DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2021 November 2021 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 (N-21)

Report of Reference Committee B

Michael Luszczak, DO, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 2 – Policing Reform
2. Board of Trustees Report 8 – Improved Access and Coverage to Non-opioid Modalities to Address Pain
3. Board of Trustees Report 10 – Physician Access to Their Medical and Billing Records
4. Board of Trustees Report 12 – Direct-to-Consumer Genetic Tests
5. Resolution 209 – Increasing Access to Hygiene and Menstrual Products
6. Resolution 226 – Addressing Adolescent Telehealth Confidentiality Concerns
7. Resolution 229 – CMS Administrative Requirements

RECOMMENDED FOR ADOPTION AS AMENDED

8. Board of Trustees Report 9 – Medical Marijuana License Safety
9. Board of Trustees Report 14 – Net Neutrality and Public Health
10. Resolution 207 – Authority to Grant Vaccine Exemptions
11. Resolution 212 – Sequestration
    Resolution 221 – Promoting Sustainability in Medicare Physician Payments
    Resolution 224 – Improve Physician Payments
    Resolution 225 – End Budget Neutrality
12. Resolution 234 – Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-dose Medications for Multiple Patients
13. Resolution 240 – Ransomware Prevention and Recovery

RECOMMENDED FOR REFERRAL

14. Resolution 203 – Poverty-Level Wages and Health

Amendments

If you wish to propose an amendment to an item of business, click here: Submit New Amendment

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 2 – POLICING REFORM

RECOMMENDATION:

Recommendations in Board of Trustees Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 2 adopted and the remainder of the report filed.

The Board recommends that the following be adopted in lieu of the Third, Fourth, and Eighth Resolve Clauses of Resolution 410-NOV-20, and that the remainder of the report be filed.

1. That our AMA advocate for efforts to implement evidence-based policing and the creation of evidence-based standards for law enforcement. (New HOD Policy)

2. That our AMA advocate for sentinel event reviews in the criminal justice system following an adverse event, such as an in-custody death. (New HOD Policy)

3. That our AMA encourage further research by subject matter experts on the issues related to the transfer of military equipment to law enforcement agencies, including the impact on communities, particularly those in minoritized and marginalized communities. (New HOD Policy)

4. That our AMA support greater police accountability, procedurally just policing models, and greater community involvement in policing policies and practices. (New HOD Policy)

5. That Policy H-65.954, "Policing Reform," be reaffirmed. (Reaffirm HOD Policy)

6. That Policy H-515.955, "Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes," be reaffirmed. (Reaffirm HOD Policy)

7. That Policy H-345.972, "Mental Health Crisis Interventions," be reaffirmed. (Reaffirm HOD Policy)

8. That Policy H-145.969, "Less-Lethal Weapons and Crowd Control," be reaffirmed. (Reaffirm HOD Policy).

Your Reference Committee heard passionate testimony on the impact of police violence on health, particularly among minoritized and marginalized communities. Your Reference Committee also heard testimony that emphasized that changes to policing practices are needed to remedy inequities. Your Reference Committee was offered an amendment that asked our AMA to support demilitarization of law enforcement agencies. However, your

Reference Committee did not hear any additional testimony in support of the amendment. Your Reference Committee was also offered an amendment concerning the qualified immunity of police officers; however, your Reference Committee was not offered concrete suggestions on exactly how qualified immunity should be altered or the legal implications of altering qualified immunity for police officers. Overall, your Reference Committee heard overwhelming testimony in support of the recommendations as written including support for the recommendations to further research the transfer of military equipment to law enforcement agencies, as well as develop policy to advance evidence-based policing, the creation of evidence-based standards for law enforcement, sentinel event reviews in the criminal justice system, greater police accountability, procedurally just policing models, and greater community involvement in policing policies and practices. Your Reference Committee agrees with the supportive testimony and, therefore, recommends that the recommendations in Board of Trustees Report 2 be adopted and the remainder of the report be filed.

(2) BOARD OF TRUSTEES REPORT 8 – IMPROVED ACCESS AND COVERAGE TO NON-OPIOID MODALITIES TO ADDRESS PAIN

RECOMMENDATION:

Recommendation in Board of Trustees Report 8 be <u>adopted</u> and the remainder of the report be <u>filed</u>.

HOD ACTION: Board of Trustees Report 8 <u>adopted</u> and the remainder of the report <u>filed</u>.

The Board recommends that the referred resolves in Alternate Resolution 218-A-19 not be adopted and the remainder of the report be filed.

Your Reference Committee heard testimony strongly in support of patients with pain receiving the care recommended by their physician. Your Reference Committee heard that health insurance companies and other payers should provide affordable access to those treatments. Your Reference Committee also heard that our Board and the new AMA Substance Use and Pain Care Task Force is heavily focusing on protecting patients with pain. Your Reference Committee considered testimony on how the nation's drug overdose epidemic has focused too much on simply reducing opioid prescriptions without actually providing access to evidence-based pain care options for patients or their physicians. Your Reference Committee heard about the work of physicians whom advocate for patients with pain and finds it disconcerting that health insurance companies have not helped to increase access to non-opioid pain care options while patients' access to opioid therapy has decreased by more than 44 percent over the past decade. Your Reference Committee heard and considered the concerns of the authors of the original resolution that stated that specific procedures have suffered from payer, administrative, and other barriers. However, your Reference Committee heard significant testimony in favor of Board of Trustees Report 8. Your Reference Committee heard that the recommendation in Board of Trustees Report 8 is guided by current AMA policy and provides clear and strong guidance to our AMA advocacy efforts that benefit all physicians who provide care to patients with pain. Your Reference Committee, therefore, recommends that the recommendation in Board of Trustees Report 8 be adopted and the remainder of the report be filed.

(3) BOARD OF TRUSTEES REPORT 10 – PHYSICIAN ACCESS TO THEIR MEDICAL AND BILLING RECORDS

RECOMMENDATION:

Recommendations in Board of Trustees Report 10 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 10 adopted and the remainder of the report filed.

