AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-14)

Report of Reference Committee A

Gary L. Bryant, MD, Chair

RECOMMENDED FOR ADOPTION

1. Council on Medical Service Report 2 - Extending Medicaid Primary Care Payment Increases to Include Obstetricians and Gynecologists

in lieu of

Resolution 103 - Continuation of Federal Augmentation of Primary Care Medicaid Payments

2. Council on Medical Service Report 9 - Improving the Affordable Care Act

3. Resolution 109 - Standardization of Advance Beneficiary Notification of Non-Coverage Forms for Medicare Advantage Plans and Original Fee-For-Service Medicare

4. Resolution 124 - Generic Changes in Medicare (Part D) Plans

5. Resolution 134 - Prescription of Durable Medical Equipment


RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

7. Board of Trustees Report 11 – Medication Non-Adherence and Errors


9. Council on Medical Service Report 3 - Medicare Update Formulas across Outpatient Sites of Service

10. Council on Medical Service Report 4 - Analysis of Place-of-Service Code for Observation Services

in lieu of

Resolution 127 - Observation Status

11. Council on Medical Service Report 7 - Coverage of and Payment for Telemedicine

12. Resolution 101 - Providing Complete Maternity Care Under the Affordable Care Act

13. Substitute Resolution 104 - Physician Payment by Medicare

14. Substitute Resolution 106 - Endorse Medicare Part D Educational Website

15. Resolution 115 - Opposition to Genetic Testing Restrictions Based on Specialty

16. Resolution 117 - Methadone Should Not Be Designated as a Preferred Analgesic
17. Resolution 118 - Facilitating State Licensure for Telemedicine Services
18. Resolution 120 - Using Nascent Technology in Lieu of Face-to-Face Interaction
19. Substitute Resolution 126 - Medicare Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes
20. Resolution 129 - CMS “Two Midnight” Policy

RECOMMENDED FOR REFERRAL

21. Resolution 102 - Critical Access Hospital Necessary Provider Designation
22. Resolution 108 - Modernizing Tricare Payment Policies
23. Resolution 112 - Minimum Insurance Benefits for Patients with Chronic Pain
25. Resolution 130 - Ensuring Affordable Care
26. Resolution 114 - Lung Cancer Screening to be Considered Standard Care

RECOMMENDED FOR NOT ADOPTION

26. Resolution 105 - Seniors Sleep
27. Resolution 110 - Support a National Poll of Physician’s Opinion Regarding a Single Payer National Health Program, Improved Medicare for All

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

28. Resolution 107 - Sleep Illness
29. Resolution 111 - Including Bariatric Surgery as Part of the Essential Benefits Plan
30. Resolution 131 - Alternatives to Value Based Modifiers
31. Resolution 132 - Delays in Medicaid Payment for Provider Services

