## PPPS Governing Council Report A – November 2021 Special Meeting

Access full text of resolutions/reports in the HOD meeting handbook.

NOTE: Items that are **highlighted in red** have not been accepted by the HOD Resolutions Committee. These items can still be considered by the PPPS, however they may not be considered by the HOD at the November meeting.

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| 1 | A | Res. 101 – Standardized Coding for Telehealth Services<br><br>(Virginia) | RESOLVED, That our American Medical Association advocate by regulation and/or legislation that telehealth services are uniformly identified by using place of service (02) without any additional requirements, such as modifiers imposed by third party payors, for claim submission and reimbursement. (Directive to Take Action) | Delegate instructed to support. |
| 2 | A | Res. 104 – Improving Access to Vaccinations for Patients<br><br>(CT, ME, MA, NH, RI, VT) | RESOLVED That our American Medical Association encourage all payors, including the Centers for Medicare and Medicaid Services, to cover, without cost sharing, all vaccines recommended by the Centers for Disease Control and Prevention, when administered in the physician office. (Directive to Take Action) | Delegate instructed to support. |
| 3 | A | Res. 118 – Expanding Site-of-Service Neutrality<br><br>(Texas) | RESOLVED, That our American Medical Association continue to support Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments (Directive to Take Action); and be it further<br><br>RESOLVED, That our AMA pursue and support passage of legislation and agency policies that expand site-neutral payment to equalize payments across sites of service for all outpatient services (Directive to Take Action); and be it further<br><br>RESOLVED, That our AMA pursue policy that creates patient incentives for services to be performed in the most cost-effective location, such as a physician's office.(Directive to Take Action) | Delegate instructed to strongly support. |
| 4 | B | BOT 10 – Physician Access to Their Medical and Billing Records | RECOMMENDATIONS<br>In light of these considerations, the Board recommends that the following be adopted in lieu of Resolution 226-A-19 and the remainder of this report be filed: | Delegate instructed to support. |

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| | | | 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)<br><br>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)<br><br>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) | |
| 5 | B | Res. 213 – Eliminating Unfunded or Unproven Mandates and Regulations<br><br>(Ohio) | RESOLVED, That our American Medical Association advocate for policies that allow for physician judgment and documented medical decision-making to supersede government regulation--including the utilization of Augmented Intelligence--in instances of disputes in patient care (Directive to Take Action); and be it further<br><br>RESOLVED, That our AMA advocate for policies that require "proof of concept," in the form of independently demonstrated quality improvement, prior to the implementation of any government, insurance company or other third party mandate or regulation on patient care and the physician-patient relationship (Directive to Take Action); and be it further<br><br>RESOLVED, That our AMA advocate for policies requiring government, insurance company or other third party entities to fully fund any mandates or regulations | No recommendation made. |

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| | | | imposed on patient care and the physician-patient relationship. (Directive to Take Action) | |
| 6 | B | Res. 218 – Physician Opposition to the Coordinated Effort by Corporations and Midlevel Providers to Undermine the Physician-Patient Relationship and Safe Quality Care<br><br>(Resident and Fellow Section) | RESOLVED, That our American Medical Association study the impact that individual physician scope of practice advocacy has had on physician employment and contract terminations (Directive to Take Action); and be it further<br><br>RESOLVED, That our AMA study the views of patients on physician and non-physician care to identify best practices in educating the general population on the value of physician-led care (Directive to Take Action); and be it further<br><br>RESOLVED, That our AMA study the utility of a physician-reported database to track and report institutions that replace physicians with midlevel providers in order to aid patients in seeking physician-led medical care as opposed to care by midlevel providers practicing without physician supervision. (Directive to Take Action) | No recommendation made. |
| 7 | B | Res. 221 – Promoting Sustainability in Medicare Physician Payments<br><br>(Texas) | 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<br><br>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<br><br>RESOLVED, That our AMA seek legislation that provides only for positive performance incentives (Directive to Take Action); and be it further<br><br>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) | Delegate instructed to strongly support. |
| 8 | B | Res. 224 – Improve Physician Payments<br><br>(Florida) | 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<br><br>RESOLVED, That our AMA utilize the necessary resources to avoid the pending Medicare physician payment cuts (Directive to Take Action); and be it further | Delegate instructed to strongly support. |