The Board recommends that the following be adopted in lieu of Resolution 226-A-19 and the remainder of this report be filed:

1. That our AMA advocate that licensed physicians have unrestricted access to all their patients' billing records and associated medical records during employment or while under contract to provide medical or health care items or services. The records should also include any billing records submitted under the physician's name, regardless of whether the physician directly provided the item or service. (Directive to Take Action)

2. That our AMA advocate that, where physician possession of all his or her billing records is not already required by state law, the employment or other contractual arrangement between a physician and entity submitting claims on behalf of the physician should specify that the physician is entitled to copies of his or her billing records subsequent to the termination of employment or contractual arrangement, when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician. (Directive to Take Action)

3. That our AMA advocate for legislation or regulation to eliminate contractual language that bars or limits the treating physician's access to his or her billing records and associated medical records, such as treating these records as trade secrets or proprietary. (Directive to Take Action)

Your Reference Committee heard unanimously supportive testimony in favor of Board of Trustees Report 10. Your Reference Committee heard testimony that the Office of the Inspector General of the U.S. Department of Health and Human Services states that physicians are responsible for claims sent to Medicare, even if the physician had no actual knowledge of a billing impropriety. Your Reference Committee heard that physicians need to have access to records regarding claims that have been submitted on their behalf or under their name both during and after employment or a contractual arrangement so that they can protect themselves from non-compliance with Medicare and other program requirements and defend themselves from other actions that might be taken against them. Your Reference Committee heard that it is vital that unnecessary barriers, such as claims of trade secrets or proprietary information, not be allowed to hinder a physician from having timely access to patient medical and billing records relating to services that a physician has provided. Your Reference Committee, therefore, recommends that the recommendation in Board of Trustees Report 10 be adopted and the remainder of the report be filed.

(4) BOARD OF TRUSTEES REPORT 12 – DIRECT-TO-CONSUMER GENETIC TESTS

RECOMMENDATION:

Recommendations in Board of Trustees Report 12 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 12 adopted and the remainder of the report filed.

The Board of Trustees recommends that the following statements be adopted in lieu of Resolution 207-A-19, and that the remainder of this report be filed.

1. That our AMA adopt the following new policy:

"Consumer Genetic Testing and Privacy"

Our AMA:

(1) will work with relevant stakeholders to advance laws and regulations that prevent genetic testing entities without explicit, informed, and non-coerced user consent from transferring information about a user such as birthdates and state of residence to third parties which may result in the re-identification of the user based on surname inference (New HOD Policy).

(2) supports privacy standards that would prohibit pharmaceutical companies, biotechnology companies, universities, and all other entities with financial ties to the genetic testing company from sharing identifiable information, including DNA, with other parties without informed consent of the user. An exception would be made when requested for a duly executed court order or when compelled for public health or safety reasons as outlined in existing AMA policy including H-315.983, "Privacy and Confidentiality," and Medical Code of Ethics 4.1.4, "Forensic Genetics." If a data security or privacy breach occurs with a direct-to-consumer (DTC) genetic company or its collaborators, then the company has the responsibility to inform all users and relevant regulatory bodies of the breach and the impact of the unprotected private data on those individuals (New HOD Policy).

(3) will advocate that research using consumer genomic data derived from saliva or cheek swabs or other human samples should be treated as research on human subjects requiring informed consent consistent with or similar to those required by the Health and Human Services (HHS) Office for Human Research Protection (OHRP), and recommend an "opt in" option to allow more consumer choice in the consent process (New HOD Policy).

(4) will advocate for extending the consumer protections of the Genetic Information Non- Discrimination Act (GINA) of 2008 by adding long-term care, disability insurance, and life insurance to the Act, modeled after the laws of other states, such as California (New HOD Policy).

2. That the following policies be reaffirmed: H-65.969, “Genetic Discrimination and the Genetic Information Nondiscrimination Act,” H-185.972, “Genetic Information and Insurance Coverage,” D-480.987, “Direct-to-Consumer Marketing and Availability of Genetic Testing,” H-480.941, “Direct-to-Consumer Laboratory Testing,” H-460.916, “Protection of Human Subjects in Research,” H-460.980, “Ethical and Societal Considerations in Research,” and H 315.983, “Patient Privacy and Confidentiality” (Reaffirm HOD Policy).

Your Reference Committee heard overwhelmingly positive testimony in support of Board of Trustees Report 12. Your Reference Committee heard testimony which emphasized that informed consent is a crucial step in protecting patient rights, and that the transferring of genetic information to third parties which do not participate in the process is not appropriate. Your Reference Committee heard testimony that was also supportive of requiring direct-to-consumer genetic testing companies to report data or privacy breaches to their customers and that such a position aligns with our current AMA policy on privacy of medical information. Your Reference Committee also heard testimony in support of an opt-in consent process for research, treating consumer genetics data similarly to any other human-derived sample. Your Reference Committee also heard that opt-in consent may reduce participation in research, but the protection of patient rights and privacy should take priority.

Additionally, your Reference Committee heard testimony which emphasized that, because of patients' fear of financial repercussions in insurance markets, patients forgo genetic counseling or genetic testing, resulting in serious health implications for individuals for whom genetic testing could be beneficial. Your Reference Committee heard that, given the rapid advancement of genomic testing available to inform diagnostic and therapeutic decision-making across a wide and growing spectrum of diseases, this fear leaves physicians with incomplete information to inform clinical decision-making and curtails the range of treatment options available to patients. Your Reference Committee heard testimony which also expressed concern that fears of discrimination hinder the open and honest patient-physician communication that is foundational in the patient-physician relationship. Your Reference Committee also heard that insurer discrimination based on genetic information financially incentivizes patients to forgo necessary testing and treatment and interferes with physicians’ ability to render optimal patient care, and believes that prohibiting genetic discrimination by life, disability, and long-term care insurers is necessary public policy. Your Reference Committee, therefore, recommends that the recommendations in Board of Trustees Report 12 be adopted and the remainder of the report to be filed.

(5) RESOLUTION 209 – INCREASING ACCESS TO HYGIENE AND MENSTRUAL PRODUCTS

RECOMMENDATION:

Resolution 209 be <u>adopted</u>.

HOD ACTION: Resolution 209 <u>adopted</u>.

RESOLVED, That our American Medical Association recognize the adverse physical and mental health consequences of limited access to menstrual products for school-aged individuals (New HOD Policy); and be it further

RESOLVED, That our AMA support the inclusion of medically necessary hygiene products, including, but not limited to, menstrual hygiene products and diapers, within the benefits covered by appropriate public assistance programs (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for federal legislation and work with state medical societies to increase access to menstrual hygiene products, especially for recipients of public assistance (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage public and private institutions as well as places of work and education to provide free, readily available menstrual care products to workers, patrons, and students (New HOD Policy); and be it further

RESOLVED, That our AMA amend H-525.974, "Considering Feminine Hygiene Products as Medical Necessities," by addition and deletion to read as follows:

CONSIDERING FEMININE HYGIENE PRODUCTS AS MEDICAL NECESSITIES, H-525.974

Our AMA will: (1) encourage the Internal Revenue Service to classify feminine hygiene products as medical necessities; ~~and~~ (2) work with federal, state, and specialty medical societies to advocate for the removal of barriers to feminine hygiene products in state and local prisons and correctional institutions to ensure incarcerated women be provided free of charge, the appropriate type and quantity of feminine hygiene products including tampons for their needs.; and (3) encourage the American National Standards Institute, the Occupational Safety and Health Administration, and other relevant stakeholders to establish and enforce a standard of practice for providing free, readily available menstrual care products to meet the needs of workers. (Modify Current HOD Policy)

