**DISCLAIMER**

**The following is a preliminary report of actions taken by the House of Delegates at its 2017 Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.**

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-17)

Report of Reference Committee A

John H. Armstrong, MD, Chair

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Your Reference Committee recommends the following consent calendar for acceptance:

**RECOMMENDED FOR ADOPTION**

1. Council on Medical Service Report 1 - Council on Medical Service Sunset Review of 2007 AMA House Policies
2. Resolution 112 - CMS Must Publish All Values for Non-Covered and Bundled Services
3. Resolution 119 - Support Efforts to Improve Access to Diabetes Self-Management Training Services
4. Resolution 120 - National Pressure Ulcer Advisory Panel Recommendation for Pressure Ulcer Nomenclature Change
5. Resolution 128 - Protecting Patients' Access to Emergency Services

**RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED**

6. Council on Medical Service Report 3 - Ensuring Continuity of Care Protections during Active Courses of Treatment
7. Council on Medical Service Report 6 - Expansion of US Veterans' Health Care Choices
   in lieu of
   Resolution 117 - Expansion of U.S. Veterans' Healthcare Choices
8. Council on Medical Service Report 9 - Capping Federal Medicaid Funding
9. Joint Report of the Council on Medical Service and the Council on Science and Public Health - Value of Preventive Services
10. Resolution 101 - Eliminating Financial Barriers for Evidence-Based HIV Pre-Exposure Prophylaxis
11. Resolution 107 - Repeal and Replace Our Outdated Refundable Advanceable Tax Credit Policy
12. Resolution 108 - Out-of-Network Insurance Benefit Availability in Individual Insurance Market and Self-Funded Plans
    Resolution 115 - Out-of-Network Care
    Resolution 118 - Third Party Patient Reimbursement for Out-of-Network Physicians
    Resolution 127 - Balance Billing State Regulation
13. Resolution 111 - VA Technology-Based Eye Care Services

14. Resolution 114 - Coverage for Preventive Care and Immunizations
15. Resolution 116 - Medicare Advantage Payment Policies
16. Resolution 123 - Improving the Prevention of Colon Cancer by Insuring the Waiver of the Co-Payment in all Cases
17. Resolution 124 - Emergency Medical Services Reimbursement for On-Site Treatment and Transport to Non-Traditional Destinations
18. Resolution 125 - Medicaid Substance Use Disorder Coverage
19. Resolution 126 - Insurance Coverage for Compression Stockings

**RECOMMENDED FOR REFERRAL**

20. Resolution 110 - Over-the-Counter Contraceptive Drug Access

**RECOMMENDED FOR REAFFIRMATION IN LIEU OF**

21. Resolution 103 - Benefit Payment Schedule
22. Resolution 106 - Medical Loss Ratio
23. Resolution 109 - Simplify Medicare Face to Face Requirement
24. Resolution 121 - Advanced Care Planning Codes

Existing policy was reaffirmed in lieu of the following resolutions via the Reaffirmation Consent Calendar:

- Resolution 102 - Establishing a Market System of Health System Financing and Delivery
- Resolution 104 - Consultation Code Reinstatement
- Resolution 105 - Opposition to Price Controls
- Resolution 113 - The AMA Will Support Payment Parity at Medicare Levels for All Medicaid Services
- Resolution 122 - Reimbursement for the Pre-Colonoscopy Visit

(1) COUNCIL ON MEDICAL SERVICE REPORT 1 - COUNCIL ON MEDICAL SERVICE SUNSET REVIEW OF 2007 AMA HOUSE POLICIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

**HOD ACTION: Recommendation in Council on Medical Service Report 1 adopted and the remainder of the report filed.**

Council on Medical Service Report 1 contains recommendations to retain or rescind 2007 AMA socioeconomic policies.

Testimony on Council on Medical Service Report 1 was limited to a member of the Council on Medical Service. Accordingly, your Reference Committee recommends that the recommendation of Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

(2) RESOLUTION 112 - CMS MUST PUBLISH ALL VALUES FOR NON-COVERED AND BUNDLED SERVICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 112 be adopted.

**HOD ACTION: Resolution 112 adopted.**

Resolution 112 asks that our AMA advocate that the Centers for Medicare and Medicaid Services must publish the RUC recommended values for all services, including non-covered and bundled services.

Your Reference Committee heard limited yet supportive testimony on Resolution 112. A member of the AMA/Specialty RVS Update Committee (RUC) testified that the RUC submitted a comment letter to the Centers for Medicare and Medicaid Services in 2015 in support of publishing the non-covered/bundled Medicare services in which the RUC had made a recommendation in the Medicare Physician Payment Schedule. As of May 2017, there are approximately 20 services in which CMS has determined a Medicare status of “Bundled”, “Not valid for Medicare purposes”, “Non-covered” or “Statutory exclusion” but did not publish the RUC recommended value. Your Reference Committee believes that it is imperative that CMS publish the work, practice expense and professional liability insurance relative values for these services because the resource-based relative value scale (RBRVS) is used by Medicaid and many private payors. Your Reference Committee notes that there is a long-standing precedent established by the preventive medicine services codes, which are Medicare status indicator “N” (non-covered), yet have had RUC recommended values published on the Medicare Physician

Payment Schedule Appendix B since their inception. Your Reference Committee believes that as CMS established this precedent, it should continue to follow it. Physicians have reported problems seeking payment for these services by other payors because CMS has not published RVUs for these services.

An amendment was proffered to include "technical components;" however, the RUC recommended values are comprised of three components: work, practice expense, and professional liability, so this is already addressed in the original resolution language. Your Reference Committee concurs with testimony and the content of the comment letter and recommends that Resolution 112 be adopted.

(3) RESOLUTION 119 - SUPPORT EFFORTS TO IMPROVE ACCESS TO DIABETES SELF-MANAGEMENT TRAINING SERVICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 119 be adopted.

**HOD ACTION: Resolution 119 adopted.**

Resolution 119 asks that our AMA actively support regulatory and legislative actions that will mitigate barriers to Diabetes Self-Management Training (DSMT) utilization; and support outreach efforts to foster increased reliance on DSMT by physician practices in order to improve quality of diabetes care.

Your Reference Committee heard generally supportive testimony on Resolution 119. As the resolution is consistent with Policy H-160.938, which seeks to have physician-directed benefits of evidence-based self-management training be provided to the beneficiaries of Medicare, Medicaid and other payers, your Reference Committee recommends that Resolution 119 be adopted.

(4) RESOLUTION 120 - NATIONAL PRESSURE ULCER ADVISORY PANEL RECOMMENDATION FOR PRESSURE ULCER NOMENCLATURE CHANGE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 120 be adopted.

**HOD ACTION: Resolution 120 adopted.**

Resolution 120 asks that our AMA formally oppose a change in nomenclature from "pressure ulcer" to "pressure injury" in the ICD-10 and other diagnostic catalogues and classification systems.

Though limited, testimony on Resolution 120 was unanimously supportive. Concerns were expressed about use of the term "injury," which could have legal ramifications.

Your Reference Committee discussed the potential for a "slippery slope" of requests to comment on specific nomenclature changes; however, we believe this resolution warrants attention. For these reasons, your Reference Committee recommends that Resolution 120 be adopted.

(5) RESOLUTION 128 - PROTECTING PATIENTS' ACCESS TO EMERGENCY SERVICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 128 be adopted.

**HOD ACTION: Resolution 128 adopted.**

Resolution 128 asks that our work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the "prudent layperson" standard of determining when to seek emergency care.

Your Reference Committee heard supportive testimony on Resolution 128. As your Reference Committee believes that the resolution strongly responds to an emerging issue for patients seeking emergency care, your Reference Committee recommends that Resolution 128 be adopted.

(6) COUNCIL ON MEDICAL SERVICE REPORT 3 - ENSURING CONTINUITY OF CARE PROTECTIONS DURING ACTIVE COURSES OF TREATMENT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 6 in Council on Medical Service Report 3 be amended by deletion to read as follows:

6. That our AMA support patients in an active course of treatment who switch to a new health plan having the opportunity to receive continued transitional care from their treating out-of-network physicians and hospitals at in-network cost-sharing levels. Transitional care should be provided at the physicians' and hospitals' discretion~~, after having agreed to payment terms with the health plan~~. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

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

Council on Medical Service Report 3 recommends that our AMA reaffirm Policies H-285.911, H-285.908 and H-285.952; modify Policies H-385.936 and H-285.924[4]; support patients in an active course of treatment who switch to a new health plan having the opportunity to receive continued transitional care from their treating out-of-network physicians and hospitals at in-network cost-sharing levels; and continue to provide assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure continuity of care protections for patients in an active course of treatment.