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| | | | RESOLVED, That our AMA modify policy D-165.941, "Sequestration Budget Cuts," by addition and deletion to read as follows:<br>**Sequestration Budget Cuts D-165.941**<br>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.<br>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<br><br>RESOLVED, That our AMA reaffirm and take immediate action on policy H-330.932, "Cuts in Medicare and Medicaid Reimbursement," that:<br>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)<br>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)<br>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<br>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<br><br>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 | |

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| | | | encourage physicians to participate in the AMA campaign to improve physician payments (Directive to Take Action); and be it further<br><br>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) | |
| 9 | B | Res. 225 – End Budget Neutrality<br><br>(Florida) | RESOLVED, That our American Medical Association work towards the elimination of budget 37 neutrality requirements under federal law (Directive to Take Action); and be it further<br><br>RESOLVED, That our AMA amend Policy H-385.905, "Merit-based Incentive Payment System (MIPS) Update," by addition and deletion to read as follows:<br><br>**Merit-based Incentive Payment System (MIPS) Update H-385.905**<br>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<br><br>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:<br><br>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 | Delegate instructed to strongly support. |

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| | | | further<br><br>RESOLVED, That our AMA reaffirm and take action on H-400.972, "Physician Payment Reform"<br><br>**H-400.972, "Physician Payment Reform**<br>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);<br>(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;<br>(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;<br>(4) seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors;<br>(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;<br>(6) seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992;<br>(7) seek the elimination of regulations directing patients to points of service;<br>(8) support further study of refinements in the practice cost component of the | |

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| | | | 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;<br>(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;<br>(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;<br>(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 22 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;<br>(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;<br>(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<br>(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) | |
| | B | Res. 236 – Repeal or Modification of the | RESOLVED, That our American Medical Association Policy H-320.940, “Medicare’s Appropriate Use Criteria Program,” be amended by addition and deletion to read as follows: | No recommendation made – Governing |

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| | | Medicare Appropriate Use Criteria (AUC)<br><br>(American Academy of Family Physicians, et al) | Our AMA will ~~continue to~~ advocate to Congress for ~~delay the effective date~~ either the full repeal of the Medicare Appropriate Use Criteria (AUC) Program or legislative modifications to the program in such a manner that ~~until the Centers for Medicare & Medicaid Services (CMS) can~~ adequately addresses technical and workflow challenges, ~~with its implementation and any interaction between~~ maximizes alignment with the Quality Payment Program (QPP), and ~~the use of advanced diagnostic imaging appropriate use criteria.~~ creates provider flexibility for the consultation of AUC or advanced diagnostic imaging guidelines using a mechanism best suited for their practice, specialty and workflow. (Modify Current HOD Policy) | Council seeks full Section discussion. |
| 10 | F | CLRPD 01 – Minority Affair Section Five-Year Review | RECOMMENDATION<br>The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Minority Affairs Section through 2026 with the next review no later than the 2026 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action) | Delegate instructed to support. |
| 11 | F | CLRPD 02 – Integrated Physician Practice Section Five-Year Review | RECOMMENDATION<br>The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Integrated Physician Practice Section through 2026 with the next review no later than the 2026 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action) | Delegate instructed to support. |
| 12 | F | Res. 603 – Abolishment of the Resolution Committee | RESOLVED, That our American Medical Association abolish the Resolution Committee by amending the AMA Bylaws B-2.13.3, "Resolution Committee," as follows by deletion:<br><br>~~**Resolution Committee. B-2.13.3**~~<br>~~The Resolution Committee is responsible for reviewing resolutions submitted for consideration at an Interim Meeting and determining compliance of the resolutions with the purpose of the Interim Meeting.~~<br>~~2.13.3.1 Appointment. The Speaker shall appoint the members of the committee. Membership on this committee is restricted to delegates.~~<br>~~2.13.3.2 Size. The committee shall consist of a maximum of 31 members.~~<br>~~2.13.3.3 Term. The committee shall serve only during the meeting at which it is appointed, unless otherwise directed by the House of Delegates.~~ | Delegate instructed to listen. |