RECOMMENDED FOR FILING

32. Board of Trustees Report 17 - Tubal Ligation and Vasectomy Consents

Existing policy was reaffirmed in lieu of the following resolutions via the Reaffirmation Consent Calendar:
- Resolution 116 - Site of Service Differential
- Resolution 119 - Counter Efforts by Insurance Companies to Drop Physicians from Plans
- Resolution 121 - Multiple Mail-Order Prescription Co-Pays
- Resolution 122 - Fairness in Pharmaceutical Pricing
- Resolution 123 - Attestation Statement
- Resolution 128 - Insurance Coverage for Interpreter Services for Hearing Impaired Patients
1 (1) COUNCIL ON MEDICAL SERVICE REPORT 2 -  
2 EXTENDING MEDICAID PRIMARY CARE PAYMENT  
3 INCREASES TO INCLUDE OBSTETRICIANS AND  
4 GYNECOLOGISTS  
5 RESOLUTION 103 - CONTINUATION OF FEDERAL  
6 AUGMENTATION OF PRIMARY CARE MEDICAID  
7 PAYMENTS  
8  
9 RECOMMENDATION:  
10  
11 Mr. Speaker, your Reference Committee recommends that  
12 the recommendations in Council on Medical Service  
13 Report 2 be adopted in lieu of Resolution 103 and the  
14 remainder of the report be filed.  
15  
16 HOD ACTION: Council on Medical Service Report 2 and  
17 Resolution 103 referred.  
18  
19 Council on Medical Service Report 2 recommends that our AMA advocate that the  
20 Affordable Care Act’s primary care payment increases for Evaluation and Management  
21 codes and vaccine administration codes include obstetricians and gynecologists as a  
22 qualifying specialty, and for the ACA’s Medicaid primary care payment increase to  
23 continue past 2014.  
24  
25 Resolution 103 asks that our AMA advocate strongly for Congress to continue the  
26 federal augmentation of primary care Medicaid payments to Medicare rates in perpetuity.  
27  
28 There was generally supportive testimony on Council on Medical Service Report 2 and  
29 Resolution 103. A member of the Council on Medical Service introduced the report,  
30 explaining that the recommendation of the report to include obstetricians and  
31 gynecologists as a qualifying specialty to receive the Affordable Care Act’s primary care  
32 payment increase builds off of already existing policy that recognizes the specialty as  
33 capable of providing both primary care and consultative care. In addition, the Council  
34 member noted that the report recommends advocating for the ACA’s Medicaid primary  
35 care payment increase to continue past 2014, the wording of which accounts for the  
36 budgetary implications of extending the payment increase. Your Reference Committee  
37 believes that Recommendation 4 of CMS Report 2 addresses the intent of Resolution  
38 103.  
39  
40 An amendment was offered to Council on Medical Service Report 2 to include  
41 obstetricians and gynecologists as a qualifying specialty to receive the ACA’s Medicaid  
42 primary care payment increases only if they can attest that at least 60 percent of their  
43 Medicaid codes billed for the year are for the designated primary care and vaccination  
44 service codes. To qualify for the increased Medicaid payments, your Reference  
45 Committee notes that physicians must first attest to practicing in a qualifying specialty  
46 (currently family medicine, general internal medicine or pediatrics) or a subspecialty of  
47 one of these categories. After that, there are two avenues for a physician in an eligible  
48 specialty to receive the increased Medicaid payments. Physicians can either self-attest  
49 that they are board-certified, or that at least 60 percent of the codes they submitted to
Medicaid in 2012 were for primary care services. The amendment offered would require ob
obstetricians and gynecologists to meet different attestation requirements to qualify for the ACA Medicaid payment increases than those required for family medicine, general internal medicine and pediatrics. However, your Reference Committee notes that AMA policy recognizes all four specialties as primary care specialties, and therefore believes the same attestation requirements to qualify for the Medicaid primary care payment increases as family medicine, general internal medicine and pediatrics should apply to obstetricians and gynecologists.

Another amendment was offered that would include obstetricians and gynecologists, psychiatrists and neurologists as qualifying specialties to receive the Affordable Care Act’s primary care payment increases. However, psychiatrists and neurologists are not recognized in AMA policy as providing primary care. Your Reference Committee notes that the third recommendation of CMS Report 2 calls for the reaffirmation of Policy H-290.976[2], which advocates that Medicaid payments to physicians – including psychiatry, neurology and other specialties - be at a minimum 100 percent of Medicare payment rates. After all amendments were offered, a member of the Council on Medical Service reiterated that the recommendations of CMS Report 2 were highly consistent with AMA policy defining primary care specialties and supporting increasing Medicaid payment rates to Medicare levels, and therefore recommended that they not be amended. Your Reference Committee agrees, and recommends that the recommendations in Council on Medical Service Report 2 be adopted in lieu of Resolution 103, and the remainder of the report filed.

(2) COUNCIL ON MEDICAL SERVICE REPORT 9 - IMPROVING THE AFFORDABLE CARE ACT

RECOMMENDATION:

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


Council on Medical Service Report 9 recommends the reaffirmation of policies in support of the AMA proposal to cover the uninsured and expand choice, and continued AMA advocacy to modify portions of the ACA and address critical issues that the ACA did not address.

There was generally supportive testimony on this report. Some speakers cited issues with the Affordable Care Act, including its impact on health care costs, the uninsured and physician office efficiencies. However, your Reference Committee notes that CMS Report 9, along with CMS Report 5-I-13, addressed those concerns. Several speakers expressed their strong support for health savings accounts. Your Reference Committee notes that CMS Report 9 recommends that Policy H-165.852 in support of health savings accounts be reaffirmed. Policy H-165.852 also supports annual HSA account
contribution limits being determined by the full family deductible or the dollar-limit for family policies, which responds to concerns raised in testimony. Additional testimony highlighted support for the Medicare Patient Empowerment Act, support for which is included in Policies H-165.833 and H-165.838 recommended for reaffirmation. Your Reference Committee commends the Council on a strong report, which was forward-thinking in highlighting emerging issues with ACA implementation. Accordingly, your Reference Committee recommends the adoption of Council on Medical Service Report 9.

(3) RESOLUTION 109 - STANDARDIZATION OF ADVANCE BENEFICIARY NOTIFICATION OF NON-COVERAGE FORMS FOR MEDICARE ADVANTAGE PLANS AND ORIGINAL FEE-FOR-SERVICE MEDICARE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 109 be adopted.

HOD ACTION: Resolution 109 adopted.