Your Reference Committee heard testimony primarily in strong support of Resolution 209. Your Reference Committee heard that the economic downturn and public shutdown, as a result of the COVID-19 public health emergency, significantly impacted the ability for individuals to access menstrual hygiene resources. Your Reference Committee also heard that our existing AMA policy recognizes menstrual hygiene products as medical necessities, and that adoption of Resolution 209 would build on our AMA policy that is supportive of reducing barriers to accessing menstrual hygiene products. Your Reference Committee also heard that being able to access menstrual hygiene products aligns with our AMA's goals of pursuing policy and advocacy efforts through a health equity framework and that access to menstrual hygiene products is a matter of equity and dignity, as well as health, for vulnerable populations. Your Reference Committee believes that the public health benefits of Resolution 209 outweigh concerns raised about making menstrual hygiene products available for free. Your Reference Committee, therefore, recommends that Resolution 209 be adopted.

(6) RESOLUTION 226 – ADDRESS ADOLESCENT TELEHEALTH CONFIDENTIALITY CONCERNS

RECOMMENDATION:

Resolution 226 be adopted.

HOD ACTION: Resolution 226 adopted.

RESOLVED, That our American Medical Association amend Policy H-60.965, "Confidential Health Services for Adolescents," by addition to read as follows:

Confidential Health Services for Adolescents H-60.965

Our AMA:
(1) reaffirms that confidential care for adolescents is critical to improving their health;
(2) encourages physicians to allow emancipated and mature minors to give informed consent for medical, psychiatric, and surgical care without parental consent and notification, in conformity with state and federal law;
(3) encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care;
(4) urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements);
(5) encourages physicians to offer adolescents an opportunity for examination and counseling apart from parent. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician;
(6) encourages state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis;
(7) urges undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law and implementation into practice;
(8) encourages health care payers to develop a method of listing of services which preserves confidentiality for adolescents; and
(9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care; and
(10) encourages physicians to recognize the unique confidentiality concerns of adolescents and their parents associated with telehealth visits; and
(11) encourages physicians in a telehealth setting to offer a separate examination and counseling apart from others and to ensure that the adolescent is in a private space.
(Modify current HOD Policy)

Your Reference Committee heard testimony in strong support of Resolution 226. Your Reference Committee heard that Resolution 226 builds on existing AMA policy on the confidentiality of health care services for adolescents and addresses the unique concern around confidentiality of health care services provided to adolescents via telehealth. Your Reference Committee heard that adolescents believe confidentiality is one of the most important aspects of their health care and that physicians also recognize that confidentiality is critical to improving adolescent health. Your Reference Committee heard that Resolution 226 is both timely and necessary as more adolescents are seeking care via telehealth, particularly for sensitive issues such as mental health care. Your Reference Committee also heard that this resolution addresses a current gap in our AMA policy. Your Reference Committee, therefore, recommends that Resolution 226 be adopted.

(7) RESOLUTION 229 – CMS ADMINISTRATIVE REQUIREMENTS

RECOMMENDATION:

Resolution 229 be <u>adopted</u>.

HOD ACTION: Resolution 229 <u>adopted</u>.

RESOLVED, That our American Medical Association forcefully advocate that the Centers for Medicare and Medicaid Services (CMS) investigate all valid allegations of HIPAA Administrative simplification requirements thoroughly and offers transparency in its processes and decisions as required by the Administrative Procedure Act (APA) (Directive to Take Action); and be it further

RESOLVED, That our AMA forcefully advocate that the CMS resolve all complaints related to the non-compliant payment methods including opt-out virtual credit cards, charging processing fees for electronic claims and other illegal electronic funds transfer (EFT) fees (Directive to Take Action); and be it further

RESOLVED, That our AMA communicate its strong disapproval of the failure by the CMS Office of Burden Reduction to effectively enforce the HIPAA administrative simplification requirements as required by the law and its failure to impose financial penalties for non-compliance by health plans (Directive to Take Action); and be it further

RESOLVED, That our AMA, through legislation, regulation or other appropriate means, advocate for the prohibition of health insurers charging physicians and other providers to process claims and make payment. (Directive to Take Action)

Your Reference Committee heard testimony in strong support of Resolution 229. Your Reference Committee heard that the Affordable Care Act required all health plans to offer standard Automated Clearing House electronic funds transfer (EFT) payments effective January 1, 2014. Your Reference Committee heard EFT promotes administrative simplification by reducing the manual burdens involved in practices accepting and processing paper checks. Your Reference Committee also heard testimony that some health plans contract with payment vendors that charge percentage-based fees to deliver EFT payments to physician practices. Your Reference Committee heard testimony that our AMA has long advocated that the Centers for Medicare and Medicaid Services has

the regulatory authority to enforce our physicians' right to free (aside from minimal banking fees) EFT payments. Additionally, your Reference Committee heard testimony that as recently as October 2021, our AMA initiated a sign-on letter with numerous specialty and state medical societies urging the current Administration to swiftly address this problem by issuing guidance that affirms physicians' right to choose and receive basic EFT payments without paying for additional services and undertaking the associated enforcement activities. Your Reference Committee, therefore, recommends that Resolution 229 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(8) BOARD OF TRUSTEES REPORT 9 – MEDICAL MARIJUANA LICENSE SAFETY

RECOMMENDATION A:

Recommendation 1 in Board of Trustees Report 9 be amended by addition and deletion to read as follows:

1. That our American Medical Association support efforts to ~~limit information about~~ include medical cannabis license certification in states' prescription drug monitoring programs ~~to only whether a patient has been certified to receive medical cannabis~~ when consistent with AMA principles safeguarding patient privacy and confidentiality; (New HOD Policy)

RECOMMENDATION B:

Board of Trustees Report 9 be amended by addition of a third recommendation to read as follows:

3. That our AMA review existing state laws that require information about medical cannabis to be shared with or entered into a state prescription drug monitoring program. The review should address impacts on patients, physicians and availability of information including types, forms, THC concentration, quantity, recommended usage, and other medical cannabis details that may be available from a dispensary.

RECOMMENDATION C:

Recommendations in Board of Trustees Report 9 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 9 adopted as amended and the remainder of the report filed.

The Board recommends that the following be adopted in lieu of Resolution 219-A-19 and the remainder of the report be filed.