Your Reference Committee heard generally supportive testimony on Council on Medical Service Report 3. A member of the Council on Medical Service introduced the report, noting that additional measures are needed to prevent disruptions in care for patients in an active course of treatment, both for new enrollees in a health plan, and existing enrollees receiving care from providers whose provider leaves or is removed from a plan's network without cause. An amendment was offered to the sixth recommendation of the report to remove language stating that transitional care should be provided after a physician or hospital agrees to payment terms with the patient's health plan. Speakers noted that it is of utmost importance for transitional care to be provided at physician and hospital discretion. The Council on Medical Service accepted the amendment as friendly. As such, your Reference Committee recommends that the recommendations of Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

(7) COUNCIL ON MEDICAL SERVICE REPORT 6 - EXPANSION OF US VETERANS' HEALTH CARE CHOICES
RESOLUTION 117 - EXPANSION OF U.S. VETERANS' HEALTHCARE CHOICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Council on Medical Service Report 6 be amended by addition of a new Recommendation to read as follows:

That our AMA encourage the acceleration of interoperability of electronic personal and medical health records in order to ensure seamless, timely, secure and accurate exchange of information between VA and non-VA providers and encourage both the VA and physicians caring for veterans outside of the VA to exchange medical records in a timely manner to ensure efficient care. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 6 be adopted as amended in lieu of Resolution 117 and the remainder of the report be filed.

That our AMA encourage the VA to engage with physicians providing care in the VA system to explore and develop solutions on improving the health care choices of veterans.

That our AMA advocate for new funding to support expansion of the Veterans Choice Program.

**HOD ACTION: Recommendations in Council on Medical Service Report 6 adopted as amended in lieu of Resolution 117 and the remainder of the report filed.**

Council on Medical Service Report 6 recommends that our AMA continue to work with the Veterans Administration (VA) to provide quality care to veterans; continue to support efforts to improve the Veterans Choice Program (VCP) and make it a permanent program; reaffirm Policy H-510.985; encourage the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care, and that the VA develop criteria by which individual veterans may request alternative pathways; support consolidation of all the VA community care programs; encourage the VA to use external assessments as necessary to identify and address systemic barriers to care; support interventions to mitigate barriers to the VA from being able to achieve its mission; and advocate that clean claims submitted electronically to the VA should be paid within 14 days and that clean paper claims should be paid within 30 days.

Resolution 117 asks that our AMA adopt as policy that the Veterans Health Administration expand all eligible veterans' health care choices by permitting them to use funds currently spent on them through the VA system, through mechanisms such as premium support, to purchase private health care coverage, and for veterans over age 65 to use these funds to defray the costs of Medicare premiums and supplemental coverage; and actively support federal legislation to achieve this expansion of healthcare choices for Veterans Administration eligible veterans.

Testimony was supportive on Council on Medical Service Report 6, and mixed on Resolution 117. An amendment was offered to ask our AMA to encourage both the VA and the physicians participating in the Veterans Choice Program VA to exchange medical records in a timely manner to ensure efficient care. A member of the Council on Medical Service accepted the amendment as friendly. As such, your Reference Committee has proposed the addition of a new recommendation to CMS Report 6.

Your Reference Committee notes that Council on Medical Service Report 6 responded to referred Resolution 229-A-16, "Expansion of US Veterans' Health Care Choices," the intent of which is consistent with that of Resolution 117. Your Reference Committee believes that Council on Medical Service Report 6 appropriately responds to the recommendation of both resolutions to permit veterans to use funds currently spent on them through the VA to purchase private health care coverage. In particular, the report explains the difficulty of providing premium support to veterans. A member of the Council on Medical Service emphasized that suggesting premium support for veterans to purchase health care in the private sector is not a new concept. Importantly, the Council member underscored that the Veterans Health Administration is not a health insurance plan with a defined amount of money to give veterans to purchase private health care. Rather, it is the largest integrated health care system in the US and provides highly specialized and comprehensive care that is not available to the same extent in the private sector. Your Reference Committee agrees, and notes that the VHA provides unique, highly specialized care for many medical conditions, such as spinal cord and traumatic brain injuries, which are not available to the same extent outside of the VHA.

Your Reference Committee believes that the recommendations of Council on Medical Service Report 6 emphasize the need for our AMA to advocate for further improvements to the care the VA provides to veterans, including supporting efforts to improve the Veterans Choice Program and make it a permanent program, and encouraging the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care. As such, your Reference Committee recommends that the recommendations of Council on Medical Service Report 6 be adopted as amended in lieu of Resolution 117, and that the remainder of the report be filed.

(8) COUNCIL ON MEDICAL SERVICE REPORT 9 - CAPPING FEDERAL MEDICAID FUNDING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Council on Medical Service Report 9 be <u>amended by addition of a new Recommendation</u> to read as follows:

<u>That our American Medical Association (AMA) oppose caps on federal Medicaid funding. (New HOD Policy)</u>

**HOD ACTION: Recommendation A <u>adopted</u> as new HOD policy.**

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Recommendation 1 in Council on Medical Service Report 9 be amended by addition and deletion as follows:

**HOD ACTION: Recommendation 1 in Council on Medical Service Report 9 referred.**

That our ~~American Medical Association (~~AMA~~)~~ advocate for the following principles of ~~safeguards if~~ federal Medicaid funding ~~is capped~~:

a. Individuals, including children and adolescents, who are currently eligible for Medicaid should not lose their coverage, and federal funding for the amount, duration, and scope of currently covered benefits should not be reduced;
b. The amount of federal funding available to states must be sufficient to ensure adequate access to all statutorily required services;
c. Cost savings mechanisms should not decrease patient access to quality care or physician payment;
d. The methodology for calculating the federal funding amount should take into consideration the state's ability to pay for health care services, rate of unemployment, concentration of low income individuals, population growth, and overall medical costs;
e. The federal funding amount should be based on the actual cost of health care services for each state;
f. The federal funding amount should continue to fund the Affordable Care Act (ACA) Medicaid expansion populations in states that have expanded Medicaid and provide non-expansion states with the option to expand Medicaid with additional funding to cover their expansion populations;
g. The federal funding ~~amount should be indexed to accurately reflect~~ should be responsive to changes in actual health care costs or state-specific trend rates, not fixed on a preset growth index (e.g., consumer price index);
h. Maximum cost-sharing requirements should not exceed five percent of family income; and
i. The federal government should continuously monitor the impact of ~~capping~~ federal Medicaid funding to ensure ~~that~~ robust patient access to care, adequate physician payment and the sustainability ~~ability~~ of state~~s to sustain their~~ programs ~~has not been compromised~~. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Recommendation 2 in Council on Medical Service Report 9 be amended by addition and deletion to read as follows:

That our AMA advocate that Congress and the Department of Health and Human Services seek and take into consideration ~~the concerns and~~ input ~~of~~ from our ~~the~~ AMA and interested state medical associations, national medical specialty societies, governors, Medicaid directors, mayors, and other stakeholders during the process of developing federal legislation, regulations, and guidelines on ~~modifications to~~ Medicaid funding. (New HOD Policy)

**HOD ACTION: Recommendation C adopted as new HOD policy.**

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 9 be adopted as amended and the remainder of the report be filed.

**HOD ACTION: Recommendations A and C adopted as new HOD Policy, with the adopted title change applicable to the categorization and inclusion of these policies in PolicyFinder.**

**Recommendation 1 in Council on Medical Service Report 9 referred.**

**The body of Council on Medical Service Report 9 referred.**

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that the title of Council on Medical Service Report 9 be changed to read as follows:

FEDERAL MEDICAID FUNDING

Council on Medical Service Report 9 recommends that our AMA advocate for a series of safeguards if federal Medicaid funding is capped; and advocate that Congress and the Department of Health and Human Services take into consideration the concerns and input of the AMA and interested state medical associations, national medical specialty societies, governors, Medicaid directors, mayors and other stakeholders during the

process of developing federal legislation, regulations, and guidelines on modifications to Medicaid funding.