Resolution 109 asks that our AMA request the Centers for Medicare & Medicaid Services provide a standardized Advance Beneficiary Notice of Non-coverage (ABN) that will be sufficient notification to inform all Medicare Advantage Plan and Original (Fee-For-Service) Medicare beneficiaries when Medicare may deny payment for an item or service. Resolution 109 also that Medicare Advantage Plan requirements for carrier specific advance beneficiary notice of non-coverage and similar forms be eliminated.

Testimony was supportive of Resolution 109. Your Reference Committee concurs that the administrative simplification of ABN forms would benefit physician practices and reduce payment delays and therefore recommends that this resolution be adopted.

(4) RESOLUTION 124 - GENERIC CHANGES IN MEDICARE (PART D) PLANS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 124 be adopted.

HOD ACTION: Resolution 124 adopted.

Resolution 124 asks that our AMA investigate the incidence and reasoning behind the conversion of one generic drug to another generic drug of the same class in Medicare Advantage drug plan, and request Centers for Medicare & Medicaid Services to ensure that pharmaceutical vendors, when they do ask for generic transitions of drugs, list the drugs they believe are more cost effective along with their tier price and alternative drug names.
Testimony was supportive of Resolution 124. Your Reference Committee agrees with the sponsor that it can be problematic for Medicare patients when a generic drug they are taking is no longer on their plan’s formulary and they are switched to a different generic. Your Reference Committee therefore recommends that Resolution 124 be adopted.

(5) RESOLUTION 134 – PRESCRIPTION OF DURABLE MEDICAL EQUIPMENT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 134 be adopted.

HOD ACTION: Resolution 134 adopted.

Resolution 134 asks that our AMA amend Policy H-330.955, Prescription of Durable Medical Equipment to include insurers.

Testimony on this resolution was limited to the sponsor who proposed broadening AMA policy to the commercial insurer field. Your Reference Committee recommends that Resolution 134 be adopted.

H-330.955 Prescription of Durable Medical Equipment

(1) Our AMA continues to voice its objection to CMS and other insurers regarding its onerous requirements that physicians initiate and complete the entire certification of medical necessity form for the prescription of durable medical equipment. (2) Our AMA advocates that additional members of a physician-led health care team be permitted to complete the certification of medical necessity form for durable medical equipment, according to their education, training and licensure and at the discretion of the physician team leader, but require that the final signature authorizing the prescription for the durable medical equipment be the responsibility of the physician. (3) Our AMA calls for CMS to revise its interpretation of the law, and advocates for other insurers, to permit that the physician's prescription be the only certification of medical necessity needed to initiate an order for and to secure Medicare or other insurer payment for durable medical equipment. (4) Our AMA calls on physicians to be aware of the abuses caused by product-specific advertising by manufacturers and suppliers of durable medical equipment, the impact on the consumers of inappropriate promotion, and the contribution such promotion makes to unnecessary health care expenditures.

(Modify HOD Policy)

(6) RESOLUTION 135 - PRESCRIPTION DRUG PLANS AND PATIENT ACCESS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 135 be adopted.
HOD ACTION: Resolution 135 adopted.

Resolution 135 asks that our AMA explore problems with prescription drug plans, including issues related to continuity of care, prior authorization, and formularies, and work with the Centers for Medicare & Medicaid Services and other appropriate organizations to resolve them. (Directive to Take Action)

Testimony was supportive of Resolution 135. Your Reference Committee notes that several resolutions addressing problems with prescription drug plans were submitted to the HOD for consideration at this meeting. Your Reference Committee thanks the OMSS for this resolution and recommends that it be adopted.

(7) BOARD OF TRUSTEES REPORT 11 - MEDICATION
NON-ADHERENCE AND ERRORS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 11 be amended by addition and deletion to read as follows:

That our American Medical Association recommend the Centers for Medicare and Medicaid Services conduct a cost/benefit analysis and an analysis of the ability of seniors and people with disabilities to use blister packs in order to determine the feasibility of expanding coverage for timed calendar blister packs for prescription medications beyond residents of long term care facilities.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 11 be adopted as amended and the remainder of the report filed.

HOD ACTION: Recommendation in Board of Trustees Report 11 adopted as amended and the remainder of the report filed.

Board of Trustees Report 11 recommends that our AMA ask the Centers for Medicare and Medicaid Services to conduct a cost/benefit analysis and determine the feasibility of expanding coverage for timed calendar blister packs for prescription medications beyond residents of long term care facilities.

There was limited but supportive testimony on this report. Your Reference Committee agrees that further analysis by the Centers for Medicare & Medicaid Services (CMS) is warranted before the agency should expand coverage of timed calendar blister packs beyond patients in long-term care. A member of the AMA Board of Trustees testified that the proposed recommendations to CMS in this report are reasonable and in order. A Senior Physicians Section representative spoke about the difficulty that some seniors...
have opening blister packs and offered an amendment addressing this issue. Your Reference Committee agrees with the suggested amendment from the Senior Physicians Section and recommends that Board of Trustees Report 11 be adopted as amended.

