20 **~~preventive services, excluding children, who should~~**  
21 **~~not be subject to cost-sharing in Medicaid as a means~~**  
22 **~~of expanding access to coverage for currently~~**  
23 **~~uninsured individuals (Modify Current HOD Policy)~~**

24  
25 **HOD ACTION: Resolution 803 adopted as amended to**  
26 **read:**

27  
28 **RESOLVED, that our American Medical Association**  
29 **oppose premiums, copayments, and other cost-sharing**  
30 **methods for Medicaid and the Children’s Health Insurance**  
31 **Program, including Section 1115 waiver applications that**  
32 **would allow states to charge premiums or copayments to**  
33 **Medicaid beneficiaries (New HOD Policy); and be it further**  
34

35 **RESOLVED, that our American Medical Association amend**  
36 **Policy H-290.982[10], “Transforming Medicaid and Long-**  
37 **Term Care and Improving Access to Care for the**  
38 **Uninsured,” by addition and deletion to read as follows:**  
39

40 **AMA policy is that our AMA ... ~~(10) supports modest co-~~**  
41 **~~pays or income-adjusted premium shares for non-~~**  
42 **~~emergent, non-preventive services as a means of~~**  
43 **~~expanding access to coverage for currently uninsured~~**  
44 **~~individuals; (Modify Current HOD Policy) and be it further~~**  
45

**RESOLVED, that our AMA encourage the Centers for Medicare & Medicaid Services to amend existing Section 1115 waivers to disallow states the ability to charge premiums or copayments to Medicaid beneficiaries. (New HOD Policy)**

RESOLVED, that our American Medical Association oppose premiums, copayments, and other cost-sharing methods for Medicaid and the Children’s Health Insurance Program, including Section 1115 waiver applications that would allow states to charge premiums or copayments to Medicaid beneficiaries (New HOD Policy); and be it further

RESOLVED, that our AMA amend policy H-290.982 “Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured” by deletion as follows;

- Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982
- AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients;
- (2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children’s Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.
- (3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;
- (4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children’s Health Insurance Programs;
- (5) calls for states to streamline the enrollment process within their Medicaid programs and State Children’s Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;
- (6) urges states to administer their Medicaid and SCHIP programs through a single state agency;
- (7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs;
- (8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions;

1 providing premium subsidies or a buy-in option for individuals in families with  
2 income between their state's Medicaid income eligibility level and a specified  
3 percentage of the poverty level; providing some form of refundable, advanceable tax  
4 credits inversely related to income; providing vouchers for recipients to use to  
5 choose their own health plans; using Medicaid funds to purchase private health  
6 insurance coverage; or expansion of Maternal and Child Health Programs. Such  
7 expansions must be implemented to coordinate with the Medicaid and SCHIP  
8 programs in order to achieve a seamless health care delivery system, and be  
9 sufficiently funded to provide incentive for families to obtain adequate insurance  
10 coverage for their children;  
11 (9) advocates consideration of various funding options for expanding coverage  
12 including, but not limited to: increases in sales tax on tobacco products; funds made  
13 available through for-profit conversions of health plans and/or facilities; and the  
14 application of prospective payment or other cost or utilization management  
15 techniques to hospital outpatient services, nursing home services, and home health  
16 care services;  
17 ~~(10) supports modest co-pays or income-adjusted premium shares for non-~~  
18 ~~emergent, non-preventive services as a means of expanding access to coverage for~~  
19 ~~currently uninsured individuals; (Modify Current HOD Policy) and be it further~~

20  
21 RESOLVED, that our AMA encourage the Centers for Medicare & Medicaid Services to  
22 amend existing Section 1115 waivers to disallow states the ability to charge premiums to  
23 Medicaid beneficiaries. (New HOD Policy)

24  
25 Testimony on Resolution 803 was mixed, with some speakers expressing strong support  
26 for eliminating Medicaid copays and citing studies that have shown that even nominal  
27 cost-sharing can create barriers to care. Additional supportive testimony noted that cost-  
28 sharing requirements pose significant hardships for many Medicaid enrollees, increase  
29 emergency department utilization, and have no impact on appropriateness of care being  
30 sought.

31  
32 Testimony in opposition to Resolution 803 was supportive of modest Medicaid copays in  
33 certain situations to discourage inappropriate utilization of services, which is consistent  
34 with Policy H-290.982[10]. Further testimony was heard on a state's successful use of  
35 copay requirements for the Medicaid expansion population.

36  
37 The Council on Medical Service offered alternate language to amend Policy H-290.982[10]  
38 as a potential compromise between those supportive and opposed to Resolution 803 and  
39 the elimination of all Medicaid cost-sharing. The Council noted that AMA policy (Policies  
40 D-165.942 and D-165.966) has for decades supported state flexibility to develop and test  
41 different Medicaid models, which allows our AMA to support or oppose waivers on a state-  
42 by-state basis. The Council also pointed out that state and federal Medicaid administrators  
43 will not be receptive to calls to eliminate all cost-sharing in Medicaid at this time, since  
44 everyone—including advocacy groups—are completely focused on and overwhelmed by  
45 the unwinding. The Council on Legislation testified in support of this alternate language  
46 and said that adoption of the resolution as written might eliminate opportunities for our  
47 AMA to meaningfully engage in Medicaid waiver design. The Council further stated that  
48 resolved clauses 1 and 3 likely exceed the statutory authority granted to the Centers for  
49 Medicare & Medicaid Services. Your Reference Committee believes the alternate  
50 language suggested by the Council on Medical Service reflects a reasonable middle

1 ground and recommends that Alternate Resolution 803 be adopted in lieu of Resolution  
2 803.