1. That our American Medical Association (AMA) support efforts to limit information about medical cannabis in states' prescription drug monitoring programs to only whether a patient has been certified to receive medicinal cannabis consistent with AMA principles safeguarding patient privacy and confidentiality; (New HOD Policy)

2. That our AMA continue its monitoring of state legislation relating to the inclusion of cannabis and related information in state PDMPs. (Directive to Take Action)

Your Reference Committee heard supportive testimony regarding Board of Trustees Report 9. Your Reference Committee heard that Board of Trustees Report 9 provided a thorough review of many of the issues presented by the original resolution. Your Reference Committee heard that physicians should know whether a patient has been certified for medical cannabis use. Your Reference Committee also heard strong support for including this information in a state prescription drug monitoring program (PDMP). Your Reference Committee heard that if a physician knows that a patient has been certified as qualifying for medical cannabis, then the physician can ask as many follow-up questions as necessary.

Your Reference Committee heard that every state and the District of Columbia has a PDMP, but not every state authorizes cannabis for medical use. Your Reference Committee also heard that most PDMPs are interoperable, that is, they can "talk" to other state PDMPs to learn whether a patient in another state has received a prescription for a controlled substance from a prescriber or a pharmacy in a different state. Your Reference Committee further heard that each state has different requirements for law enforcement and other non-health care entities to access the state PDMP. Your Reference Committee heard concerns surrounding the variability in state laws and access by law enforcement and others to registries. Your Reference Committee also heard that PDMPs raise multiple unknown and potentially unintended consequences of having cannabis-related information in a state PDMP given that law enforcement has often used state PDMPs to data mine physician and patient records. Your Reference Committee heard testimony on the importance of limiting information to only patient certification out of a shared concern for patient privacy and confidentiality.

Your Reference Committee also heard limited, but supportive testimony that physicians need to know more than just whether a patient has been certified as having a medical condition that qualifies that patient for medical cannabis—if the state has legalized cannabis for medical use. Your Reference Committee also heard supportive testimony about the need to know about duration, dosage, type, frequency, amount, date, prescriber, and other information related to medical cannabis. Your Reference Committee also heard that PDMPs should be limited to actionable information.

Your Reference Committee received a proposed amendment from Oklahoma concerning supporting efforts to include medical cannabis license certification in states' prescription drug monitoring programs and supporting AMA state model legislation on this topic. Your Reference Committee also heard mixed testimony on creating AMA state model legislation including concerns that additional information is needed to determine what actually could be reported by a medical cannabis dispensary, and how it would be displayed in a state PDMP. Your Reference Committee also heard persuasive testimony that AMA model legislation on this topic is premature since we do not know the effects of current legislation on physicians and patients. Your Reference Committee, therefore, recommends that Board of Trustees Report 9 be adopted as amended and the remainder of the report filed.

(9) BOARD OF TRUSTEES REPORT 14 – NET NEUTRALITY AND PUBLIC HEALTH

RECOMMENDATION A:

Your Reference Committee recommends Board of Trustees Report 14 be amended by addition of a recommendation to read as follows:

That our American Medical Association support (1) policies ensuring that the transmission speed of essential healthcare data is no slower than other data using the same transmission modality, and (2) data speeds sufficient for high quality, real-time video and audio Telehealth, without paid prioritization.

RECOMMENDATION B:

Recommendation in Board of Trustees Report 14 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 14 adopted as amended and the remainder of the report filed.

The Board of Trustees recommends that Resolution 211-I-19, "Effects of Net Neutrality on Public Health," and Resolution 208-I-19, "Net Neutrality and Public Health," not be adopted and that the remainder of the report be filed.

Your Reference Committee heard mixed testimony regarding Board of Trustees Report 14. Your Reference Committee heard strong testimony favoring maintaining the rules of net neutrality, as repeal could lead companies to place limits on how, where, and when patients and providers are able to access health care data. Your Reference Committee also heard concerns regarding repeal of net neutrality which focused on the potential for companies to pursue policies that could lessen both innovation and competition in health care technology. Your Reference Committee also heard concerns that the repeal of net neutrality could increase the cost of health care delivery, thus negatively impacting both physicians and patients. Your Reference Committee also heard that, as a result of the COVID-19 pandemic and public health emergency, net neutrality is no longer an immediate priority issue for the U.S. Congress. Your Reference Committee heard testimony that Congress has turned its attention to expanding broadband access and affordability, which our AMA policy strongly supports. Additionally, your Reference Committee heard testimony that our AMA should support both the expansion of broadband and the expansion of net neutrality. Your Reference Committee heard testimony in support of re-addressing net neutrality in Board of Trustees Report 14 and understands that this issue is constantly evolving as technology is rapidly changing. Your Reference Committee agrees with testimony in support of adopting policy that would supplement current AMA policy on increasing access to broadband by also ensuring that the transmission of essential healthcare data is no slower than other data using the same transmission modality. Your Reference Committee, therefore, recommends that Board of Trustees Report 14 be adopted as amended and the remainder of the report be filed.

(10) RESOLUTION 207 – AUTHORITY TO GRANT VACCINE EXEMPTIONS

RECOMMENDATION A: Resolution 207 be amended by deletion to read as follows:

RESOLVED, That our AMA opposes medical vaccine exemptions by non-physicians by amending H-440.970, "Nonmedical Exemptions from Immunizations," by addition as follows:

Nonmedical Exemptions from Immunizations, H-440.970

1. Our AMA believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large.

Therefore, our AMA (a) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (b) supports legislation eliminating nonmedical exemptions from immunization; (c) encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; (d) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (e) encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and (f) recommends that states have in place: (i) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and (ii) policies that permit immunization exemptions for medical reasons only.

2. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to (a) eliminate non-medical exemptions from mandated ~~pediatric~~ immunizations and (b) limit medical vaccine exemption authority to only licensed physicians.

RECOMMENDATION B:

Resolution 207 be adopted as amended.

HOD ACTION: Resolution 207 adopted as amended.

RESOLVED, That our American Medical Association oppose medical vaccine exemptions by non-physicians by amending Policy H-440.970, "Nonmedical Exemptions from Immunizations," by addition to read as follows:

Nonmedical Exemptions from Immunizations, H-440.970

1. Our AMA believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large. Therefore, our AMA: (a) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (b) supports legislation eliminating nonmedical exemptions from immunization; (c) encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; (d) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (e) encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and (f) recommends that states have in place: (i) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and (ii) policies that permit immunization exemptions for medical reasons only.
2. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to: (a) eliminate non-medical exemptions from mandated pediatric immunizations; and (b) limit medical vaccine exemption authority to only licensed physicians. (Modify Current HOD Policy)

Your Reference Committee heard testimony in strong support of Resolution 207. Your Reference Committee heard that limiting the determination of medical exemptions of vaccines to physicians is in line with current AMA policy on vaccines and our policy on scope of practice. Your Reference Committee heard testimony expressing concern about the qualification of non-physicians to authorize medical exemptions for vaccines, despite being permitted to do so in some states. Your Reference Committee considered an amendment to add the terms “allopathic and osteopathic” to the resolution; however, our AMA has existing policy (H-405.951 - Definition and Use of the Term Physician) that already defines “physicians” as allopathic and osteopathic physicians. Your Reference Committee also received an amendment to allow select non-physicians to authorize medical exemptions; however, your Reference Committee agrees with the weight of the testimony which did not support the addition of this amendment. Finally, your Reference Committee received an amendment to remove the word “pediatric” from the original resolution and believes this is consistent with the testimony heard which was not limited to pediatric vaccines. Your Reference Committee, therefore, recommends that Resolution 207 be adopted as amended.