(8) COUNCIL ON MEDICAL SERVICE REPORT 1 –
COUNCIL ON MEDICAL SERVICE SUNSET REPORT OF 2004 HOUSE POLICIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendation of Council on Medical Service Report 1 be amended by addition and deletion on lines 32-34 to read as follows:

The Council on Medical Service recommends that our American Medical Association policies listed in the appendix to this report be acted upon in the manner indicated, with the exception of Policy D-330.964, which should be retained, and the remainder of the report be filed. (Directive to Take Action)

RECOMMENDATION B:

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

HOD Action: Recommendation in Council on Medical Service Report 1 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 1 contains recommendations to retain or rescind 2004 AMA socioeconomic policies.

There was limited testimony on Council on Medical Service Report 1. A member of the Council on Medical Service introduced the report and noted the efforts of the Council to review and analyze the policies that it was assigned. A speaker requested that Policy D-330.964 be retained, which states that our AMA urge the Centers for Medicare and Medicaid Services to immediately update the ambulatory surgery center list of covered procedures. Your Reference Committee agrees with this suggestion, as the list of covered procedures is continually changing. Therefore, your Reference Committee recommends adoption of Council on Medical Service Report 1 as amended.
(9) COUNCIL ON MEDICAL SERVICE REPORT 3 -
MEDICARE UPDATE FORMULAS ACROSS
OUTPATIENT SITES OF SERVICE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 4 in Council on Medical Service Report 3 be amended by addition and deletion to read as follows:

4. That our AMA amend Policy H-330.925 by insertion and deletion as follows:
   H-330.925 Appropriate Payment Level Differences by Place and Type of Service
   Our AMA (1) encourages CMS to adopt policy and establish mechanisms to fairly reimburse physicians for office-based procedures; (2) encourages CMS to adopt a single facility payment schedule/site neutral payment policy for hospital outpatient departments and ambulatory surgical centers; (3) advocates for the use of valid and reliable data in the development of any payment methodology for the provision of ambulatory services; (4) advocates that in place of the Consumer Price Index for all Urban Consumers (CPI-U), CMS use the hospital market basket index to annually update ambulatory surgical center payment rates; (4) continues to oppose the implementation of any prospectively determined classification and payment system for Medicare ambulatory services that is based upon a methodology that bundles or groups services; (5) advocates for payments for hospital outpatient department services and ambulatory surgical services that are based on individual services; (6) encourages the use of CPT codes across all sites-of-service as the only acceptable approach to payment methodology; and (7) will join other interested organizations and lobby for any needed changes in existing and proposed regulations affecting payment for ambulatory surgical centers to assure a fair rate of reimbursement for ambulatory surgery. (Modify HOD Policy)

RECOMMENDATION B:

Mr. 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 the Centers for Medicare & Medicaid Services use the hospital market basket index to annually update ambulatory surgical center (ASC) payment rates, and that our AMA continue to encourage CMS to collect data on the frequency, type and cost of services furnished in off-campus, provider-based departments.

Testimony was generally supportive of Council on Medical Service Report 3. A member of the Council on Medical Service pointed out that AMA policy already addresses most of the concerns raised in Resolution 112-A-13, which led to the development of this report, and that Medicare payment disparities across outpatient sites of service are also addressed in Council on Medical Service Report 3-A-13.

There was substantial support for the Council’s recommendation regarding use of the hospital market basket index to calculate annual inflationary updates for ASC payment rates, which is the same index used to update hospital outpatient department payment rates. Your Reference Committee agrees that the hospital market basket index better reflects changes in ASC costs than the CPI-U, which measures prices paid for household goods and is highly weighted for housing.

Hospital acquisition of physician practices and resulting changes to Medicare payments when hospital-owned practices bill as outpatient departments under the Outpatient Prospective Payment System was mentioned by several speakers. Concerns were also expressed regarding efforts to “level the playing field” that may result in payment reductions to hospital outpatient departments. Speakers emphasized the need to equalize payments in a way that is fair to physicians and hospitals in all settings. Your Reference Committee opted not to amend Recommendation 2, which recommends reaffirmation of Policy D-330.997, as suggested by testimony because this is a longstanding policy of the AMA. Your Reference Committee agrees with another speaker’s suggestion to substitute “site neutral payment policy” for “single facility payment schedule” in Policy H-330.925[2], and recommends that Council on Medical Service Report 3 be adopted as amended.