3  
4 (16) RESOLUTION 806 -- EVIDENCE-BASED ANTI-OBESITY  
5 MEDICATIONS AS A COVERED BENEFIT  
6 RESOLUTION 820 -- AFFORDABILITY AND  
7 ACCESSIBILITY OF TREATMENT OF OVERWEIGHT  
8 AND OBESITY

9  
10 **RECOMMENDATION A:**

11  
12 **Your Reference Committee recommends that Alternate**  
13 **Resolution 806 be adopted in lieu of Resolution 806 and**  
14 **Resolution 820.**

15  
16 **RESOLVED, that our American Medical Association**  
17 **amend Policy H-150.953, “Obesity as a Major Public**  
18 **Health Problem,” by addition of a new clause to read as**  
19 **follows:**

20  
21 **9. Urge all payers to ensure coverage parity for**  
22 **evidence-based treatment of obesity, including FDA-**  
23 **approved medications without exclusions or additional**  
24 **carve-outs.**

25  
26 **HOD ACTION: Alternate Resolution 806 adopted in lieu of**  
27 **Resolution 806 and Resolution 820.**

28  
29 Resolution 806

30 RESOLVED, that our American Medical Association amend Policy H-150.953, “Obesity  
31 as a Major Public Health Problem,” by addition as follows:

32 9. Urge national payers to ensure coverage parity for FDA-approved anti-obesity  
33 medications without exclusions or additional carve-outs. (Modify Current HOD  
34 Policy)

35  
36 Resolution 820

37 RESOLVED, that our American Medical Association join in efforts to convince Congress  
38 to address the affordability and accessibility of prevention and evidence-based treatment  
39 of obesity across the United States as well as, urge individual state delegations to  
40 directly advocate for their state insurance agencies and insurance providers in their  
41 jurisdiction to: 1. Revise their policies to ensure that prevention and evidence-based  
42 treatment of obesity is covered for patients who meet the appropriate medical criteria;  
43 and 2. Ensure that insurance policies in their states do not discriminate against potential  
44 evidence-based treatment of obese patients based on age, gender, race, ethnicity,  
45 socioeconomic status. (Directive to Take Action)

46  
47 Your Reference Committee heard overwhelming testimony in support of combining  
48 Resolutions 806 and 820, including support from both authors. There was strong support  
49 for amending AMA Policy H-150.953 to ensure coverage parity for evidence-based  
50 treatment of obesity, including medications. While concerns were raised regarding the cost



1 of covering anti-obesity medications, your Reference Committee believes existing policy  
2 adequately addresses these concerns. For these reasons, your Reference Committee  
3 recommends Alternate Resolution 806 be adopted in lieu of Resolution 820.

4  
5 (17) RESOLUTION 807 – ANY WILLING PROVIDER

6  
7 **RECOMMENDATION A:**

8  
9 **Your Reference Committee recommends that Alternate**  
10 **Resolution 807 be adopted in lieu of Resolution 807.**

11  
12 **RESOLVED, that our American Medical Association**  
13 **support improved physician access to provider**  
14 **networks by continuing to work with interested state**  
15 **medical associations to enact our AMA Physicians Fair**  
16 **Process Protections model act, which requires health**  
17 **insurers to provide physicians with due process prior**  
18 **to making changes to, terminating physicians from, or**  
19 **denying physicians participation in, a provider network.**  
20 **(New HOD Policy)**

21  
22 **HOD ACTION: Original Resolution 807 adopted.**

23  
24 RESOLVED, that our American Medical Association shall develop and advocate for  
25 model "Any Willing Provider" legislation nationwide, enabling all physicians to build  
26 successful practices and deliver quality patient care (Directive to Take Action); and be it  
27 further  
28  
29 RESOLVED, that our AMA shall lobby for federal regulations or legislation mandating  
30 insurers to implement "Any Willing Provider" policies as a prerequisite for participating in  
31 federally-supported programs (Directive to Take Action); and be it further  
32  
33 RESOLVED, that our AMA will work with state and national organizations, including  
34 insurance companies, to promote and support the adoption of "Any Willing Provider"  
35 laws, and will monitor the implementation of these laws to ensure that they are having a  
36 positive impact on access to quality health care. (Directive to Take Action)

37  
38 Testimony on Resolution 807 was mixed. Supportive testimony indicated that this  
39 resolution could have a positive effect on maintaining private practice viability, especially  
40 for early career physicians. Comments made in opposition to mandating "any willing  
41 provider" policies indicated that these policies could result in negative consequences such  
42 as acceptance of non-physicians or physicians who do not provide high quality care.  
43 Testimony indicated that these policies may also be problematic for physician-led groups  
44 and integrated health systems and that our AMA's focus should be on competition in  
45 insurer markets and ensuring network adequacy. Testimony also pointed out that  
46 insurance companies will never adopt "any willing provider" policies, as requested in the  
47 third resolved clause.