(11) RESOLUTION 212 – SEQUESTRATION
RESOLUTION 221 – PROMOTING SUSTAINABILITY IN MEDICARE PHYSICIAN PAYMENTS
RESOLUTION 224 – IMPROVE PHYSICIAN PAYMENTS
RESOLUTION 225 END BUDGET NEUTRALITY

RECOMMENDATION A:

Alternative Resolution 212 be adopted in lieu of Resolutions 212, 221, 224, and 225.

RESOLVED, That our AMA: continue to prioritize and actively pursue vigorous and strategic advocacy to prevent sequester and other cuts in Medicare payments due to take effect on January 1, 2022; seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs; ensure Medicare physician payments are sufficient to safeguard beneficiary access to care; work towards the elimination of budget neutrality requirements within Medicare Part B; eliminate, replace, or supplement budget neutrality in MIPS with positive incentive payments; advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and that continued budget neutrality is not an option; advocate for payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services.

RECOMMENDATION B:

That the following HOD policies be reaffirmed: D-165.941—Sequestration Budget Cuts, H-330.932—Cuts in Medicare and Medicaid Reimbursement, H-400.972—Physician Payment Reform, H-330.888—Exempt Physician-Administered Drugs from Medicare Sequestration, H-400.990—Refinement of Medicare Physician Payment System, H-400.991—Guidelines for the Resource-Based Relative Value Scale, H-385.905—Merit-based Incentive Payment System (MIPS) Update, H-390.838—MIPS and MACRA Exemption, D-390.963—Improving the Medicare Economic Index, D-390.988—Patient Access Jeopardized By Senate Failure to Correct Medicare Payment Error, H-390.849—Physician Payment Reform.

HOD ACTION: Alternative Resolution 212 adopted in lieu of Resolutions 212, 221, 224, and 225.

Policies D-165.941—Sequestration Budget Cuts, H-330.932—Cuts in Medicare and Medicaid Reimbursement, H-400.972—Physician Payment Reform, H-330.888—Exempt Physician-Administered Drugs from Medicare Sequestration, H-400.990—Refinement of Medicare Physician Payment System, H-400.991—Guidelines for the Resource-Based Relative Value Scale, H-385.905—Merit-based Incentive Payment System (MIPS) Update, H-390.838—MIPS and MACRA Exemption, D-390.963—Improving the Medicare Economic Index, D-390.988—Patient Access Jeopardized By Senate Failure to Correct Medicare Payment Error, H-390.849—Physician Payment Reform reaffirmed.

Resolution 212
RESOLVED, That our American Medical Association prioritize strong advocacy in opposition to the application of sequestration to Medicare, including to drugs administered under Medicare Part B. (Directive to Take Action)

Resolution 221
RESOLVED, That our American Medical Association continue to advocate for legislation that prevents Medicare cuts from taking place prior to Jan. 1, 2022 (Directive to Take Action); and be it further

RESOLVED, That our AMA seek annual and full Medicare Economic Index updates for Medicare Part B physician payments (Directive to Take Action); and be it further

RESOLVED, That our AMA seek legislation that provides only for positive performance incentives (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services by instituting a three-year look-back period to correct Medicare conversion factor estimations. (Directive to Take Action)

Resolution 224
RESOLVED, That our American Medical Association make avoiding the Medicare payment cuts on physician practices a top priority (Directive to Take Action); and be it further

RESOLVED, That our AMA utilize the necessary resources to avoid the pending Medicare physician payment cuts (Directive to Take Action); and be it further

RESOLVED, That our AMA modify policy D-165.941, “Sequestration Budget Cuts,” by addition and deletion to read as follows:

Sequestration Budget Cuts D-165.941

1. Our AMA will urge Congress to develop a fiscally responsible alternative that would prevent the automatic budget sequestration cuts that would endanger critical programs related to medical research, public health, workforce, food and drug

safety, and health care for uniformed service members, as well as trigger cuts in Medicare payments to graduate medical education programs, hospitals, and physicians that will endanger access to care and training of physicians.

2. Our AMA will take all necessary legislative and administrative steps to prevent extended ~~or~~ and deeper sequester cuts in Medicare payments to physician practices using the financial means necessary to do so and make this a top priority. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA reaffirm and take immediate action on policy H-330.932, "Cuts in Medicare and Medicaid Reimbursement," that:

(1) supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the Medicare population, and the cost of new technology;(calls for elimination of budget neutrality) (current policy)
(2) aggressively encourages CMS to affirm the patient's and the physician's constitutional right to privately contract for medical services; (freedom of choice for patients), (current policy)
(3) if the reimbursement is not improved, the AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee; (current policy); and
(4) supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases. (current policy) (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA reach out to the physicians of the United States via all possible means, to include but not be limited to email, US mail, social media, to encourage physicians to participate in the AMA campaign to improve physician payments (Directive to Take Action); and be it further

RESOLVED, That our AMA have an open and transparent dialogue with Congressional leaders and the Centers for Medicare and Medicaid Services regarding continued devaluation of the American physician and communicate such with America's physicians (both member and non-member). (Directive to Take Action)

Resolution 225
RESOLVED, That our American Medical Association work towards the elimination of budget neutrality requirements under federal law (Directive to Take Action); and be it further

RESOLVED, That our AMA amend Policy H-385.905, "Merit-based Incentive Payment System (MIPS) Update**,"** by addition and deletion to read as follows:

Merit-based Incentive Payment System (MIPS) Update H-385.905

Our AMA will work toward creating and pursuing ~~supports~~ legislation that ensures Medicare physician payments are ~~is~~ sufficient to safeguard beneficiary access to care,

~~replaces or supplements budget~~ eliminate budget neutrality requirements within the MPFS and with respect to ~~in~~ MIPS ~~with~~ incentive payments ~~or~~ and implements ~~positive~~ annual Medicare physician payment updates that keep pace with rising practice costs. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA reaffirm D-400.989, "Equal Pay for Equal Work," with a special emphasis on the third bullet point and work to create legislation to eliminate budget neutrality:

Our AMA: (1) shall make its first legislative priority to fix the Medicare payment update problem because this is the most immediate means of increasing Medicare payments to physicians in rural states and will have the greatest impact; (2) shall seek enactment of legislation directing the General Accounting Office to develop and recommend to Congress policy options for reducing any unjustified geographic disparities in Medicare physician payment rates and improving physician recruitment and retention in underserved rural areas; and **(3) shall advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system and that continued budget neutrality is not an option.**(Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA reaffirm and take action on H-400.972, "Physician Payment Reform"

H-400.972, "Physician Payment Reform

It is the policy of the AMA to (1) take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but not limited to, (a) reduction of allowances for new physicians; (b) the non-payment of EKG interpretations; (c) defects in the Geographic Practice Cost Indices and area designations; (d) inappropriate Resource-Based Relative Value Units; (e) the deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system; (f)the need for RBRVS conversion factor updates that are not subject to budget neutrality requirements; (g) the inadequacy of payment for services of assistant surgeons; and (h) the loss of surgical-tray benefit for many outpatient procedures (Reaffirmed by Rules & Credentials Cmt., A-96);
(2) seek an evaluation of (a) stress factors (i.e., intensity values) as they affect the calculation of the Medicare Payment Schedule, seeking appropriate, reasonable, and equitable adjustments; and (b) descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and payment levels and to seek adjustments so that the resulting values and payment levels appropriately pertain to the elderly and often infirm patients;
(3) evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment Schedule and to ascertain that the concept for the work component continues to be an appropriate part of a resource-based relative value system;
(4) seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors;
(5) seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with preoperative office visits, concomitant office procedures, and/or future procedures;

(6) seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992;
(7) seek the elimination of regulations directing patients to points of service;
(8) support further study of refinements in the practice cost component of the RBRVS to ensure better reflection of both absolute and relative costs associated with individual services, physician practices, and medical specialties, considering such issues as data adequacy, equity, and the degree of disruption likely to be associated with any policy change;
(9) take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs;
(10) support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of 1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare geographic practice costs indices (GPCIs) and work with CMS and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect actual physician costs, including gross receipt taxes;
(11) request that CMS refine relative values for particular services on the basis of valid and reliable data and that CMS rely upon the work of the AMA/Specialty Society RVS Updating Committee (RUC) for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations;
(12) pursue aggressively recognition and CMS adoption for Medicare payment schedule conversion factor updates of an index providing the best assurance of increases in the monetary conversion factor reflective of changes in physician practice costs, and to this end, to consider seriously the development of a "shadow" Medicare Economic Index;
(13) continue to implement and refine the Payment Reform Education Project to provide member physicians with accurate and timely information on developments in Medicare physician payment reform; and
(14) take steps to assure all relative value units contained in the Medicare Fee Schedule are adjusted as needed to comply with ever-increasing federal and state regulatory requirements. (created in 1992, reaffirmed 10 times) (Reaffirm HOD Policy)

Your Reference Committee heard testimony in strong support of Resolutions 212, 221, 224, and 225. Your Reference Committee heard that the looming payment cuts facing physician practices at the end of this year, including sequester and budget neutrality, must be addressed to ensure that practices can remain fiscally viable. Your Reference Committee also heard that physician practices have not yet recovered from the financial strain of the COVID-19 pandemic. Your Reference Committee also heard that these upcoming cuts place an unreasonable burden on physician practices and severely impact patient access to care as many practices will struggle to keep their doors open.

Your Reference Committee heard testimony that extensive Medicare Payment cuts totaling 9.75 percent are scheduled to go into effect on January 1, 2021. Your Reference Committee heard testimony that these payment cuts are a result of the 2 percent sequester stemming from the Budget Control Act of 2011, the 4 percent Statutory Pay As You Go (PAYGO) sequester resulting from the passage of the American Rescue Plan Act of 2021, and the expiration of the Congressionally enacted 3.75 percent temporary increase in the Medicare physician fee schedule conversion factor to avoid payment cuts

associated with budget neutrality adjustments tied to physician fee schedule policy changes. Your Reference Committee also heard that in addition to these expected Medicare cuts, potential penalties under the Merit-Based Incentive Payment System (MIPS), which apply to Medicare Physician Fee Schedule services, will increase to 9 percent in 2022. Your Reference Committee heard testimony that these expected payment cuts also threaten the fiscal viability of physician practices in 2022.

Your Reference Committee heard testimony that our AMA has been ringing the alarm bell on this looming fiscal cliff. Your Reference Committee heard that our AMA has been engaged in comprehensive advocacy and legislative activities aimed at eliminating these payment cuts, including several letters to Congress (e.g., July 15 letter, July 21 letter, July 23 letter, July 30 letter, August 30 letter, September 15 letter.) Your Reference Committee heard testimony that our AMA is committing substantial resources to reach policy makers and the public, including digital advertisements, online articles, targeted electronic information pieces to policy makers, op-eds from patients, physicians, and local policy leaders. Your Reference Committee also heard that our AMA's advocacy activities have been widely reported to the Federation and AMA membership through Advocacy Update, AMA News Articles, and the AMA website. Your Reference Committee further heard that our AMA is currently engaged in a grass roots campaign to urge Congress to take action to stop these devastating Medicare cuts from going into effect. In addition, your Reference Committee heard that our AMA continues to advocate that the Centers for Medicare and Medicaid Services (CMS) exercise the full breadth and depth of its administrative authority to avert or, at a minimum, mitigate these payment cuts. Your Reference Committee heard that our AMA has held several stakeholder meetings with Federation members and provided CMS with extensive comments on the need to mitigate the Medicare cuts.

Your Reference Committee agrees with the online and oral testimony that urged your Reference Committee to blend these important Resolutions into a "Perfect Whole." Your Reference Committee, therefore, recommends that Alternative Resolution 212 be adopted in lieu of Resolutions 212, 221, 224, and 225.

Sequestration Budget Cuts D-165.941

1. Our AMA will urge Congress to develop a fiscally responsible alternative that would prevent the automatic budget sequestration cuts that would endanger critical programs related to medical research, public health, workforce, food and drug safety, and health care for uniformed service members, as well as trigger cuts in Medicare payments to graduate medical education programs, hospitals, and physicians that will endanger access to care and training of physicians.

2. Our AMA will take all necessary legislative and administrative steps to prevent extended or deeper sequester cuts in Medicare payments.