(10) COUNCIL ON MEDICAL SERVICE REPORT 4 - ANALYSIS OF PLACE-OF-SERVICE CODE FOR OBSERVATION SERVICES

RESOLUTION 127 – OBSERVATION STATUS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 4 be amended by addition of a seventh recommendation to read as follows:

7. That our AMA advocate with Centers for Medicare & Medicaid Services that the status of any observation
patient who remains confined at a hospital for more than 24 hours be changed automatically to inpatient, and if they had spent a midnight in observation status, that midnight would be counted toward the three-day prior hospitalization requirement for Medicare coverage of skilled nursing facility care. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 4 be adopted as amended in lieu of Resolution 127 and the remainder of the report be filed.


Council on Medical Service Report 4 recommends the reaffirmation of policy in support of repealing the Two-Midnight Rule, as well as the continuation of AMA advocacy in support of the Centers for Medicare & Medicaid Services exploring payment solutions to reduce the inappropriate use of hospital observation status.

Resolution 127 asks that our AMA advocate with the Centers for Medicare & Medicaid Services for the modification of their observation status rules, such that observation status would be limited to patients cared for in either the outpatient or inpatient setting of a hospital for less than 24 hours. Resolution 127 also asks that our AMA advocate with CMS that the status of any observation patient who remains confined at a hospital for more than 24 hours be changed automatically to inpatient, and if they had spent a midnight in observation status, that midnight would be counted toward the three midnight rule.

Testimony on Council on Medical Service Report 4 was supportive and also indicative of ongoing physician concerns regarding the inappropriate assignment of patients to hospital observation status. Many speakers testified as to the enormity of the problems related to observation care, especially the financial consequences for observation patients who may be surprised to learn that they are responsible for Medicare Part B cost-sharing amounts for services provided as part of observation care.

Your Reference Committee points out that AMA policy designates a hospital stay of 24 hours as a guideline for patient inpatient admissions, which is the focus of the first resolve clause in Resolution 127. The AMA has consistently advocated that CMS use a 24-hour benchmark to distinguish between hospital inpatient and observation status instead of the two-midnight rule, which AMA is actively working to repeal. Your Reference Committee was persuaded by testimony to amend Council on Medical Service Report 4 by incorporating Resolution 127’s second resolve clause as a new recommendation.

Your Reference Committee commends the Council for a comprehensive and well-written report. Your Reference Committee feels strongly that the AMA should continue working
diligently to ensure that CMS develops payment solutions that address the inappropriate use of hospital observation status, and is pleased to hear that CMS may investigate use of a short-stay outlier as a potential option. Your Reference Committee recommends adoption of the recommendations in Council on Medical Service Report 4 as amended in lieu of Resolution 127.

(11) COUNCIL ON MEDICAL SERVICE REPORT 7 - COVERAGE OF AND PAYMENT FOR TELEMEDICINE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 of Council on Medical Service Report 7 be amended by addition and deletion to read as follows:

1. That American Medical Association (AMA) policy be 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.

   at minimum a face-to-face examination provided in person or virtually using real-time audio and video technology, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine.
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.

de) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.

ed) The delivery of telemedicine services must be consistent with state scope of practice laws.

fe) 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.

gf) The standards and scope of telemedicine services should be consistent with related in-person services.

hg) 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.

ia) 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.

ji) The patient’s medical history must be collected as part of the provision of any telemedicine service.

kj) The provision of telemedicine services must be properly documented, which and should include providing a visit summary to the patient and a copy of the medical record to any identified primary and/or referring physician, in order to facilitate continuity of care.

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.

mk) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.
RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 7 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 7 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 7 recommends principles to ensure the appropriate coverage of and payment for telemedicine services, supporting additional research, pilot programs and demonstration projects regarding telemedicine, and national specialty societies to take the lead in the development of telemedicine clinical practice guidelines.

There was generally supportive testimony on Council on Medical Service Report 7. At the time of introducing the report, a member of the Council on Medical Service offered proposed language to Recommendation 1(b) to clarify that 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. In addition, the member of the Council offered language for a new Recommendation 1(c), based off of the testimony given in the online member forum, which asserts that 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. Your Reference Committee believes that this amendment is very consistent with existing policy that supports a full and unrestricted state license for the practice of telemedicine, while allowing for flexibility for states that have license reciprocity agreements and other arrangements. Your Reference Committee heard additional testimony concerning licensure, but believes that the focus of CMS Report 7 was coverage of and payment for telemedicine, not changing licensure pertaining to the provision of telemedicine services. Rather, your Reference Committee notes that Resolution 118 addressed issues associated with state licensure for telemedicine services. There was also a suggestion that the recommendations of the report address geographic variations in physician payment, but your Reference Committee believes that such an amendment is outside the scope of the report. However, your Reference Committee notes that a member of the Council on Medical Service indicated that the Council will continue to monitor this evolving issue.