Testimony unanimously opposed per capita caps on federal Medicaid funding. However, testimony was mixed about whether AMA should adopt policy on safeguards in the event that Congress establishes per capita caps. Many speakers raised of concerns that the policy would be misinterpreted as tacit support for per capita caps and instead recommended reaffirmation of Policy D-290.985, which calls for payment levels based on costs of care and utilization and payment arrangements that do not expose practitioners to excessive financial risk, in lieu of the recommendations in the report. Others testified in support of amendment to explicitly state our AMA's opposition to per capita capped funding and in support of the recommendations that would provide AMA with tools to oppose harmful federal reform proposals. Another amendment was offered to remove all references to capped funding and instead apply the safeguards to any changes to the Medicaid funding scheme.

Your Reference Committee agrees with testimony calling for opposition to capping federal Medicaid funding. However, your Reference Committee also believes that the first recommendation of the report should be retained as general principles for federal Medicaid funding. To accurately reflect these changes, your Reference Committee also recommends a title change. In summary, your Reference Committee recommends that Council on Medical Service Report 9 be adopted as amended and the remainder of the report be filed.

(9) JOINT REPORT OF THE COUNCIL ON MEDICAL SERVICE AND THE COUNCIL ON SCIENCE AND PUBLIC HEALTH - VALUE OF PREVENTIVE SERVICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 4 of the Joint Report of the Council on Medical Service and the Council on Science and Public Health be amended by addition and deletion to read as follows:

That our AMA encourage committees that make preventive services recommendations to:
a. Follow processes that promote transparency~~,~~ and clarity ~~and uniformity~~ among their methods;
b. Develop evidence reviews and recommendations with enough specificity to inform cost-effectiveness analyses;
c. Rely on the very best evidence available, with consideration of expert consensus only when other evidence is not available;
d. Work together to identify preventive services that are not supported by evidence or are not cost-effective, with the goal of prioritizing preventive services; and
e. Consider the development of recommendations on both primary and secondary prevention. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendation 7 of the Joint Report of the Council on Medical Service and the Council on Science and Public Health be amended by addition and deletion as follows:

That our AMA encourage public and private payers to cover ~~prioritize coverage of~~ preventive services for which consensus has emerged in the recommendations of multiple guidelines-making groups. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the recommendations of the Joint Report of the Council on Medical Service and the Council on Science and Public Health be adopted as amended and the remainder of the report be filed.

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

The Joint Report of the Council on Medical Service and the Council on Science and Public Health recommends that our AMA reaffirm Policies H-185.939, H-110.986 and H-410.953; encourages committees that make preventive services recommendations to follow processes that promote transparency, clarity and uniformity among their methods, develop evidence reviews and recommendations with enough specificity to inform cost-effectiveness analyses, rely on the very best evidence available, with consideration of expert consensus only when other evidence is not available, work together to identify preventive services that are not supported by evidence or are not cost-effective, with the goal of prioritizing preventive services, and consider the development of recommendations on both primary and secondary prevention; encourage relevant national medical specialty societies to provide input during the preventive services recommendation development process; encourage comparative-effectiveness research on secondary prevention to provide data that could support evidence-based decision making; and encourage public and private payers to prioritize coverage of preventive services for which consensus has emerged in the recommendations of multiple guidelines-making groups.

Testimony on the Joint Report of the Council on Medical Service and the Council on Science and Public Health was supportive. Testimony particularly emphasized the value of preventive services and the need for value-based insurance design that accounts for the cost effectiveness of preventive care. Testimony emphasized that physicians, rather than payers, prioritize preventive services; payers merely cover services. Accordingly, an amendment was offered to the seventh recommendation directing our AMA to encourage payers to cover preventive services. Another amendment was offered to

strike language calling for uniformity among methods of the guidelines-making committees because those committees have different objectives and differing methods may be appropriate. Your Reference Committee agrees and recommends that the Joint Report of the Council on Medical Service and the Council on Science and Public Health be adopted as amended and the remainder of the report be filed. Your Reference Committee also notes that an error in the report referring to the "Women's Preventive Services Institute" will be corrected to read "Women's Preventive Services Initiative."

(10) RESOLUTION 101 - ELIMINATING FINANCIAL BARRIERS FOR EVIDENCE-BASED HIV PRE-EXPOSURE PROPHYLAXIS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 101 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association amend Policy H-20.895 by addition to read as follows: H-20.895, Pre-Exposure Prophylaxis (PrEP) for HIV 1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines. 2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances. 3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant. ~~3~~4. Our AMA advocates that individuals not be denied any ~~various financial products, including disability~~ insurance~~,~~ on the basis of ~~HIV pre-exposure prophylaxis (PrEP)~~ use. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 101 be adopted as amended.

**HOD ACTION: Resolution 101 adopted as amended with a change in title.**

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 101 be changed to read as follows:

ELIMINATING BARRIERS FOR EVIDENCE-BASED HIV PRE-EXPOSURE PROPHYLAXIS

Resolution 101 asks that our AMA amend Policy H-20.895 by addition to advocate that individuals not be denied various financial products, including disability insurance, on the basis of HIV pre-exposure prophylaxis (PrEP) use.

Testimony was supportive of Resolution 101. Speakers emphasized that insurance denials levied against those who make efforts to protect themselves against contracting HIV are excessively discriminatory. Your Reference Committee agrees and also believes that the language should be amended to apply to insurance products generally, as limitation to financial products is ambiguous. An amendment was offered to broaden the scope of Resolution 101 to include removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant. Your Reference Committee agrees with this amendment, and has amended the resolution accordingly. Your Reference Committee recommends that Resolution 101 be adopted as amended with a change in title.

(11) RESOLUTION 107 - REPEAL AND REPLACE OUR OUTDATED REFUNDABLE ADVANCEABLE TAX CREDIT POLICY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 107.

**HOD ACTION: The following resolution adopted in lieu of Resolution 107.**

~~IMPROVING HEALTH INSURANCE MARKETPLACE AFFORDABILITY, COMPETITION AND STABILIZATION~~

STUDYING MECHANISMS INCLUDING A PUBLIC OPTION TO IMPROVE HEALTH INSURANCE MARKETPLACE AFFORDABILITY, COMPETITION AND STABILIZATION

That our AMA study mechanisms to improve affordability, competition and stability in the individual health insurance marketplace. (Directive to Take Action)

RESOLVED, that our AMA study the feasibility of a public option insurance plan as a model as a part of a pluralistic health care system to improve access to care.

Resolution 107 asks that our AMA study whether our current advanceable refundable tax credit policy is feasible given the worsening health care market failure that has occurred since this policy was developed; and study the feasibility of a Medicare public option model as a model to improve access to care, considering options for modifications to benefits package and cost sharing.

There was mixed testimony on Resolution 107. A member of the Council on Legislation noted that premium tax credits contribute to market stability, rather than instability as suggested in Resolution 107. For example, the Congressional Budget Office (CBO) in May 2017 concluded that the subsidies to purchase coverage provided for under the ACA, combined with the effects of the individual mandate, are anticipated to cause sufficient demand for insurance by enough people, including people with low health care expenditures, for the market to be stable in most areas. The CBO also has found that the ACA's Medicaid expansion has positively impacted health insurance coverage rates. Of note, our AMA already has policy in support of the Medicaid expansion – Policies H-290.997 and D-290.979.

Importantly, a member of the Council on Medical Service testified that the Council is preparing a report for the 2017 Interim Meeting that will address health insurance marketplace stability. Addressing the intent of Resolution 107, your Reference Committee believes a study is warranted of mechanisms to improve affordability, competition and stability in the individual health insurance marketplace. As such, your Reference Committee believes that that the recommended alternate language be adopted in lieu of Resolution 107.

(12) RESOLUTION 108 - OUT-OF-NETWORK INSURANCE BENEFIT AVAILABILITY IN INDIVIDUAL INSURANCE MARKET AND SELF-FUNDED PLANS
RESOLUTION 115 - OUT-OF-NETWORK CARE
RESOLUTION 118 - THIRD PARTY PATIENT REIMBURSEMENT FOR OUT-OF-NETWORK PHYSICIANS
RESOLUTION 127 - BALANCE BILLING STATE REGULATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolutions 108, 115, 118 and 127.