48  
49 The Council on Medical Service highlighted existing AMA model legislation, which is  
50 requested in the first resolved clause, and proposed alternate language supporting the

1 Physicians Fair Process Protections model act, which requires health insurers to provide  
2 physicians with due process prior to making changes to, terminating physicians from, or  
3 denying physicians participation in, a provider network. The Council also pointed to  
4 several strong policies (including Policies H-285.984, D-285.972 and H-285.908) intended  
5 to protect physicians from unfairly being excluded from provider networks.  
6

7 The Council on Legislation testified in support of the alternate language and the existing  
8 model bill which was written to provide a high level of fair process to physicians. The  
9 Council noted that “any willing provider” policies are supported by physicians and medical  
10 societies in some states; however, other states may have competing views on the  
11 effectiveness and appropriateness of such laws. Amendments proffered online and in-  
12 person suggested replacing “any willing provider” with “any willing physician” or “any  
13 qualified physician;” however, additional testimony emphasized that “any willing provider”  
14 is the commonly recognized term used across states. Your Reference Committee agrees  
15 and favors alternate language supportive of our AMA’s model bill and reflective of  
16 testimony highlighting the need for improved physician access to provider networks.  
17 Accordingly, your Reference Committee recommends adoption of Alternate Resolution  
18 807 in lieu of Resolution 807.

1 (18) RESOLUTION 808 -- PROSTHODONTIC COVERAGE  
2 AFTER ONCOLOGIC RECONSTRUCTION  
3

4 **RECOMMENDATION A:**

5  
6 **Your Reference Committee recommends that Alternate**  
7 **Resolution 808 be adopted in lieu of Resolution 808.**  
8

9 **RESOLVED, that our American Medical Association**  
10 **amend Policy H-475.992, "Definitions of "Cosmetic"**  
11 **and "Reconstructive" Surgery," by addition and**  
12 **deletion:**

13  
14 **Definitions of "Cosmetic" and "Reconstructive"**  
15 **Surgery H-475.992**

16 (1) Our AMA supports the following definitions of  
17 "cosmetic" and "reconstructive" surgery: Cosmetic  
18 surgery is performed to reshape normal structures  
19 of the body in order to improve the patient's  
20 appearance and self-esteem. Reconstructive  
21 surgery is performed on abnormal structures of the  
22 body, including prosthodontic reconstruction  
23 (including dental implants) caused by congenital  
24 defects, developmental abnormalities, trauma,  
25 infection, tumors, or disease. ~~It is generally~~  
26 ~~performed to improve function, but may also be~~  
27 ~~done to approximate a normal appearance.~~ (2) Our  
28 AMA supports that reconstructive surgery be  
29 covered by all insurers and encourages third party  
30 payers to use these definitions in determining  
31 services eligible for coverage under the plans they  
32 offer or administer.  
33

34 **HOD ACTION: Alternate Resolution 808 adopted in lieu of**  
35 **Resolution 808 to read as follows:**  
36

**Definitions of "Cosmetic" and "Reconstructive" Surgery H-475.992**

**(2) 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, including prosthodontic reconstruction (including dental implants) 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 supports that reconstructive surgery be covered by all insurers and encourages third party payers to use these definitions in determining services eligible for coverage under the plans they offer or administer.**

RESOLVED, that our American Medical Association with appropriate stakeholders to advocate: (a) that prosthodontic reconstruction (including dental implants) after orofacial reconstruction secondary to oncologic resection be covered by all insurers, (b) that such coverage, shall include treatment which, in the opinion of the treating physician is medically necessary to optimize the patient's appearance and function to their original form as much as possible, and (c) that such insurability be portable, i.e. not denied as a pre-existing condition if the patients insurance coverage changes before treatment has been initiated or completed. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 808. Opponents suggested that the scope is too narrow as patients lose dentition for a myriad of reasons besides cancer. Supporters indicated that dental care *is* health care and has a direct impact on an individual's nutritional intake and overall health. Further, dentition is a cornerstone of psychosocial well-being. An amendment and title change were proffered to include trauma as a covered indication. The Council on Medical Service testified that existing AMA policy addresses the medical necessity of prosthodontic reconstruction following oncologic procedures and recommended amending the resolution to reinforce AMA policy. Your Reference Committee identified amendments to existing policy that fulfill the intent of the resolution and, therefore, recommends that Alternate Resolution 808 be adopted in lieu of Resolution 808.

1 (19) RESOLUTION 814 -- PROVIDING PARITY FOR  
2 MEDICARE FACILITY FEES

3  
4 **RECOMMENDATION A:**

5  
6 **Your Reference Committee recommends that Alternate**  
7 **Resolution 814 be adopted in lieu of Resolution 814.**

8  
9 **RESOLVED, that our American Medical Association**  
10 **continue advocating for an annual, inflation-based**  
11 **update to Medicare physician payment, which will**  
12 **increase payment parity across outpatient sites of**  
13 **service by allocating additional funds for the Medicare**  
14 **physician payment system. (New HOD Policy)**

15  
16 **HOD ACTION: Resolution 814 referred for decision.**

17  
18 RESOLVED, that our American Medical Association promote awareness that the ‘site of  
19 service’ payment differential does not reflect quality of care (Directive to Take Action);  
20 and be it further

21  
22 RESOLVED, that our AMA seek legislative action or relief for independent physician  
23 practices, including rural and underserved practices, to be paid equally for office-based  
24 procedures whether or not they practice in offices, facilities or hospitals (Directive to  
25 Take Action); and be it further