A member of the Council on Legislation (COL) offered an amendment that outlined different avenues through which a valid patient-physician relationship could be established before the provision of telemedicine services, outlined in Recommendation 1(a), and included language that emphasized that telemedicine must include care coordination with the medical home where the patient receives in-person care. The Council on Medical Service accepted the COL amendment as friendly. Your Reference Committee commends the COL for its amendment to Recommendation 1(a) concerning the need to establish a valid patient-physician relationship. Your Reference Committee believes that the amendment strongly defines a valid patient-physician relationship pertaining to telemedicine, while not being overly prescriptive and recognizing that
specialties use telemedicine differently. Your Reference Committee believes that these amendments sufficiently respond to testimony given, and accordingly recommends that Council on Medical Service Report 7 be adopted as amended.

(12) RESOLUTION 101 - PROVIDING COMPLETE MATERNITY CARE UNDER THE AFFORDABLE CARE ACT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 101 be amended by addition of a second resolve to read as follows:

RESOLVED, That our American Medical Association advocate that individual, small and large group health plans provide 60 days of newborn coverage for all newborns born to participants in the plan. (Directive to Take Action)

RECOMMENDATION B:

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

HOD ACTION: Resolution 101 adopted as amended.

Resolution 101 asks that our AMA advocate for expanding coverage of maternity care to dependent women under the age of 26 on their parents’ large group plans.

There was highly supportive testimony on this resolution. An amendment was offered to assure coverage of newborns born to all health plan participants, including dependents of the policyholder. Your Reference Committee finds this amendment to be consistent with Policy H-185.997, which encourages health insurance coverage for care of the newborn from the moment of birth. Another amendment was offered to require pregnancy be considered a qualifying life event that would trigger a special enrollment period. However, your Reference Committee believes that this amendment broadens the intent of this resolution, which is to fill the gap in maternity coverage that currently exists. Resolution 101 would support expanding coverage of maternity coverage to dependent women on their parents’ large group health plans. Having a baby is considered to be a qualifying life event so these women would have additional coverage options upon giving birth.

Your Reference Committee believes that dependent coverage without maternity benefits is incomplete, and could impose substantial costs on dependents and their parents. As extending maternity coverage to dependents would be consistent with Policy H-185.997 in support of insurance coverage for complete maternity care, and Policy H-180.964 in support of extending family coverage to young adults to age 28, your Reference Committee recommends that Resolution 101 be adopted as amended.
RESOLUTION 104 - PHYSICIAN PAYMENT BY MEDICARE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends adoption of Substitute Resolution 104.

RESOLVED, that our AMA reaffirm Policies H-400.956, H-400.959, H-400.969, H-330.925 and D-330.997 (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA study the impact of hospital acquisition of physician practices on health care costs, patient access to health care and physician practice.

(Directive to Take Action)

HOD ACTION: Substitute Resolution 104 adopted.

Resolution 104 asks that our AMA annually examine the methodology for determining “allowable” Medicare fee schedules (E&M and CPT code) to determine if the reimbursement is consistent with the government’s stated amounts and alert its membership as to that consistency or lack thereof, and examine the reason that Medicare pays far more for “hospital-based” clinics/doctors than for private practice physicians.

Testimony acknowledged that our AMA has policy related to Resolution 104, including policy that supports the work of the RUC, which as an expert panel regularly reviews the valuation of physician services and also studies the methodology behind the valuation of CPT codes. A member of the CPT Editorial Panel and former member of the RUC testified that the RUC routinely accomplishes what is asked for in the first resolve of Resolution 104.

Your Reference Committee also points out that Policies H-330.925 and D-330.997 support defining Medicare services consistently across settings, and encourage CMS to adopt payment methodologies that assist in leveling the playing field across all sites of service. Moreover, Council on Medical Service Report 3 explains in great detail why Medicare pays more for hospital-based services than for services provided in physician offices and ASCs. However, several speakers testified that this is a complicated topic that is worthy of further study. Your Reference Committee therefore recommends substitute language that asks the AMA to study the impact of hospital acquisition of physician practices on health care costs, patient access to care and physician practice.

Because AMA policy addresses the issues put forth in Resolution 104, your Reference Committee also recommends that Policies H-400.956, H-400.959, H-400.969, H-330.925 and D-330.997 be reaffirmed.