**HOD ACTION: The following resolution adopted in lieu of Resolutions 108, 115, 118 and 127.**

OUT-OF-NETWORK CARE

RESOLVED, That our AMA reaffirm Policies H-165.839, H-373.998, H-285.911 and H-285.908 (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA adopt the following principles related to ~~unexpected~~ unanticipated out-of-network care:
1. Patients must not be financially penalized for receiving ~~unexpected~~ unanticipated care from an out-of-network provider.

2. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
3. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
4. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
5. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
6. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
7. ~~In lieu of balance billing of patients in these circumstances, a m~~Minimum coverage standards for ~~unexpected~~ unanticipated out-of-network services should be identified. ~~The m~~Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary ~~being~~ based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
8. ~~Physician triggered m~~Mediation should be permitted in those instances where ~~their~~ a physician's unique background or skills (~~i.e.~~ e.g. the Gould Criteria) are not accounted for within a minimum coverage standard. (New HOD Policy); and be it further

RESOLVED, That our AMA develop model state legislation addressing the coverage of and payment for ~~unexpected~~ unanticipated out-of-network care. (Directive to Take Action)

Resolution 108 asks that our AMA seek the availability of out-of-network benefits for all federally sponsored health insurance plans, federal exchange, and/or self-funded plans including plans utilizing usual, customary and reasonable (UCR) payment methodology.

Resolution 115 asks that our AMA adopt a series of principles related to unexpected out-of-network care; and reaffirm Policies H-185.939, H-450.941 and D-285.972.

Resolution 118 asks that our AMA policy seek to require insurers and third-party payors to properly reimburse patients and/or out-of-network physicians their usual charges, and that there be no increase in deductibles or co-payments for those patients requiring care from out-of-network physicians because of urgent and emergent treatment needed in emergency rooms and hospitals and/or seek federal legislation addressing these issues.

Resolution 127 asks that our AMA report on the status of the various current efforts across the country, including the many state legislative efforts, to limit non-Medicare balance billing; develop model state legislation to assist its component members in their advocacy efforts against current efforts to regulate balance billing; and report back to the House of Delegates at the 2017 Interim Meeting according to AMA Policy D-380.996.

Your Reference Committee heard generally supportive testimony on Resolution 115 and the recommendation of Resolution 127 calling for model state legislation, and mixed testimony regarding Resolutions 108 and 118. Your Reference Committee believes that existing AMA policy, as well as the alternate language proposed by the Reference Committee based on Resolution 115, addresses the issues highlighted in Resolutions 108 and 118. As such, your Reference Committee is recommending the reaffirmation of Policies H-165.839, H-373.998, H-285.911 and H-285.908. An eight principle also has been added, which states that physician-triggered mediation should be permitted in those instances where their unique background or skills (i.e. the Gould Criteria) are not accounted for within a minimum coverage standard. The Gould criteria are used to determine the reasonable and customary value of non-contracted services, and consider a provider's training, qualification and length of practice.

Concerning Resolution 115, on which the proposed alternate language is based, a member of the Council on Legislation noted that with more than 20 bills this year in the states, most using problematic payment standards that would undermine fair contracting efforts and cap physician payment below market rates, the AMA was not able, due to existing policy, to fully support proactive solutions or develop our own proposals. In addition, many state medical societies worked with national and state medical specialty societies on proposals to equitably and fairly solve the issue of so-called "surprise billing," and many of those proposals reflected the goal of Resolution 115 – establishing a fair payment standard in lieu of being able to send that surprise bill. Your Reference Committee appreciates the amendment proffered to the seventh principle of Resolution 115, and added language to ensure that the intent of Resolution 115 was not lost, and that the intent of the seventh principle of Resolution 115 would not be scaled back to merely a reaffirmation of existing policy.

Overall, your Reference Committee believes that the intent of Resolution 115 provides the AMA with a strong pathway forward on out-of-network care, "surprise billing," and balance billing. Your Reference Committee agrees with testimony that suggested that this issue is due to an insurance market failure, and that the proposed policy in

Resolution 115 is a fair solution that protects patients from financially burdensome "surprise" balance bills, while also ensuring that incentives for insurers to offer fair contracts to hospital-based physicians are in place. Your Reference Committee believes that it is incredibly important and noteworthy that impacted national medical specialty societies, as well as several states with experience dealing with this legislative issue, have come together to support new policy that allows for proactive advocacy. Your Reference Committee also agrees with testimony that stated that Resolution 115 offers a much-needed unified message for medicine and allows the AMA to be proactive in these debates at the state level. Your Reference Committee understands testimony that emphasized that without stronger and more unified advocacy, troubling policies will likely be enacted.

At the same time, your Reference Committee heard mixed testimony on the AMA having policy that could support a bar on balance billing in the hospital setting. But, your Reference Committee believes that the seventh principle of Resolution 115, as incorporated into the proposed alternate language, would allow the AMA to support proactive solutions in the states that benefit both patients and physicians. Also, of note, nothing in the alternate language would permit the AMA to come into and offer this policy in a state, for example, where the medical societies believe they can maintain the right to balance bill or where they do not want to engage in this manner. Your Reference Committee believes that alternate language that incorporates the intent of Resolutions 108, 115, 118 and 127 would provide the AMA with additional strong and proactive policy on the issues of out-of-network care, "surprise billing," and balance billing, and believes that such alternate language should be adopted in lieu of the resolutions.

> H-165.839 Health Insurance Exchange Authority and Operation
> 1. Our American Medical Association adopts the following principles for the operation of health insurance exchanges: A) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features. B) Any benefits standards implemented for plans participating in the exchange and/or to determine minimum creditable coverage for an individual mandate should be designed with input from patients and actively practicing physicians. C) Physician and patient decisions should drive the treatment of individual patients. D) Actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options. E) Regulations addressing physician participation in public, private or non-profit health insurance options in the exchange that impact physician practice should ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process. F) Any necessary federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices. 2. Our AMA: (A) supports using the open marketplace model for any health insurance exchange, with strong patient and physician protections in place, to

increase competition and maximize patient choice of health plans, (B) will advocate for the inclusion of actively practicing physicians and patients in health insurance exchange governing structures and against the categorical exclusion of physicians based on conflict of interest provisions; (C) supports the involvement of state medical associations in the legislative and regulatory processes concerning state health insurance exchanges; and (D) will advocate that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information. (CMS Rep. 3, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 105, A-10; Appended: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 812, I-13; Reaffirmed: Sub. Res. 813, I-13)

H-373.998 Patient Information and Choice
Our AMA supports the following principles: 1. Greater reliance on market forces, with patients empowered with understandable fee/price information and incentives to make prudent choices, and with the medical profession empowered to enforce ethical and clinical standards which continue to place patients' interests first, is clearly a more effective and preferable approach to cost containment than is a government-run, budget-driven, centrally controlled health care system. 2. Individuals should have freedom of choice of physician and/or system of health care delivery. Where the system of care places restrictions on patient choice, such restrictions must be clearly identified to the individual prior to their selection of that system. 3. In order to facilitate cost-conscious, informed market-based decision-making in health care, physicians, hospitals, pharmacies, durable medical equipment suppliers, and other health care providers should be required to make information readily available to consumers on fees/prices charged for frequently provided services, procedures, and products, prior to the provision of such services, procedures, and products. There should be a similar requirement that insurers make available in a standard format to enrollees and prospective enrollees information on the amount of payment provided toward each type of service identified as a covered benefit. 4. Federal and/or state legislation should authorize medical societies to operate programs for the review of patient complaints about fees, services, etc. Such programs would be specifically authorized to arbitrate a fee or portion thereof as appropriate and to mediate voluntary agreements, and could include the input of the state medical society and the AMA Council on Ethical and Judicial Affairs. 5. Physicians are the patient advocates in the current health system reform debate. Efforts should continue to seek development of a plan that will effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients' freedom to select physicians and/or health plans of their choice. 6. Efforts should continue to vigorously pursue with Congress and the Administration the strengthening of our health care system for the benefit of all patients and physicians by advocating policies that put patients, and the patient/physician relationships, at the forefront. (BOT Rep. QQ, I-91; Reaffirmed: BOT Rep. TT, I-92; Reaffirmed: Ref. Cmte. A, A-93; Reaffirmed: BOT Rep. UU, A-93; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: CMS Rep. G, A-93; Reaffirmed: Sub. Res. 701, A-93; Sub. Res. 125, A-93; Reaffirmation A-93; Reaffirmed: BOT Rep. 25, I-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: CMS Rep. 5, I-93; Reaffirmed: CMS Rep. 10, I-93; Reaffirmed: Sub. Res. 107, I-93; Reaffirmed: BOT Rep. 46, A-94; Reaffirmed: Sub. Res. 127,