26  
27 RESOLVED, that our AMA amend policy D-330.902, The Site-of-Service Differential, by  
28 addition to read as follows:

29  
30 Our AMA will produce a graphic report yearly illustrating the fiscal losses and  
31 inequities that practices without facility fees have endured for decades as a result of  
32 the site of service differential factoring in inflation. (Modify Current HOD Policy)

33  
34 Testimony on Resolution 814 was mixed. Supportive testimony emphasized that, in order  
35 to preserve independent physician practices, services provided in hospitals and physician  
36 practices must be paid equally. Similar to testimony offered in the Online Member Forum,  
37 the Council on Medical Service maintained that this resolution is addressed by numerous  
38 AMA policies developed over the years to address payment differentials across outpatient  
39 sites of service. The Council proffered alternate language that is consistent with existing  
40 policy and our AMA’s Medicare physician payment efforts. The Council spoke specifically  
41 against adoption of the third resolved clause, explaining that the graphic report called for  
42 in Policy D-330.902 was completed earlier this year but the data provided only limited  
43 information on the payment differential and was not useful to physicians or to our AMA’s  
44 advocacy in support of payment parity.

45  
46 The Council on Legislation testified in support of the alternate language proffered by the  
47 Council on Medical Service, stating that our AMA has addressed parity concerns for many  
48 years using robust AMA policy which supports site-neutral payments without lowering total  
49 Medicare payments (Policy D-330.902), calls for payment equity between hospital  
50 outpatient services and similar services in physician offices (Policy H-240.993), and urges

1 third party payers to implement coverage policies that do not unfairly discriminate between  
2 hospital-owned and independently-owned outpatient facilities with respect to payment of  
3 “facility” costs (Policy H-240.979). The Council explained that AMA’s advocacy supports  
4 site neutrality and recognizes that achieving parity is best accomplished by increases in  
5 physician payment, underscoring that most policy proposals addressing problematic pay  
6 differentials would actually reduce payments for all sites to rates paid at the least costly  
7 setting, usually by lowering payments for all sites to Medicare physician fee schedule  
8 rates. The Council spoke against the second resolved clause because it could lower  
9 physician payments for everyone. Instead, the Council stated that our AMA strongly  
10 advocates for site-neutral payments that do not lower total Medicare payments and urges  
11 Congress to allocate additional funds into the payment system through legislation,  
12 including H.R. 2474, which provides an inflation-based payment update based on the  
13 Medicare Economic Index.

14  
15 Your Reference Committee agrees that several AMA policies address the intent of  
16 Resolution 814 and recognizes that advocating for an annual, inflation-based update to  
17 Medicare physician payment will increase payment parity. Accordingly, your Reference  
18 Committee recommends that Alternate Resolution 814 be adopted in lieu of Resolution  
19 814.

1 (20) RESOLUTION 815 -- LONG-TERM CARE AND  
2 SUPPORT SERVICES FOR SENIORS  
3

4 **RECOMMENDATION A:**

5  
6 **Your Reference Committee recommends that Alternate**  
7 **Resolution 815 be adopted in lieu of Resolution 815.**  
8

9 **RESOLVED, that our American Medical Association**  
10 **amend Policy D-280.982, Promoting and Ensuring Safe,**  
11 **High Quality, and Affordable Elder Care Through**  
12 **Examining and Advocating for Better Regulation of and**  
13 **Alternatives to the Current, Growing For-Profit Long**  
14 **Term Care Options, by addition to read as follows:**  
15

16 **Promoting and Ensuring Safe, High Quality, and**  
17 **Affordable Elder Care Through Examining and**  
18 **Advocating for Better Regulation of and Alternatives to**  
19 **the Current, Growing For-Profit Long Term Care**  
20 **Options D-280.982**

21 **1. Our AMA will advocate for business models in long**  
22 **term care for the elderly which incentivize and promote**  
23 **the ethical and equitable use of resources to maximize**  
24 **care quality, staff and resident safety, and resident**  
25 **quality of life, and which hold patients' interests as**  
26 **paramount over maximizing profit.**

27 **2. Our AMA will, in collaboration with other**  
28 **stakeholders, including major payers, advocate for**  
29 **further research into alternatives to current options for**  
30 **long term care to promote the highest quality and value**  
31 **long term care services and supports (LTSS) models as**  
32 **well as functions and structures which best support**  
33 **these models for care.**

1           **RESOLVED**, that our AMA amend Policy H-280.945,  
2           **Financing of Long-Term Services and Supports**, by  
3           **addition to read as follows:**

4  
5           **Financing of Long-Term Services and Supports H-**  
6           **280.945**