H-400.956 RBRVS Development

(1) That the AMA strongly advocate CMS adoption and implementation of all the RUC’s recommendations for the five-year review; (2) That the AMA closely
monitor all phases in the development of resource-based practice expense relative values to ensure that studies are methodologically sound and produce valid data, that practicing physicians and organized medicine have meaningful opportunities to participate, and that any implementation plans are consistent with AMA policies; (3) That the AMA work to ensure that the integrity of the physician work relative values is not compromised by annual budget neutrality or other adjustments that are unrelated to physician work; (4) That the AMA encourage payers using the relative work values of the Medicare RBRVS to also incorporate the key assumptions underlying these values, such as the Medicare global periods; and (5) That the AMA continue to pursue a favorable advisory opinion from the Federal Trade Commission regarding AMA provision of a valid RBRVS as developed by the RUC process to private payers and physicians. (BOT Rep. 16, A-95; BOT Rep. 11, A-96; Reaffirmed: CMS Rep. 4, I-02; Reaffirmed: BOT Rep. 14, A-08)

H-400.959 Refining and Updating the Physician Work Component of the RBRVS The AMA: (1) supports the efforts of the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee's (RUC's) work with the American Academy of Pediatrics and other specialty societies to develop pediatric-specific CPT codes and physician work relative value units to incorporate children's services into the RBRVS; (2) supports the RUC's efforts to improve the validity of the RBRVS through development of methodologies for assessing the relative work of new technologies and for assisting CMS in a more comprehensive review and refinement of the work component of the RBRVS; and (3) continues to object to use of the relative values as a mechanism to preserve budget neutrality. (BOT Rep. I-93-26; Reaffirmed by BOT Rep. 8 - I-94; Res. 806, I-94; Reaffirmed: Sub. Res. 816, I-99; Reaffirmed: CMS Rep. 4, I-02; Reaffirmed: BOT Rep. 14, A-08)
H-400.969 RVS Updating
Status Report and Future Plans: The AMA/Specialty Society RVS Update Committee (RUC) represents an important opportunity for the medical profession to maintain professional control of the clinical practice of medicine. The AMA urges each and every organization represented in its House of Delegates to become an advocate for the RUC process in its interactions with the federal government and with its physician members. The AMA (1) will continue to urge CMS to adopt the recommendations of the AMA/Specialty Society RVS Update Committee for physician work relative values for new and revised CPT codes; (2) supports strongly use of this AMA/Specialty Society process as the principal method of refining and maintaining the Medicare RVS; (3) encourages CMS to rely upon this process as it considers new methodologies for addressing the practice expense components of the Medicare RVS and other RBRVS issues; and (4) opposes changes in Relative Value Units that are in excess of those recommended by the AMA/Specialty Society Relative Value Scale Update Committee (RUC). (BOT Rep. O, I-92; Reaffirmed by BOT Rep. 8 - I-94; Reaffirmed by BOT Rep. 7, A-98; Reaffirmed: CMS Rep.12, A-99; Reaffirmed: CMS Rep. 4, I-02; Reaffirmed: BOT Rep. 14, A-08; Reaffirmation I-10; Appended: Res. 822, I-12; Reaffirmation I-13)

H-330.925 Appropriate Payment Level Differences by Place and Type of Service
Our AMA: (1) encourages CMS to adopt policy and establish mechanisms to fairly reimburse physicians for office-based procedures; (2) encourages CMS to adopt a single facility payment schedule for hospital outpatient departments and ambulatory surgical centers; (3) advocates for the use of valid and reliable data in the development of any payment methodology for the provision of ambulatory services; (4) continues to oppose the implementation of any prospectively determined classification and payment system for Medicare ambulatory services that is based upon a methodology that bundles or groups services; (5) advocates for payments for hospital outpatient department services and ambulatory surgical services that are based on individual services; (6) encourages the use of CPT codes across all sites-of-service as the only acceptable approach to payment methodology; and (7) will join other interested organizations and lobby for any needed changes in existing and proposed regulations affecting payment for ambulatory surgical centers to assure a fair rate of reimbursement for ambulatory surgery. (Sub. Res. 104, A-98; Reaffirmation I-98; Appended: CMS Rep. 7, A-99; Reaffirmation A-00; Reaffirmation I-03; Reaffirmation A-11; Reaffirmed: CMS Rep. 3, A-13)

D-330.997 Appropriate Payment Level Differences by Place and Type of Service
Our AMA encourages CMS to: (1) define Medicare services consistently across settings and, in particular, to avoid the use of diagnosis codes in determining Medicare payments to hospital outpatient departments and other ambulatory settings; and (2) adopt payment methodology for hospital outpatient departments and ambulatory surgical centers that will assist in leveling the playing field across all sites-of-service. If necessary, the AMA should consider seeking a legislative remedy to the payment disparities between hospital outpatient departments and ambulatory surgical centers. (CMS Rep. 7, A-99; Reaffirmation I-03)
(14) RESOLUTION 106 - ENDORSE MEDICARE PART D 
EDUCATIONAL WEBSITE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends adoption of Substitute Resolution 106.