Cuts in Medicare and Medicaid Reimbursement H-330.932

Our AMA: (1) continues to oppose payment cuts in the Medicare and Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients;

(2) supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the Medicare population, and the cost of new technology;

(3) aggressively encourages CMS to affirm the patient's and the physician's constitutional right to privately contract for medical services;

(4) if the reimbursement is not improved, the AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee; and

(5) supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases.

Physician Payment Reform H-400.972

It is the policy of the AMA to (1) take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but not limited to, (a) reduction of allowances for new physicians; (b) the non-payment of EKG interpretations; (c) defects in the Geographic Practice Cost Indices and area designations; (d) inappropriate Resource-Based Relative Value Units; (e) the deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system; (f) the need for restoration of the RBRVS conversion factor to levels consistent with the statutory requirement for budget neutrality; (g) the inadequacy of payment for services of assistant surgeons; and (h) the loss of surgical-tray benefit for many outpatient procedures (Reaffirmed by Rules & Credentials Cmt., A-96);

(2) seek an evaluation of (a) stress factors (i.e., intensity values) as they affect the calculation of the Medicare Payment Schedule, seeking appropriate, reasonable, and equitable adjustments; and (b) descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and payment levels and to seek adjustments so that the resulting values and payment levels appropriately pertain to the elderly and often infirm patients;

(3) evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment Schedule and to ascertain that the concept for the work component continues to be an appropriate part of a resource-based relative value system;

(4) seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors;
(5) seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with preoperative office visits, concomitant office procedures, and/or future procedures;

(6) seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992;

(7) seek the elimination of regulations directing patients to points of service;

(8) support further study of refinements in the practice cost component of the RBRVS to ensure better reflection of both absolute and relative costs associated with individual services, physician practices, and medical specialties, considering such issues as data adequacy, equity, and the degree of disruption likely to be associated with any policy change;

(9) take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs;
(10) support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of 1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare geographic practice costs indices (GPCIs) and work with CMS and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect actual physician costs, including gross receipt taxes;

(11) request that CMS refine relative values for particular services on the basis of valid and reliable data and that CMS rely upon the work of the AMA/Specialty Society RVS Updating Committee (RUC) for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations;

(12) pursue aggressively recognition and CMS adoption for Medicare payment schedule conversion factor updates of an index providing the best assurance of increases in the monetary conversion factor reflective of changes in physician practice costs, and to this end, to consider seriously the development of a "shadow" Medicare Economic Index;

(13) continue to implement and refine the Payment Reform Education Project to provide member physicians with accurate and timely information on developments in Medicare physician payment reform; and

(14) take steps to assure all relative value units contained in the Medicare Fee Schedule are adjusted as needed to comply with ever-increasing federal and state regulatory requirements.

Exempt Physician-Administered Drugs from Medicare Sequestration H-330.888

Our AMA supports passage of federal legislation 1) exempting payments for biologics and other drugs provided under Medicare Part B from sequestration cuts, and 2) reimbursing providers for reductions in payments for biologics and other drugs furnished under Medicare Part B on or after April 1, 2013.

Refinement of Medicare Physician Payment System H-400.990

The AMA: (1) reaffirms its support for development and implementation of a Medicare indemnity payment schedule according to the policies established in Policy 400.991; (2) supports reasonable attempts to remedy geographic Medicare physician payment inequities that do not substantially interfere with the AMA's support for an RBRVS-based indemnity payment system; (3) supports continued efforts to ensure that implementation of an RBRVS-based Medicare payment schedule occurs upon the expansion, correction, and refinement of the Harvard RBRVS study and data as called for in Board Report AA (I-88), and upon AMA review and approval of the relevant proposed enabling legislation; and (4) continues to oppose any effort to link the acceptance of an RBRVS with any proposal that is counter to AMA policy, such as expenditure targets or mandatory assignment.

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

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

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

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

(4) The AMA reaffirms its opposition to the continuation of the Medicare maximum allowable actual charge (MAAC) limits.
(5) The AMA promotes enhanced physician discussion of fees with patients as an explicit objective of a Medicare indemnity payment system.

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

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

(8) The AMA believes that payment localities should be determined based on principles of reasonableness, flexibility and common sense (e.g., localities could

consist of a combination of regions, states, and metropolitan and nonmetropolitan areas within states) based on the availability of high quality data.

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

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

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

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

Merit-based Incentive Payment System (MIPS) Update H-385.905

Our AMA supports legislation that ensures Medicare physician payment is sufficient to safeguard beneficiary access to care, replaces or supplements budget neutrality in MIPS with incentive payments, or implements positive annual physician payment updates.

MIPS and MACRA Exemption H-390.838

Our AMA will advocate for an exemption from the Merit-Based Incentive Payment System (MIPS) and Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for small practices.

Improving the Medicare Economic Index D-390.963

Our AMA will urge the Centers for Medicare and Medicaid Services and the Medicare Payment Advisory Commission to review the Medicare Economic Index productivity offset and consider eliminating it or revising it so that it more accurately reflects the effects of productivity increase in medical practice.

Patient Access Jeopardized By Senate Failure to Correct Medicare Payment Error D-390-988

Our AMA will: (1) aggressively promote expanded grassroots participation in the Medicare Update Campaign through the use of blast fax, e-mails and the toll-free grassroots hotline (1-800-833-6354); (2) continue to work with state and national medical specialty societies, as well as group practices, on physician surveys to measure the effect on patient access to care; (3) immediately disseminate the latest information to physicians regarding Medicare participation, non-participation and private contracting arrangements; and (4) concurrent with all of the above legislative, grassroots and targeted political actions, continue to evaluate aggressive, appropriate legal remedies through court action that could serve to rectify physician concerns about Medicare payment cuts and their impact on patient care.

Physician Payment Reform H-390.849

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

a) promote improved patient access to high-quality, cost-effective care;

b) be designed with input from the physician community;

c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions;
d) not require budget neutrality within Medicare Part B;

e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice;

f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process;

g) make participation options available for varying practice sizes, patient mixes, specialties, and locales;

h) use adequate risk adjustment methodologies;

i) incorporate incentives large enough to merit additional investments by physicians;

j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols;

k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization;

l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and

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

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

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

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

5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

(12) RESOLUTION 234 – PERMITTING THE DISPENSING OF STOCK MEDICATIONS FOR POST DISCHARGE PATIENT USE AND THE SAFE USE OF MULTI-DOSE MEDICATIONS FOR MULTIPLE PATIENTS

RECOMMENDATION A:

Resolve 2 of Resolution 234 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work with the Food and Drug Administration, national specialty societies, state medical societies and/or other interested parties to advocate for legislative and regulatory language that permits the practice of using multi dose medications, such as eye drops, ~~bottles~~ injectables and topical medications ~~post-operatively~~ in accordance with safe handling and dispensing protocols that help ensure patient safety, minimize duplicated patient costs, and reduce medication waste. (Directive to Take Action)

RECOMMENDATION B:

Resolution 234 be adopted as amended.