7           **Our AMA supports:**

8           **(1) policies and incentives that standardize and simplify**  
9           **private Long Term Care Insurance (LTCI) to achieve**  
10           **increased coverage and improved affordability for all**  
11           **Americans; (2) adding transferable and portable LTCI**  
12           **coverage as part of workplace automatic enrollment**  
13           **with an opt-out provision potentially available to both**  
14           **current employees and retirees; (3) allowing employer-**  
15           **based retirement savings to be used for LTCI premiums**  
16           **and LTSS expenses, including supporting penalty-free**  
17           **withdrawals from retirement savings accounts for**  
18           **purchase of private LTCI; (4) innovations in LTCI**  
19           **product design, including the insurance of home and**  
20           **community-based services, and the marketing of long-**  
21           **term care products with health insurance, life**  
22           **insurance, and annuities; (5) permitting Medigap plans**  
23           **to offer a limited LTSS benefit as an optional**  
24           **supplemental benefit or as separate insurance policy;**  
25           **(6) Medicare Advantage plans offering LTSS in their**  
26           **benefit packages; (7) permitting Medigap and Medicare**  
27           **Advantage plans to offer a respite care benefit as an**  
28           **optional benefit; (8) a back-end public catastrophic**  
29           **long-term care insurance program; (9) incentivizing**  
30           **states to expand the availability of and access to home**  
31           **and community-based services; and (10) better**  
32           **integration of health and social services and supports,**  
33           **including the Program of All-Inclusive Care for the**  
34           **Elderly. (Modify HOD Policy)**



1           **RESOLVED**, that our American Medical Association  
2 amend Policy H-280.991, Policy Directions for the  
3 Financing of Long-Term Care, by addition to read as  
4 follows:  
5

6           **Policy Directions for the Financing of Long-Term Care**  
7 **H-280.991**

8           **1. Our AMA believes that programs to finance long-term**  
9 **care should: (1) assure access to needed services when**  
10 **personal resources are inadequate to finance care; (2)**  
11 **protect personal autonomy and responsibility in the**  
12 **selection of LTC service providers; (3) prevent**  
13 **impoverishment of the individual or family in the face of**  
14 **extended or catastrophic service costs; (4) account for**  
15 **equity in order to assure affordability of long-term care**  
16 **for all Americans (45) cover needed services in a timely,**  
17 **coordinated manner in the least restrictive setting**  
18 **appropriate to the health care needs of the individual;**  
19 **(56) coordinate benefits across different LTC financing**  
20 **program; (67) provide coverage for the medical**  
21 **components of long-term care through Medicaid for all**  
22 **individuals with income below 100 percent of the**  
23 **poverty level; (78) provide sliding scale subsidies for**  
24 **the purchase of LTC insurance coverage for individuals**  
25 **with income between 100-200 percent of the poverty**  
26 **level; (89) encourage private sector LTC coverage**  
27 **through an asset protection program; equivalent to the**  
28 **amount of private LTC coverage purchased; (910)**  
29 **create tax incentives to allow individuals to**  
30 **prospectively finance the cost of LTC coverage,**  
31 **encourage employers to offer such policies as a part of**  
32 **employee benefit packages and otherwise treat**  
33 **employer-provided coverage in the same fashion as**  
34 **health insurance coverage, and allow tax-free**  
35 **withdrawals from IRAs and Employee Trusts for**  
36 **payment of LTC insurance premiums and expenses;**  
37 **and (4011) authorize a tax deduction or credit to**  
38 **encourage family care giving. Consumer information**  
39 **programs should be expanded to emphasize the need**  
40 **for prefunding anticipated costs for LTC and to**  
41 **describe the coverage limitations of Medicare,**  
42 **Medicaid, and traditional medigap policies. State**  
43 **medical associations should be encouraged to seek**  
44 **appropriate legislation or regulation in their**  
45 **jurisdictions to: (a) provide an environment within their**  
46 **states that permit innovative LTC financing and delivery**  
47 **arrangements, and (b) assure that private LTC financing**  
48 **and delivery systems, once developed, provide the**  
49 **appropriate safeguards for the delivery of high quality**  
50 **care. (Modify HOD Policy)**

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49

The AMA continues to evaluate and support additional health system reform legislative initiatives that could increase states' flexibility to design and implement long-term care delivery and financing programs. The AMA will also encourage and support the legislative and funding changes needed to enable more accurate and disaggregated collection and reporting of data on health care spending by type of service, so as to enable more informed decisions as to those social components of long-term care that should not be covered by public or private health care financing mechanisms. 2. Our AMA will 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. (Modify HOD Policy)

RESOLVED, that our AMA support increased awareness and education about long-term care insurance, including a mandate for public and private insurers to provide such information to potential enrollees during their annual health insurance election. (New HOD Policy)

**HOD ACTION: Alternate Resolution 815 adopted in lieu of Resolution 815.**

RESOLVED, that our American Medical Association advocate that private payers offer an affordable insurance product[s] to address long-term care needs (Directive to Take Action); and be it further

RESOLVED, that our AMA with other interested organizations, including the insurance industry, explore ways to ensure the viability of long-term care insurance by a mix of mandates and/or incentives that can be advocated for (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for equity in the financing of long-term care in order to assure affordable care of long-term care for all Americans (Directive To Take Action); and be it further

RESOLVED, that our AMA reaffirm Policy H-25.991, to continue to advocate for fiscal support for "aging in place" by promoting state and federal policy to expand home and community-based services (Reaffirm HOD Policy); and be it further

RESOLVED, that our AMA promote research regarding evidence-based interventions to assure the quality of long-term care for seniors both in the home and institutional settings. (Directive to Take Action)

1 Your Reference Committee heard unanimously supportive testimony of Resolution 815  
2 with comments emphasizing the need to equitably prepare for the demands that will be  
3 placed on Long-Term Services and Supports (LTSS) as Baby Boomers age. Your  
4 Reference Committee recognizes that many individuals do not have access to quality,  
5 equitable, and affordable long-term care. The Council on Medical Service offered Alternate  
6 Resolution 815 that leveraged amendments to existing policy to promote quality,  
7 equitable, and affordable long-term care for all Americans. Accordingly, your Reference  
8 Committee recommends adopting Alternate Resolution in lieu of Resolution 815.