A-94; Reaffirmed: Sub. Res. 132, A-94; Reaffirmed: BOT Rep. 16, I-94; BOT Rep. 36 - I-94; Reaffirmed: CMS Rep. 8, A-95; Reaffirmed: Sub. Res. 109, A-95; Reaffirmed: Sub. Res. 125, A-95; Reaffirmed by Sub. Res. 107, I-95; Reaffirmed: Sub. Res. 109, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmation A-96; Reaffirmation I-96; Reaffirmation A-97; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMS Rep. 3, I-97; Reaffirmation I-98; Reaffirmed: CMS Rep. 9, A-98; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-04; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 4, A-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmation I-14; Reaffirmed: CMS Rep. 4, A-15)

H-285.911 Health Insurance Safeguards
Our AMA will advocate that health insurance provider networks should be sufficient to provide meaningful access to subscribers, for all medically necessary and emergency care, at the preferred, in-network benefit level on a timely and geographically accessible basis. (CMS Rep. 8, A-10; Reaffirmed in lieu of Res. 815, I-13; Reaffirmation I-15)

H-285.908 Network Adequacy
1. Our AMA supports state regulators as the primary enforcer of network adequacy requirements. 2. Our AMA supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. Physicians may be added to the network at any time. 3. Our AMA supports requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy, including the number and type of providers that have joined or left the network; the number and type of specialists and subspecialists that have left or joined the network; the number and types of providers who have filed an in network claim within the calendar year; total number of claims by provider type made on an out-of-network basis; data that indicate the provision of Essential Health Benefits; and consumer complaints received. 4. Our AMA supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities. 5. Our AMA advocates for regulation and legislation to require that out-of-network expenses count toward a participant's annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies. 6. Our AMA supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities. 7. Our AMA supports health insurers paying out-of-network physicians fairly and equitably for emergency and out-of-network bills in a hospital. AMA policy is that any legislation which addresses this issue should assure that insurer payment for such care be based upon a number of factors, including the physicians' usual charge, the usual and customary charge for such service, the circumstances of the care and the expertise of the particular physician. 8. Our AMA provides

assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure physicians and patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks. 9. Our AMA supports the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities.10. Our AMA advocates for legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited. 11. Our AMA advocates that health plans should be required to document to regulators that they have met requisite standards of network adequacy including hospital-based physician specialties (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible. (CMS Rep. 4, I-14; Reaffirmation I-15; Reaffirmed in lieu of Res. 808, I-15; Modified: Sub. Res. 811, I-15)

(13) RESOLUTION 111 - VA TECHNOLOGY-BASED EYE CARE SERVICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 111 be amended by addition of a new Resolve to read as follows:

That our AMA reaffirm Policy H-480.946. (Reaffirm HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 111 be adopted as amended.

**HOD ACTION: Resolution 111 adopted as amended.**

Resolution 111 asks that our AMA encourage the Department of Veterans Affairs to continue to explore telemedicine approaches that increase access to quality health care to U.S. Veterans, including the Technology-Based Eye Care Services (TECS) program; and work with Congress to ensure that U.S. Veterans can access eye care through the Technology-Based Eye Care Services (TECS) program.

There was generally supportive testimony on Resolution 111. A speaker underscored that VA telehealth services must provide appropriate care; in response, your Reference Committee is recommending the reaffirmation of Policy H-480.946, which outlines principles to guide the coverage of and payment for telemedicine. In particular, the principles state that the standards and scope of telemedicine services should be consistent with related in-person services, and that the delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to

ensure patient safety, quality of care and positive health outcomes. Your Reference Committee recommends that Resolution 111 be adopted as amended.

H-480.946 Coverage of and Payment for Telemedicine
1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles: a) A valid patient-physician relationship must be established before the provision of telemedicine services, through: - A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or - A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or - Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology. Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services. b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services. c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board. d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services. e) The delivery of telemedicine services must be consistent with state scope of practice laws. f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit. g) The standards and scope of telemedicine services should be consistent with related in-person services. h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes. i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine. j) The patient's medical history must be collected as part of the provision of any telemedicine service. k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient. l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record. m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services. 2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information. 3. Our AMA encourages additional research to develop a

stronger evidence base for telemedicine. 4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine. 5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models. 6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service. 7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines. (CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed in lieu of Res. 815, I-15; Reaffirmed: CME Rep. 06, A-16; Reaffirmed: CMS Rep. 06, I-16)

(14) RESOLUTION 114 - COVERAGE FOR PREVENTIVE CARE AND IMMUNIZATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 114 be adopted as amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate that all public and private payers be required to provide first dollar coverage of ~~identify as policy that~~ routine preventive pediatric care, as recommended by the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP), and immunizations, as recommended by the Centers for Disease Control and Prevention, ~~with approval of the~~ AAP and AAFP ~~American Academy of Family Physicians, be a required benefit of any public or private health insurance product and that it has first dollar coverage, without copays or deductibles~~. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 114 be adopted as amended.

**HOD ACTION: Resolution 114 adopted as amended.**

Resolution 114 asks that our AMA identify as policy that routine preventive pediatric care, as recommended by the American Academy of Pediatrics (AAP), and immunizations, as recommended by the Centers for Disease Control and Prevention with approval of the AAP and American Academy of Family Physicians, be a required

benefit of any public or private health insurance product and that it has first dollar coverage, without copays or deductibles.

There was positive testimony on Resolution 114. Speakers emphasized the need to remove all financial barriers to pediatric preventive care. Some recommended that all routine preventive care should receive first dollar coverage; however, others cautioned against expanding the scope of the resolution to include preventive care for adults because doing so could make health insurance premiums unaffordable. Your Reference Committee agrees that the resolution should remain specific to pediatric care and notes that several existing policies address this subject: Policy H-165.846 advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children; Policy H-185.969 urges insurance coverage for immunization with no co-pays or deductibles; Policy H-440.992 states that there should be no financial barrier to immunization of children; and Policy H-290.972 advocates for first-dollar coverage of preventive services for Medicaid beneficiaries. Your Reference Committee also recommends amendment to provide greater clarity.

(15) RESOLUTION 116 - MEDICARE ADVANTAGE PAYMENT POLICIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 116 be <u>amended by addition of a new Resolve</u> to read as follows:

<u>RESOLVED, That our AMA reaffirm Policy D-330.923, which encourages the Centers for Medicare & Medicaid Services to award Medicare Advantage Programs to those health plans where physician payment rates are no less than Medicare Fee for Service rates. (Reaffirm HOD Policy)</u>

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 116 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our American Medical Association ~~urge the Centers for Medicare and Medicaid Services (CMS) to require~~ support that Medicare Advantage plans must provide enrollees with coverage for, at a minimum, all Part A and Part B original Medicare services, if the enrollee is entitled to benefits under both parts. ~~to abide by all traditional Medicare Fee-for-Service payment and medical policies when reimbursing physicians on a fee-for-service basis to ensure uniformity in Medicare benefits and to reduce physician burdens. This policy is not intended to impact capitation rates that are agreed to between a Medicare Advantage plan and a physician or physician organization.~~ (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 116 be adopted as amended.

**HOD ACTION: Resolution 116 adopted as amended with a change in title.**

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the title of Resolution 116 be changed to read as follows:

MEDICARE ADVANTAGE POLICIES

Resolution 116 asks that our AMA urge the Centers for Medicare and Medicaid Services (CMS) to require Medicare Advantage plans to abide by all traditional Medicare Fee-for-Service payment and medical policies when reimbursing physicians on a fee-for-service basis to ensure uniformity in Medicare benefits and to reduce physician burdens. The resolution stipulates that this policy is not intended to impact capitation rates that are agreed to between a Medicare Advantage plan and a physician or physician organization.