HOD ACTION: Resolution 234 adopted as amended.

RESOLVED, That our American Medical Association work with national specialty societies, state medical societies and/or other interested parties to advocate for legislative and regulatory language that permits the practice of dispensing stock-item medications to individual patients upon discharge in accordance with labeling and dispensing protocols that help ensure patient safety, minimize duplicated patient costs, and reduce medication waste (Directive to Take Action); and be it

RESOLVED, That our AMA work with the Food and Drug Administration, national specialty societies, state medical societies and/or other interested parties to advocate for legislative and regulatory language that permits the practice of using multi dose eye drop bottles post-operatively in accordance with safe handling and dispensing protocols that help ensure patient safety, minimize duplicated patient costs, and reduce medication waste.

Your Reference Committee heard overwhelmingly positive testimony on Resolution 234. Your Reference Committee heard that regulations governing the ability to dispense the remaining portion of topical stock-item medications for post-discharge use can be unclear or appear overly burdensome, and that many facilities do not allow the practice. Your Reference Committee heard testimony that, as a result of current regulations, patients may need to purchase duplicate agents for post-discharge use, increasing patient cost and creating medication waste. Your Reference Committee heard testimony that this is an issue that impacts many specialties, including, but not limited to, ophthalmologists. Your Reference Committee agrees and is recommending an amendment that broadens the Second Resolved. Further, your Reference Committee heard testimony that our AMA has no existing policy on this specific issue. Your Reference Committee, therefore, recommends that Resolution 234 be adopted as amended.

(13) RESOLUTION 240 – RANSOMWARE PREVENTION AND RECOVERY

RECOMMENDATION A:

Resolved 1 of Resolution 240 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our American Medical Association work with other stakeholders to seek legislation or regulation that <u>supports resources</u> ~~funds assistance~~ to cover cyberattack prevention and recovery expenses for physician practices, hospitals, and healthcare entities to ensure continuity of optimal patient care (Directive to Take Action); and be it further

RECOMMENDATION B:

Resolution 240 be <u>adopted as amended</u>.

HOD ACTION: Resolution 240 <u>adopted as amended</u>.

RESOLVED, That our AMA work with other stakeholders to seek legislation or regulation that funds assistance to cover cyberattack prevention and recovery expenses for physician practices, hospitals, and healthcare entities to ensure continuity of optimal patient care (Directive to Take Action); and be it further

RESOLVED, That our AMA, in collaboration with appropriate stakeholders, develop a toolkit for physician practices, hospitals, and healthcare entities to include best practices on preventing cyberattacks and a plan of action for when such an attack happens to their practice or institution; the toolkit should include guides to financial resources (Directive to Take Action).

Your Reference Committee heard mixed testimony regarding Resolution 240. Your Reference Committee heard that cyberattacks on healthcare systems have spiked during the COVID-19 pandemic. Your Reference Committee heard that if a rural hospital serving several counties with thousands of people in a geographic area were attacked, patients served by that hospital may not have any other healthcare options. Your Reference Committee also heard that our AMA is well-positioned to provide physician input in cybersecurity efforts as cybersecurity infrastructure discussions move forward. Your Reference Committee heard testimony that our AMA has existing policy that speaks directly to the issues related to cybersecurity outlined in Resolution 240. Your Reference Committee heard that our AMA is a member of the Healthcare and Public Health Sector Coordinating Council (HSCC) Cybersecurity Working Group, a coalition of industry associations and their members born out of Presidential Policy Directive 21, that works jointly and collaboratively with the federal government. Your Reference Committee heard that our AMA has provided numerous cybersecurity resources to physicians, their staffs, and IT stakeholders including resources jointly developed by the AMA and the American Hospital Association (AHA) for use during the COVID-19 public health emergency and beyond. Your Reference Committee also heard that our AMA and the AHA have specifically developed checklists, guides, and other resources (toolkits) for hospitals and physician practices to protect their computers and network and to keep their patient health records and other data safe from cyberattacks. Your Reference Committee also heard that a large percentage of hospitals and practices have been hit by cyberattacks, and that the impact of these attacks can be especially problematic for rural practices. Your Reference Committee heard testimony that physician practices need assistance, via federal funding and other resources, to effectively combat the barrage of cybersecurity attacks they face on a daily basis. Your Reference Committee understands that there is not a one-size-fits all solution to combating cyberattacks and that some physician practices may prefer utilizing non-monetary resources. Your Reference Committee agrees that there is a need to provide increased flexibility for our AMA to advocate for additional resources for cyberattack prevention and the recovery of expenses. Your Reference Committee, therefore, recommends that Resolution 240 be adopted as amended.

RECOMMENDED FOR REFERRAL

(14) RESOLUTION 203 – POVERTY-LEVEL WAGES AND HEALTH

RECOMMENDATION:

Resolution 203 be referred.

HOD ACTION: Resolution 203 referred.

RESOLVED, That our American Medical Association support federal minimum wage regulation such that the minimum wage increases at least with inflation in order to prevent full-time workers from experiencing the adverse health effects of poverty. (New HOD Policy)

Your Reference Committee heard mixed testimony regarding Resolution 203. Your Reference Committee heard testimony that increasing the federal minimum wage would raise the earnings and family income of most low-wage workers, lifting some families out of poverty. Conversely, your Reference Committee heard that increasing the federal minimum wage would cause some employers to have to let go of some of their employees, which would cause some low-wage workers to become jobless and their family income to fall. Your Reference Committee heard testimony that the federal minimum wage has been stagnant, yet the average yearly inflation has increased steadily during that time. Your Reference Committee also heard testimony that our AMA has been vocal in expressing that social determinants of health include education, housing, wealth, income, and employment. Your Reference Committee heard testimony that our AMA has stated publicly that although we all experience conditions that socially determine our health, we do not all experience them equally. Your Reference Committee heard testimony that having a living wage is essential to promoting health and equity. However, your Reference Committee also heard that a living wage in one part of the country may not be sufficient to be considered a living wage in another part of the country. Your Reference Committee also heard testimony that supporting federal minimum wage regulation tied to inflation may negatively impact the ability of small physician practices to pay their staff. Your Reference Committee understands that there is not consensus on this issue and, therefore, recommends that Resolution 203 be referred.

Mister Speaker, this concludes the report of Reference Committee B. I would like to thank Bryan Johnson, MD, Janice Tildon-Burton, MD, Michael DellaVecchia, MD, Nicole Henry-Dindial, MD, Ryan Hall, MD, William Freeman, MD, and all those who testified before the Committee.

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