**RECOMMENDED FOR REFERRAL**

1 (21) COUNCIL ON MEDICAL SERVICE REPORT 7 --  
2 SUSTAINABLE PAYMENT FOR COMMUNITY  
3 PRACTICES

4  
5 **RECOMMENDATION A:**

6  
7 **Your Reference Committee recommends that Council**  
8 **on Medical Service Report 7 be referred.**

9  
10 **HOD ACTION: Council on Medical Service Report 7**  
11 **referred.**

12  
13 The Council on Medical Service recommends that the following be adopted in lieu of  
14 Resolution 108-A-23, and the remainder of the report be filed:

15  
16 1. That our American Medical Association (AMA) amend Policy H-290.976[2] by  
17 addition and deletion, and modify the title by deletion, as follows:

18  
19 ~~Enhanced SCHIP Enrollment, Outreach, and Reimbursement Payment~~ H-290.976

20 1. It is the policy of our AMA that prior to or concomitant with states' expansion of  
21 State Children's Health Insurance Programs (SCHIP) to adult coverage, our AMA  
22 urge all states to maximize their efforts at outreach and enrollment of SCHIP  
23 eligible children, using all available state and federal funds.

24 2. Our AMA affirms its commitment to advocating for reasonable SCHIP, ~~and~~  
25 Medicaid, and private insurance payment reimbursement for its medical  
26 providers, defined as at minimum 100 percent of RBRVS Medicare allowable.  
27 (Modify Current HOD Policy)

28  
29 2. That our AMA amend Policy H-385.921 by addition and deletion, and modify the  
30 title by deletion, as follows:

31  
32 ~~Health Care Access for Medicaid Patients~~ H-385.921

33 It is AMA policy that to increase and maintain access to health care for all,  
34 payment for physician providers for Medicaid, TRICARE, ~~and~~ any other publicly  
35 funded insurance plan, and private insurance must be at minimum 100 percent of  
36 the RBRVS Medicare allowable. (Modify Current HOD Policy)

37  
38 3. That our AMA reaffirm Policy D-400.990, which seeks legislation and/or  
39 regulation to prevent insurance companies from utilizing a physician payment  
40 schedule below the updated Medicare professional fee schedule. (Reaffirm HOD  
41 Policy)

42  
43 4. That our AMA reaffirm Policy H-385.986, which opposes any type of national  
44 mandatory fee schedule. (Reaffirm HOD Policy)

45  
46 5. That our AMA reaffirm Policy H-200.949, which supports development of  
47 administrative mechanisms to assist primary care physicians in the logistics of

1 their practices to help ensure professional satisfaction and practice sustainability,  
2 support increased financial incentives for physicians practicing primary care,  
3 especially those in rural and urban underserved areas, and advocate for public  
4 and private payers to develop physician payment systems to promote primary  
5 care and specialty practices in progressive, community-based models of  
6 integrated care focused on quality and outcomes. (Reaffirm HOD Policy)

7  
8 6. That our AMA reaffirm Policy D-405.988, which calls for advocacy in Congress to  
9 ensure adequate payment for services rendered by private practicing physicians,  
10 creating and maintaining a reference document establishing principles for entering  
11 into and sustaining a private practice, and issuing a report in collaboration with the  
12 Private Practice Physicians Section at least every two years to communicate  
13 efforts to support independent medical practices. (Reaffirm HOD Policy)

14  
15 Your Reference Committee heard mixed testimony on CMS Report 7, with some strongly  
16 supporting the report as written and others recommending referral. Those supporting  
17 referral provided robust testimony, indicating that the report did not adequately address  
18 the impact of Medicaid rates on community practice payments as demonstrated by its  
19 narrow focus and recommendations that co-opted existing AMA Medicaid policies.  
20 Further, report recommendations were deemed deficient since they did not uncouple  
21 private payer rates from a Medicare benchmark, thus continuing to tether private payment  
22 to a dropping Medicare rate and possibly encouraging insurers currently paying more than  
23 100 percent of the Medicare allowable to lower payment to that level. While your  
24 Reference Committee acknowledges that CMS opposed referral as the report responded  
25 to the specific referred resolution on Medicare versus private payment, testimony offered  
26 additional suggestions not addressed in the report. Accordingly, your Reference  
27 Committee recommends that CMS Report 7 be referred to allow reconsideration of a) non-  
28 Medicare benchmarks for private payers; b) a minimum government rate, including  
29 Medicaid; and c) the impact that rates below these benchmarks have on small community  
30 practices.