Your Reference Committee heard limited, mixed testimony on Resolution 116. The resolution asks the AMA to urge the CMS to require Medicare Advantage plans to abide by all traditional Medicare fee-for-service payment and medical policies when reimbursing physicians on a fee-for-service basis. However, your Reference Committee notes that this is already clearly stated in the Medicare Managed Care Manual (Chapter 4):

> 10.2 – Basic Rule (Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16) A Medicare Advantage Organization (MAO) offering a Medicare Advantage (MA) plan must provide enrollees in that plan with all Part A and Part B original Medicare services, if the enrollee is entitled to benefits under both parts, and Part B services if the enrollee is a grandfathered "Part B only"

enrollee. The MAO fulfills its obligation of providing original Medicare benefits by furnishing the benefits directly, through arrangements, or by paying for the benefits on behalf of enrollees.

Your Reference Committee agrees that adopting a broad policy statement that would support this existing Medicare payment policy would be prudent. Testimony attested that following the Medicare services guidelines should be a floor not a ceiling in regard to services and payment. Your Reference Committee believes that Policy D-330.923 addresses the payment issues raised in this resolution by stating that MA programs should be awarded only to those health plans where "physician payment rates are no less than Medicare Fee for Service rates." For these reasons, your Reference Committee recommends that Resolution 116 be adopted as amended.

D-330.923 Medicare Advantage Plans
Our AMA encourages the Centers for Medicare & Medicaid Services to award Medicare Advantage Programs only to those health plans that meet all of the following criteria: (1) an 85% or higher medical loss ratio; (2) physician payment rates are no less than Medicare Fee for Service rates; and (3) use enforceable contracts that prohibit unilateral changes in physician payment rates. (Res. 837, I-08)

(16) RESOLUTION 123 - IMPROVING THE PREVENTION OF COLON CANCER BY INSURING THE WAIVER OF THE CO-PAYMENT IN ALL CASES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 123 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA reaffirm Policies H-165.840, H-185.954, H-185.960, H-425.987 and H-425.992 (Reaffirm HOD Policy); and be it further

~~RESOLVED, That our American Medical Association strongly advocate that all approved preventive services be included in all health plans (New HOD Policy); and be it further~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 123 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support requiring Medicare to waive the coinsurance for colorectal screening tests, including therapeutic intervention(s) required during the procedure ~~strongly urge members of the Congress and the President to support legislation to correct the oversight in the original legislation providing the benefit of colonoscopy screening with the inducement that the copay would not be required when a polyp or other lesion is found as part of the screening process~~. (New HOD Policy ~~Directive to Take Action~~)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 123 be adopted as amended.

**HOD ACTION: Resolution 123 adopted as amended.**

Resolution 123 asks that our AMA strongly advocate that all approved preventive services be included in all health plans; and strongly urge members of the Congress and the President to support legislation to correct the oversight in the original legislation providing the benefit of colonoscopy screening with the inducement that the copay would not be required when a polyp or other lesion is found as part of the screening process.

There was generally supportive testimony on Resolution 123. Members of the Council on Medical Service cited policies on preventive service coverage, and raised concerns with the wording of the first Resolve. Your Reference Committee agrees that existing policy addresses the intent of the first Resolve, and as such recommends the reaffirmation of Policies H-165.840, H-185.954, H-185.960, H-425.987 and H-425.992 in lieu of the first Resolve. In addition, your Reference Committee amended the second Resolve to align with AMA advocacy efforts to date. AMA advocacy efforts have called for requiring Medicare to waive the coinsurance for colorectal screening tests, regardless of whether therapeutic intervention is required during the procedure. For example, as noted in testimony, the AMA submitted letters to sponsors of relevant legislation in both the House of Representatives and the Senate.

H-165.840 Preventive Medical Care Coverage for All
Our AMA advocates for (1) health care reform that includes evidence-based prevention insurance coverage for all; (2) evidence-based prevention in all appropriate venues, such as primary care practices, specialty practices, workplaces and the community. (Res. 827, I-08; Reaffirmed in lieu of Res. 107, A-12)

H-185.954 Coverage for Certain Types of Well Care Examinations by Health Insurers

Our AMA: (1) will continue to facilitate the education of the American public and physicians as to the benefits of clinical preventive services, such as mammography screening and periodic physical examinations; (2) will continue to evaluate on a regular basis the benefits and cost-effectiveness of clinical preventive services guidelines; and (3) urges all health insurers to make available for purchase a wide variety of group and individual health insurance policies that provide coverage for a range of clinical preventive services. (Sub. Res. 108, A-97; Modified: CMS Rep. 7, A-00; Reaffirmed: CMS Rep. 3, A-02; Renumbered: CMS Rep. 7, I-05; Reaffirmed in lieu of Res. 107, A-12)

H-185.960 Support for the Inclusion of the Benefit for Screening for Colorectal Cancer in All Health Plans
Our AMA supports health plan coverage for the full range of colorectal cancer screening tests. (Res. 726, I-04; Reaffirmation I-07)

H-425.987 Preventive Medicine Services
1. Our AMA supports (A) continuing to work with the appropriate national medical specialty societies in evaluating and coordinating the development of practice parameters, including those for preventive services; (B) continuing to actively encourage the insurance industry to offer products that include coverage for general preventive services; and (C) appropriate reimbursement and coding for established preventive services. 2. Our AMA will seek legislation or regulation so that evidence-based screenings are paid for separately when provided as part of a comprehensive well-patient examination/review. (CMS Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-07; Reaffirmed and Appended: Res. 804, I-11; Reaffirmed in lieu of Res. 107, A-12)

H-425.992 Coverage of Preventive Medical Services by Medicare
The AMA advocates revision of current Medicare guidelines to include coverage of appropriate preventive medical services. (Res. 85, A-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmation A-99; Reaffirmed in lieu of Res. 104, A-06; Reaffirmation A-07; Reaffirmation I-07)

(17) RESOLUTION 124 - EMERGENCY MEDICAL SERVICES REIMBURSEMENT FOR ON-SITE TREATMENT AND TRANSPORT TO NON-TRADITIONAL DESTINATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 124 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our American Medical Association amend ~~existing AMA~~ Policy H-240.978, “Medicare's Ambulance Service Regulations,” by <u>addition and deletion</u> to read as follows:

The AMA supports changes in Medicare regulations governing ambulance service coverage guidelines that would expand the term "appropriate facility" to allow full payment for transport to ~~facilities other than the closest based upon the physician's judgment~~ the most appropriate facility based on the patient's needs and the determination made by physician medical direction; and expand the list of eligible transport locations from the current three sites of care (nearest hospital, critical access hospital, or skilled nursing facility) based upon the on-site evaluation and ~~consulting physician's~~ physician medical direction (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA work with the Centers for Medicare & Medicaid Services (CMS) to ~~reimburse~~ pay emergency medical services providers for the evaluation and transport of patients to the most ~~current~~ appropriate ~~next~~ site of care ~~rather than only~~ not limited to the current CMS defined ~~and limited~~ transport locations.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 124 be adopted as amended.

**HOD ACTION: Resolution 124 adopted as amended with a change in title.**

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 124 be changed to read as follows:

EMERGENCY MEDICAL SERVICES PAYMENT FOR ON-SITE TREATMENT AND TRANSPORT TO NON-TRADITIONAL DESTINATIONS

Resolution 124 asks that our AMA amend Policy H-240.978 by addition to support expanding the list of eligible transport locations from the current three sites of care (nearest hospital, critical access hospital, or skilled nursing facility) based upon the on-site evaluation and consulting physician's judgement; and work with the Centers for Medicare and Medicaid Services (CMS) to reimburse emergency medical services providers for the evaluation and transport of patients to the appropriate next site of care rather than only to CMS defined and limited transport locations.

Your Reference Committee heard limited testimony in support of Resolution 124. Testimony asserted that the current limited list of eligible transport locations impedes care. A speaker offered amended language in response to concerns regarding the consulting physician. Your Reference Committee accepts the amendment and further

recommends a change from the term “reimbursement” to “payment.” For these reasons, your Reference Committee recommends that Resolution 124 be adopted as amended.