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| | | | ~~2.13.3.4 Quorum. A majority of the members of the committee shall constitute a quorum.~~<br>~~2.13.3.5 Meetings. The committee shall not be required to hold meetings. Action may be taken by written or electronic communications.~~<br>~~2.13.3.6 Procedure. A resolution shall be accepted for consideration at an Interim Meeting upon majority vote of committee members voting. The Speaker shall only vote in the case of a tie. If a resolution is not accepted, it may be submitted for consideration at the next Annual Meeting in accordance with the procedure in Bylaw 2.11.3.1.~~<br>~~2.13.3.7 Report. The committee shall report to the Speaker. A report of the committee shall be presented to the House of Delegates at the call of the Speaker. (Modify Bylaws)~~ | |
| 13 | F | Res. 604 – The Critical Role of Physicians in the COVID-19 Pandemic<br><br>(TX, FL, NJ, CA & WA) | RESOLVED, That our American Medical Association create and fund a public awareness campaign recognizing the vital role physicians have played in the COVID-19 pandemic and highlighting:<br>• Physician leadership in public health messaging, raising awareness of vital prevention and treatment recommendations;<br>• Medical treatment of patients during this time of great crisis;<br>• Remembrance of physicians who died of COVID-19 while rendering care during the pandemic;<br>• The personal sacrifices borne by physicians related to the pandemic; and<br>• The emotional stress from the long hours spent taking care of patients (Directive to Take Action); and be it further<br><br>RESOLVED, That the target audience for this campaign be physicians, legislators, and the public (Directive to Take Action); and be it further<br><br>RESOLVED, That the purpose of this campaign is to thank our physician colleagues and make government officials and the public aware of the personal costs physicians have shouldered during this crisis. (Directive to Take Action) | Delegate instructed to support. |
| | F | Res. 610 – Creation of Employed Physician Section | RESOLVED, That our American Medical Association study the necessity and feasibility to create a Section for Employed Physicians (Directive to Take Action); and be it further | No recommendation made. |

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| | | (Florida) | RESOLVED, That the section would work toward determining problems associated with employment; recommend solutions; and utilize necessary resources when resolving conflicts and challenges between employed physicians and their employers. (Directive to Take Action) | |
| | F | Res 615 – Employed Physicians<br><br>(AL, DC, GA, MS, NJ, NC, OK, SC, TN) | RESOLVED, that Corporate AMA establish an entity (say, the AMA Office of the Employed Physician) dedicated to the Employed Physician with full time staffing to aggressively address relevant AMA Policy pertaining to the Employed Physician. (New Policy and New Action); and Be IT Also<br><br>RESOLVED, that our AMA study AMENDING Policy # 615.105 as follows:<br><br>1. Our AMA will become the lead association for physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities.<br><br>2. As a benefit of membership our AMA will provide, through the new AMA Office of the Employed Physician, assistance, such as information, advice, and legal opinions, as appropriate, to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other entities, including, but not limited to, breach of contracts, contract negotiations and contract renewals, medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.<br><br>3. Our AMA will also work through the Organized Medical Staff Section and other sections and special groups as appropriate to represent and address the unique needs of physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities.<br>(New or Amended Policy); and Be IT Also<br><br>RESOLVED, that the Representation of the Organized Medical Staff Section (OMSS) in the AMA House of Delegates be increased from the Current One Delegate to many Delegates based on AMA membership numbers of Employed Physicians using the mathematical model(s), to calculate the numbers of the New OMSS Delegates, currently being used at AMA for the Medical Student and Resident and Fellows | No recommendation made. |

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| | | | Sections to calculate the numbers of Regional Medical Students and the numbers of Regional Resident/Fellows in the AMA House of Delegates. The AMA would develop a practical meaning of the phrase "Employed Physician" for the purposes of AMA membership counting, but as an editorial comment, the SED suggests starting with employed Non-Resident/non-Fellow physicians who have no ownership interest (or, say, less than 1% ownership each) in their employer organization. (New Policy); and BE IT Further<br>RESOLVED, that the Organized Medical Staff Section have one designated member who is a defined Employed Physician on all AMA Boards and Committees and Councils to match the MMS, the RFS and the YPS. (New Policy) | |
| 14 | G | Res. 702 – System Wide Prior and Post-Authorization Delays and Effects on Patient Care Access<br><br>(Ohio) | RESOLVED, That our American Medical Association encourage and advocate health care insurers and Medicare/Medicaid Products to ensure that the systems of communication for prior authorization include: live personnel access, simplification of website navigation, immediate response with confirmation number of submission and an expedient decision for authorizations. (Directive to Take Action) | No recommendation made. |
| 15 | G | Res. 703 – Clear Statement Regarding the Use of CPT E/M Outpatient Visit Codes<br><br>(American Academy of Pediatrics) | RESOLVED, That our American Medical Association identify and collect data regarding payer deviation from CPT code descriptors to adjudicate claims, assess efficacy of and challenges in existing appeals and hassle factor processes available to physicians, and prepare and present a report at the 2022 House of Delegates Interim Meeting. (Directive to Take Action) | No recommendation made. |