31  
32 (22) RESOLUTION 802 -- IMPROVING NONPROFIT  
33 HOSPITAL CHARITY CARE POLICIES

34  
35 **RECOMMENDATION A:**

36  
37 **Your Reference Committee recommends that**  
38 **Resolution 802 be referred.**

39  
40 **HOD ACTION: Resolution 802 referred.**

41  
42 RESOLVED, that our American Medical Association advocate for legislation and  
43 regulations that require nonprofit hospitals to notify and screen all patients for financial  
44 assistance according to their own eligibility criteria prior to billing (Directive to Take  
45 Action); and be it further

46  
47 RESOLVED, that our AMA support efforts to establish regulatory standards for nonprofit  
48 hospital financial assistance eligibility (New HOD Policy); and be it further  
49

1 RESOLVED, that our AMA encourages the Centers for Medicare & Medicaid Services  
2 (CMS) to publish the charity-care-to-expense ratio and the charity-care-to-benefit ratio  
3 for hospitals listed in Medicare Cost Reports to improve transparency and compliance of  
4 charitable care and community benefit activities. (New HOD Policy)

5 Testimony on Resolution 802 was mixed. Opposition noted that the resolution did not  
6 accurately address specific benchmarks for charity to expense and charity to benefit  
7 ratios. Some supported only the third resolved clause, stating that nonprofit hospitals have  
8 significantly benefited from taxation relief without providing sufficient charity care. The  
9 Council on Medical Service offered interest in studying the issue. Given the mixed  
10 testimony, your Reference Committee recommends that Resolution 802 be referred.

11  
12 (23) RESOLUTION 818 -- AMENDMENT TO AMA POLICY ON  
13 HEALTH CARE SYSTEM REFORM PROPOSALS

14  
15 **RECOMMENDATION A:**

16  
17 **Your Reference Committee recommends that the first**  
18 **Resolve of Resolution 818 not be adopted.**

19  
20 **RECOMMENDATION B:**

21  
22 **Your Reference Committee recommends that the**  
23 **second Resolve of Resolution 818 be referred.**

24  
25 **HOD ACTION: The first Resolve of Resolution 818 not**  
26 **adopted and the second Resolve of Resolution 818**  
27 **referred.**

28  
29 RESOLVED, that our American Medical Association remove opposition to single-payer  
30 health care delivery systems from its policy, and instead evaluate all health care system  
31 reform proposals based on our stated principles as in AMA policy (Directive to Take  
32 Action); and be it further

33  
34 RESOLVED, that our AMA support a national unified financing health care system that  
35 meets the principles of freedom of choice, freedom and sustainability of practice, and  
36 universal access to quality care for patients. (New HOD Policy)

37  
38 Testimony on Resolution 818 was mixed, with opinions ranging from strong support to  
39 strong opposition for removing AMA opposition to single-payer health care systems from  
40 AMA policy. Referral was also suggested given the complexity of the topic and its conflict  
41 with numerous AMA policies.

42  
43 Testimony highlighted the benefits of single payer systems, stating that they save lives,  
44 reduce administrative burdens, unify health care financing in multi- or single payer  
45 systems by public and/or private payers, and expand freedom of choice/practice. Some  
46 suggested that only a single payer system or a model including a public option alongside  
47 private insurance could achieve universal coverage. Further, proponents of the resolution  
48 stated that a neutral stance on single payer systems would allow our AMA to evaluate all  
49 health reform proposals for consistency with AMA policy and principles.

1  
2 Opposition affirmed support for a pluralistic system that ensures choice of coverage and  
3 cited problems with monopoly power in single payer systems and analogs such as  
4 Medicare, Medicaid, and Indian Health Service programs. Testimony stated that a single  
5 payer system would restrict patient access to care, limit physician autonomy, and erode  
6 physician practice sustainability. Concerns were expressed that adoption of this resolution  
7 would jeopardize our AMA's efforts to fix Medicare physician payment.

8 The Chair of the Board of Trustees testified on behalf of the Board in opposition to  
9 Resolution 818, stating that a uniform health care financing system would not necessarily  
10 guarantee access to timely, affordable, and high-quality care and could potentially cause  
11 harm to patients. Furthermore, the Board Chair emphasized that adoption of this resolution  
12 would severely compromise AMA Medicare physician payment reform advocacy efforts  
13 and undermine our AMA's relationships with key members of Congress across all parties.  
14

15 The Council on Medical Service recommended that Resolution 818 not be adopted. The  
16 Council on Legislation indicated that current AMA policy does not preclude our AMA from  
17 evaluating all health reform proposals.  
18

19 Your Reference Committee appreciates all of the testimony provided in the Online  
20 Member Forum and during the in-person hearing. Having heard substantial testimony  
21 opposing the first resolved clause, as well as apprehension about the second resolved  
22 clause, your Reference Committee recommends that the first resolved clause Resolution  
23 818 not be adopted and the second resolved clause be referred.

1 (24) RESOLUTION 821 -- MODERNIZING THE  
2 AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE  
3 (RUC) PROCESSES  
4

5 **RECOMMENDATION A:**

6  
7 **Your Reference Committee recommends that**  
8 **Resolution 821 be referred.**  
9