(18) RESOLUTION 125 - MEDICAID SUBSTANCE USE DISORDER COVERAGE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 125 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~work with~~ advocate that the Centers for Medicare and Medicaid Services (CMS) ~~to~~ provide expanded Medicaid payment coverage for the medical management and treatment of all substance use disorders (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 125 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate for ~~work with CMS to establish~~ clear billing and coding processes regarding the medical management and treatment of all substance use disorders. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 125 be amended by addition of a new Resolve to read as follows:

RESOLVED, That our AMA recognize the expertise of addiction specialist physicians and the importance of improving access to management and treatment of addiction services with Medicaid payment for all physician specialties. (New HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 125 be amended by addition of a new Resolve to read as follows:

RESOLVED, That our AMA reaffirm Policy H-320.945, which opposes abuse of prior authorization. (Reaffirm HOD Policy)

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 125 be adopted as amended.

**HOD ACTION: Resolution 125 adopted as amended.**

Resolution 125 asks that our AMA work with the Centers for Medicare and Medicaid Services (CMS) to provide expanded Medicaid payment coverage for the medical management and treatment of all substance use disorders; and work with CMS to establish clear billing and coding processes regarding the medical management and treatment of all substance use disorders.

There was supportive testimony on Resolution 125. Testimony stressed the need for improved access to and additional providers of substance use disorder treatment and that Medicaid payment policies hinder access to care. An amendment was offered to advocate for the elimination of prior authorization requirements that impede care; however, your Reference Committee believes that existing policy addresses the intent of the amendment. As such, your Reference Committee recommends the reaffirmation of Policy H-320.945, which opposes abuse of prior authorization. An amendment was also offered that would affirm the expertise of addiction medicine specialists and call for payment policies that do not preclude payment on the basis of physician specialty. Your Reference Committee agrees with the intent of the amendment and also recommends additional amendments to clarify the intent of the resolution. In particular, your Reference Committee notes that states and Medicaid managed care plans, in addition to CMS, set billing processes and recommends language to be inclusive of those entities. Accordingly, your Reference Committee recommends Resolution 125 be adopted as amended.

H-320.945 Abuse of Preauthorization Procedures
Our AMA opposes the abuse of preauthorization by advocating the following positions: (1) Preauthorization should not be required where the medication or procedure prescribed is customary and properly indicated, or is a treatment for the clinical indication, as supported by peer-reviewed medical publications or for a patient currently managed with an established treatment regimen. (2) Third parties should be required to make preauthorization statistics available, including the percentages of approval or denial. These statistics should be provided by various categories, e.g., specialty, medication or diagnostic test/procedure, indication offered, and reason for denial. (Sub. Res. 728, A-10; Reaffirmation I-10; Reaffirmation A-11; Reaffirmed: Res. 709, A-12)

(19) RESOLUTION 126 - INSURANCE COVERAGE FOR COMPRESSION STOCKINGS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 126 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support ~~engage all relevant stakeholders in ensuring unconditional~~ Medicare ~~compensation~~ payment for gradient compression stockings as prescribed by a physician under Medicare benefits coverage ~~the durable medical equipment portion of coverage, including for cases of preventative use and for patients without a present venous stasis ulcer~~. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 126 be adopted as amended.

**HOD ACTION: Resolution 126 adopted as amended.**

Resolution 126 asks that our AMA engage all relevant stakeholders in ensuring unconditional Medicare compensation for gradient compression stockings as prescribed by a physician under the durable medical equipment portion of coverage, including for cases of preventative use and for patients without a present venous stasis ulcer.

There was generally supportive testimony on Resolution 126. An amendment was offered to specify that Medicare pay for gradient compression stockings under Medicare benefits coverage. Your Reference Committee agrees with the amendment, and as such recommends that Resolution 126 be adopted as amended.

(20) RESOLUTION 110 - OVER-THE-COUNTER CONTRACEPTIVE DRUG ACCESS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 110 be referred.

**HOD ACTION: Resolution 110 referred.**

Resolution 110 asks that our AMA condemn age-based, cost-based, and other non-medical barriers to contraceptive drug access; adopt policy supporting equitable access to over-the-counter (OTC) contraception, including those forms of contraception recommended for OTC sale, patient risk assessment screening tools, and prescribing by non-physicians; support policy solutions that prohibit cost-sharing obstacles to OTC contraceptive drug access, and full coverage of all contraception without regard to prescription or OTC utilization, since all contraception is essential preventive health care; and advocate for the legislative and/or regulatory mechanisms needed to achieve improvements for OTC contraceptive drug access and quality.

Testimony on Resolution 110 was mixed. Testimony was supportive of the general intent to increase access to contraception and many speakers emphasized that contraception is safe and effective and that increased access to contraceptives would benefit patients, especially disadvantaged patient populations. Testimony was in favor of language in support of first dollar coverage of contraception. However, testimony also raised several concerns. Some emphasized that because there are no contraceptives currently available OTC, the resolution may be premature. Other concerns were raised that some age-based barriers to contraception drug access are appropriate. Other testimony emphasized that patients should not self-screen for contraception and physician judgement is needed to prescribe the appropriate form of contraception. Amendment was offered to remove language to advocate for access to OTC contraception prescribed by non-physicians.

Your Reference Committee believes that while increasing access to contraception in all forms is important, complex issues were raised that deserve further study. Accordingly, your Reference Committee recommends that Resolution 110 be referred.

(21) RESOLUTION 103 - BENEFIT PAYMENT SCHEDULE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-385.987 be reaffirmed in lieu of Resolution 103.

**HOD ACTION: Policy H-385.987 reaffirmed in lieu of Resolution 103.**

Resolution 103 asks that our AMA adopt as policy a definition of “Benefit Payment Schedule plan,” and support the inclusion of Benefit Payment Schedule plans as one option in a pluralistic system of health care financing.

There was mixed testimony on Resolution 103, including a call for reaffirmation. Your Reference Committee notes that the definition of “Benefit Payment Schedule plan” outlined in Resolution 103 is consistent with that of an indemnity payment system, to which there is already AMA policy directly applicable. In addition, your Reference Committee notes that the term “indemnity payment system” is used and widely understood by health care and other stakeholders outside of our AMA. Your Reference Committee agrees with testimony that stated that existing AMA policy appropriately responds to the issues raised in Resolution 103, and as such recommends that Policy H-385.987 be reaffirmed in lieu of Resolution 103.

> H-385.987 Support for Indemnity Payment System
> The AMA reaffirms its support for the validity of the indemnity payment system as one of a pluralistic approach to payment methods, and supports implementation of the indemnity payment system as a preferred policy at the national level as is appropriate and feasible. (Res. 65, A-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: Res. 105, A-99; Reaffirmed: CMS Rep. 5, A-09)

(22) RESOLUTION 106 - MEDICAL LOSS RATIO

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-155.959, D-155.993 and H-320.968 be reaffirmed in lieu of Resolution 106.

**HOD ACTION: Policies H-155.959, D-155.993 and H-320.968 reaffirmed in lieu of Resolution 106.**

Resolution 106 asks that our AMA encourage medical insurance companies to change the term "Medical Loss Ratio" to "Medical Benefit Ratio" and that insurance companies define the elements comprising the “Medical Benefit Ratio;” and advocate that in the interest of full transparency, health financing plans, including insurance, prepaid care and value based payment models, should be required to publish their Medical Benefit Ratios.

There was mixed testimony on Resolution 106. Testimony noted that our AMA already has a strong policy foundation addressing medical loss ratios. As a result, the AMA has been engaged in federal advocacy on this issue, as well as at the National Association of Insurance Commission (NAIC), with our AMA continuing to be part of a medical loss ratio workgroup at NAIC. In addition, testimony noted that the term “medical loss ratio” is defined at the federal and state levels in numerous statutes and regulations – insurers cannot change the name of the requirement. Your Reference Committee also believes that Resolution 106 may have unintended consequences, as advocating for the use of the term “medical benefit ratio” may undermine AMA advocacy on this issue. Overall, your Reference Committee believes that existing AMA policy appropriately responds to the issues raised in Resolution 106. In particular, AMA policy prioritizes health plans

clearly and concisely disclosing their medical loss ratios to prospective enrollees, consistent with the intent of Resolution 106 to make medical loss ratios more patient-centric. As such, your Reference Committee recommends that Policies H-155.959, Policy D-155.993 and H-320.968 be reaffirmed in lieu of the resolution.