10 **HOD ACTION: Resolution 821 referred.**

11  
12 RESOLVED, that our American Medical Association encourage the AMA/Specialty  
13 Society RVS Update Committee (RUC) to modernize the RUC’s processes and  
14 implement the following principles:  
15 1. Data-Driven Decision Making: Enhance the data used in making recommendations by  
16 shifting from almost exclusive reliance on surveys of physicians and others who perform  
17 services to broader use of evidence-based data and metadata (e.g., procedure time from  
18 operating logs, hospital length of stay data, and other extant data sources) that permit  
19 assessment of resource use and the relative value of physician and other qualified  
20 healthcare professional services comprehensively. This can ensure that data is reliable,  
21 verifiable, and can be accurately compared to or integrated with other important  
22 databases.  
23 2. Collaboration and Transparency: Seek collaboration with healthcare data experts,  
24 stakeholders, and relevant organizations to maintain transparent data collection and  
25 analysis methodologies.  
26 3. Continuous Review and Adaptation: Expand and enhance its system for continuous  
27 review and adaptation of relative value determinations beyond its Relativity Assessment  
28 Workgroup and other current strategies (e.g., New Technology/New Services list) to stay  
29 aligned with evolving healthcare practices and technologies.  
30 4. Equity and Access: Work with the Current Procedural Terminology Editorial Panel and  
31 others, as appropriate, to identify the impact that factors related to healthcare equity and  
32 access have on the resources used to provide the services of physicians and other  
33 qualified healthcare professionals and how to account for those resources in the  
34 description and subsequent valuation of those services.  
35 5. Broader Engagement: Actively engage with other parties to gather input and ensure  
36 that relative value determinations align with the broader healthcare community's goals  
37 and values.  
38 6. Education and Training: Invest in the education and training of its members, AMA and  
39 specialty society staff, and other participants (e.g., specialty society RUC advisors) to  
40 build expertise in evidence-based data analysis and metadata utilization.  
41 7. Timely Implementation: Invest the necessary resources and establish a clear timeline  
42 for the implementation of these modernization efforts, with regular progress self-  
43 assessments and adjustments as needed (Directive to Take Action); and be it further  
44  
45 RESOLVED, that our AMA provide an informational report back to the House of  
46 Delegates at the 2025 annual meeting on the RUC process and modernizations efforts.  
47 (Directive to take Action)  
48



1 Your Reference Committee heard vigorous testimony regarding Resolution 821.  
2 Supportive testimony stated that the current RUC process is dated and could benefit from  
3 modernization by leveraging additional data to supplement the RUC survey process.

4  
5 Many supported referral, specifically because of the complexity of the RUC and necessity  
6 of defining what data was available to determine an accurate fiscal note. Opposition did  
7 not consider this resolution relevant for this meeting and found no urgency for its  
8 consideration. Some, including the Council on Medical Service, recommended  
9 reaffirmation of existing policy. It was noted that our AMA cannot “direct” the RUC to follow  
10 specific methodology and process as the RUC operates independently of our AMA and  
11 must follow federal law in submitting recommendations to the Centers for Medicare &  
12 Medicaid Services.

13  
14 Our AMA is currently funding a multi-million dollar Physician Practice Information (PPI)  
15 Survey to collect practice cost data and improve the accuracy of the RBRVS in determining  
16 Medicare physician payment. Rather than micromanaging the RUC process, organized  
17 medicine must work with policymakers on immediate and long-term solutions to reform  
18 the Medicare Physician Fee Schedule.

19  
20 Given disparate testimony, your Reference Committee recommends referring Resolution  
21 821.

## RECOMMENDED FOR REFERRAL FOR DECISION

1 (25) RESOLUTION 809 -- OUTSOURCING OF  
2 ADMINISTRATIVE AND CLINICAL WORK TO  
3 DIFFERENT TIME ZONES -- AN ISSUE OF EQUITY,  
4 DIVERSITY, AND INCLUSION  
5

6 **RECOMMENDATION A:**

7  
8 **Your Reference Committee recommends that**  
9 **Resolution 809 be referred for decision.**

10  
11 **HOD ACTION: Resolution 809 referred for decision.**

12  
13 RESOLVED, that our American Medical Association advocate that health plans that  
14 outsource their customer service facing operations to foreign countries in time zones  
15 separated by more than 4 hours from the US should implement 16 or 24-hour availability  
16 for their support services staffed by outsourced employees to allow local day shift work  
17 schedules for their own outsourced employees in different time zones and provider  
18 employees located in similar time zones (Directive to Take Action); and be it further  
19

20 RESOLVED, that our AMA support national legislation that calls on health plans that  
21 outsource their customer service facing operations to foreign countries in time zones  
22 separated by more than 4 hours from the US to implement 16 or 24-hour availability for  
23 their support services staffed by outsourced employees to allow local day shift work  
24 schedules for their own outsourced employees in different time zones and provider  
25 employees located in similar time zones (New HOD Policy); and be it further  
26

27 RESOLVED, that our AMA advocate for fair treatment of outsourced employees in vastly  
28 different time zones by health plans. (Directive to Take Action)  
29

30 Testimony was mixed on Resolution 809. Opposition stated that it was beyond the scope  
31 of our AMA. The Board of Trustees recommended that this item be referred for decision  
32 in order to be incorporated into an ongoing Board report. Your Reference Committee  
33 recommends that Resolution 809 be referred for decision.

- 1 This concludes the report of Reference Committee J. I would like to thank Shawn Baca,
- 2 MD, Alëna Balasanova, MD, Anna Brown, MD, MPhil, F. Wilson Jackson, III, MD, Jana
- 3 Montgomery, MD, Bing Pao, MD, and all those who testified before the Committee.

---

Shawn Baca, MD (Alternate)  
Florida

---

F. Wilson Jackson, III, MD  
Pennsylvania

---

Alëna Balasanova, MD  
American Academy of Addiction  
Psychiatry

---

Jana Montgomery, MD (Alternate)  
American College of Cardiology

---

Anna Brown, MD, MPhil (Alternate)  
Women Physicians Section

---

Bing Pao, MD (Alternate)  
California

---

Man-Kit Leung, MD  
California  
Chair