H-155.959 Legislation to Reduce Administrative Waste in Health Insurance by Accurate Reporting of Medical Expense Ratios
AMA policy is that private health plans should be required to report data related to administrative costs, expenses and rate setting to appropriate state regulatory bodies to allow for the calculation of medical expense ratios to be consistent on the state level. (Res. 727, A-08)

D-155.993 Legislation to Reduce Administrative Waste in Health Insurance by Accurate Reporting of Medical Expense Ratios
Our AMA: (1) will develop model state legislation and regulations that would require that all private health plans make publicly available annually, and publish separately, their medical care costs and their administrative costs, using the format called for in AMA Policy H 155.963; (2) supports state legislation to require that all private health plans make publicly available annually, and publish separately, their medical care costs and their administrative costs; and (3) supports the development and implementation of a uniform, national accounting and reporting system to report administrative expenses and medical expense ratios as part of greater, national uniformity of market regulation. (Res. 727, A-08)

H-320.968 Approaches to Increase Payer Accountability
Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability. **(1) Disclosure Requirements. Our AMA supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on** (a) coverage provisions, benefits, and exclusions; (b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient; **(d) medical expense ratios;** and (e) cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97) (2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review; (c) Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an

opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay. (3) Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above. (BOT Rep. M, I-90; Reaffirmed by Res. 716, A-95; Reaffirmed by CMS Rep. 4, A-95; Reaffirmation I-96; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMS Rep. 13 , I-98; Reaffirmation I-98; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-00; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation A-09; Reaffirmed: Sub. Res. 728, A-10; Modified: CMS Rep. 4, I-10; Reaffirmation A-11; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 07, A-16)

(23) RESOLUTION 109 - SIMPLIFY MEDICARE FACE TO FACE REQUIREMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy D-330.914 be reaffirmed in lieu of Resolution 109.

**HOD ACTION: Policy D-330.914 reaffirmed in lieu of Resolution 109.**

Resolution 109 asks that our AMA advocate to simplify the Medicare requirements for a "Face to Face" visit with a patient by a physician as a precondition for Medicare home health coverage, including advocating for alternatives for such "Face to Face" visit such as by telehealth.

Mixed testimony was heard on Resolution 109. Testimony from the Council on Medical Service recognized that CMS Report 3-I-12, "Face-to-Face Encounter Rule," addressed this topic. While several speakers raised concerns about telehealth issues and requested referral, the author testified that this was not intended to be a telehealth issue. Your Reference Committee believes that existing AMA policy appropriately responds to the issues raised in Resolution 109, and as such recommends that Policy D-330.914 be reaffirmed in lieu of Resolution 109.

D-330.914 Face-to-Face Encounter Rule
1. Our AMA will: (A) work with the Centers for Medicare & Medicaid Services (CMS) and appropriate national medical specialty societies to ensure that physicians understand the alternative means of compliance with and payment policies associated with Medicare's face-to-face encounter policies, including those required for home health, hospice and durable medical equipment; (B) work with CMS to continue to educate home health agencies on the face-to-face documentation required as part of the certification of eligibility for Medicare home health services to ensure that the certification process is streamlined and minimizes paperwork burdens for practicing physicians; and (C) continue to monitor legislative and regulatory proposals to modify Medicare's face-to-face encounter policies and work to prevent any new unfunded mandatory administrative paperwork burdens for practicing physicians. 2. Our AMA will work with CMS to enable the use of HIPAA-compliant telemedicine and video monitoring services to satisfy the face-to-face requirement in certifying eligibility for Medicare home health services. (CMS Rep. 3, I-12; Appended Res. 120, A-14)

(24) RESOLUTION 121 - ADVANCED CARE PLANNING CODES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-70.919, H-85.956 and H-140.845 be reaffirmed in lieu of Resolution 121.

**HOD ACTION: Policies H-70.919, H-85.956 and H-140.845 reaffirmed in lieu of Resolution 121.**

Resolution 121 asks that our AMA assess the degree of use of CPT Codes 99497 and 99498 since they were established; study the barriers to discussion about advanced care planning by physicians and patients; and advocate for the expanded use of CPT Codes 99497 and 99498 when sufficient time and effort is spent in face-to-face contact with patients and families and when spread out over multiple clinical visits in order to satisfy the time requirements, due to the complexity of the subject matter.

Your Reference Committee heard limited testimony in support of Resolution 121. Testimony attested to the value of the advance care planning CPT codes and to the AMA/Specialty Society RVS Update Committee (RUC) support of the creation and payment of these codes in 2014-15. It was noted that the request in the first Resolve has been accomplished in that Medicare utilization data is available for CPT codes 99497

and 99498. In 2016, the codes were reported 619,658 and 11,982 times, respectively. The third Resolve asks the AMA to advocate for expanded use of these codes. Your Reference Committee stresses that any changes to code definitions would have to be requested through a code change proposal using the established CPT process that is outlined in Policy H-70.919. Interpretations of current CPT code definitions should also be obtained through the CPT process.

Finally, while testimony supported the spirit of the resolution, your Reference Committee concurs that there is extensive AMA policy to support and encourage the use of advance directives. Most recently, BOT Report 5-I-16 addressed this issue in the context of the IOM "Dying in America" report. Therefore, the report that is requested in the second resolve clause has been accomplished. As such, your Reference Committee recommends that Policies H-70.919, H-140.845 and H-85.956 be reaffirmed in lieu of Resolution 121.

H-70.919 Use of CPT Editorial Panel Process
Our AMA reinforces that the CPT Editorial Panel is the proper forum for addressing CPT code set maintenance issues and all interested stakeholders should avail themselves of the well-established and documented CPT Editorial Panel process for the development of new and revised CPT codes, descriptors, guidelines, parenthetic statements and modifiers.

H-140.845 Encouraging the Use of Advance Directives and Health Care Powers of Attorney
Our AMA will: (1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies; (2) encourage nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility; (3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD); (4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas; (7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license; (8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our

current AMA policies and legislative priorities on advance directives; (9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (11) advocate for the implementation of secure electronic advance health care directives. (CCB/CLRPD Rep. 3, A-14; Reaffirmed: BOT Rep. 9, I-15; Reaffirmed: Res. 517, A-16; Reaffirmed: BOT Rep. 05, I-16)

H-85.956 Educating Physicians About Advance Care Planning

Our AMA: (1) will continue efforts to better educate physicians in the skills necessary to increase the prevalence and quality of meaningful advance care planning, including the use of advance directives, and to improve recognition of and adherence to a patient's advance care decisions; (2) supports development of materials to educate physicians about the requirements and implications of the Patient Self-Determination Act, and supports the development of materials (including, but not necessarily limited to, fact sheets and/or brochures) which physicians can use to educate their patients about advance directives and requirements of the Patient Self-Determination Act; (3) encourages residency training programs, regardless of or in addition to current specialty specific ACGME requirements, to promote and develop a high level of knowledge of and ethical standards for the use of such documents as living wills, durable powers of attorney for health care, and ordering DNR status, which should include medical, legal, and ethical principles guiding such physician decisions. This knowledge should include aspects of medical case management in which decisions are made to limit the duration and intensity of treatment; (4) will work with medical schools, graduate medical education programs and other interested groups to increase the awareness and the creation of personal advance directives for all medical students and physicians; and (5) encourages development of a model educational module for the teaching of advance directives and advance care planning. (CCB/CLRPD Rep. 3, A-14; Appended: Res. 307, A-14; Reaffirmed: BOT Rep. 05, I-16)

Madam Speaker, this concludes the report of Reference Committee A. I would like to thank Dana Block-Abraham, DO, Hoyt Burdick, MD, Stuart Glassman, MD, Thomas H. Hicks, MD, Robert Lee, MD, Michael Zimmer, MD, and all those who testified before the Committee. I would also like to thank AMA staff: Courtney Perlino, MPP, Annalia Michelman, JD, MPP, and Rebecca Gierhahn, MS.

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