RESOLVED, That our American Medical Association request that the Centers for Medicare & Medicaid Services educate Medicare beneficiaries on how to access assistance for enrolling in Medicare Part D and Medicare Advantage plans. (Directive to Take Action)

HOD ACTION: Substitute Resolution 106 adopted.

Resolution 106 asks that our AMA request that the federal government provide on an annual basis to the Medicare population an individualized report showing the estimated out of pocket costs for each of the available Medicare D and Advantage plans, based on the medications taken during the prior year, similar to the report which an individual can obtain on medicare.gov; and that the AMA ask electronic medical record vendors to provide the capability to give patients on Medicare such reports.

Testimony on Resolution 106 was supportive but limited. Your Reference Committee is uncertain about the intent of Resolution 106 as originally written. Your Reference Committee also points out that the Medicare.gov website provides Medicare patients with a tool to look up estimated out-of-pocket costs under various available Medicare Part D and Advantage plans. Based on testimony from the sponsor indicating concern regarding patients’ use of insurance brokers to enroll in Medicare Part D and Medicare Advantage plans, your Reference Committee developed Substitute Resolution 106 which is recommended for adoption in lieu of Resolution 106.

(15) RESOLUTION 115 - OPPOSITION TO GENETIC TESTING RESTRICTIONS BASED ON SPECIALTY

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 115 be amended by addition to read as follows:

RESOLVED, That our AMA oppose public and private payers imposing a standard of practice with requirements for utilization of non-affiliated medical specialists or non-physicians prior to ordering genetic testing (New HOD Policy)

RECOMMENDATION B:
Mr. Speaker, your Reference Committee recommends that Resolution 115 be amended by the addition of a fourth resolve to read as follows:

RESOLVED, That our AMA continue to support the importance of pre- and post-testing counseling when a patient is considered to be at risk for a hereditary susceptibility for cancer and other diseases by a qualified health professional so that patients have the benefit of informed decision-making regarding genetic testing. (New HOD Policy)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 115 be adopted as amended.

HOD ACTION: Resolution 115 adopted as amended.

Resolution 115 asks that our AMA oppose limiting the ordering of genetic testing based solely on physician specialty or other non-medical care based criteria, and requirements for utilization of non-affiliated medical specialists or non-physicians prior to ordering genetic testing. Resolution 115 also asks that our AMA, working with other interested specialty and component societies, communicate our opposition to non-medical restrictions to genetic testing to relevant health insurers.

Testimony was supportive of amendments that (1) suggested a new resolve clause reiterating the AMA’s support of the importance of pre-and post-testing counseling by qualified health professionals for patients thought to be genetically susceptible to cancer and other diseases; and (2) specified that the AMA oppose requirements by outside agencies that the standard of practice include utilization of non-affiliated medical specialists or non-physicians prior to ordering genetic testing. Because your Reference Committee believes “outside agencies” to be vague, substitute language was offered to the second amendment to specify its intent.

Your Reference Committee appreciates the efforts of the resolution’s sponsors to work collaboratively with organizations that focus on genetic testing to craft these amendments, and recommends that Resolution 115 be adopted as amended.

(16) RESOLUTION 117 - METHADONE SHOULD NOT BE DESIGNED AS A PREFERRED ANALGESIC

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 117 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association recommend that methadone should not be designated as
the sole preferred analgesic by any insurance payer, whether public or private. (New HOD Policy); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends the second resolve of Resolution 117 be deleted.

RESOLVED, That our AMA send letters to all of the states who currently have methadone on their Preferred Drug List that clearly states this new policy. (Directive to Take Action)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 117 be adopted as amended.

HOD ACTION: Resolution 117 adopted as amended with a title change.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 117 be changed to read as follows:

METHADONE SHOULDN'T BE DESIGNATED AS THE SOLE PREFERRED ANALGESIC

Resolution 117 asks that our AMA recommend that methadone should not be designated as a preferred analgesic by any insurance payer, whether public or private; and send letters to all of the states who currently have methadone on their Preferred Drug List that clearly states this new policy.

There was limited testimony on this resolution. An amendment was offered to specify that the AMA recommend that methadone should not be the sole preferred analgesic included on drug formularies because it contributes disproportionately to opioid-related overdose deaths when prescribed for pain. Testimony noted the substantial increase in methadone-associated overdoses that is far beyond its proportional prescribing rate.

Your Reference Committee agrees with these concerns and also points out that methadone may be prescribed for some hospice patients and neonates who may benefit from its unique properties. Furthermore, your Reference Committee believes it would be inappropriate for the AMA to send letters to all states that include methadone on their preferred drug list. Therefore, your Reference Committee recommends that Resolution 117 be adopted as amended.
(17) RESOLUTION 118 - FACILITATING STATE LICENSURE FOR TELEMEDICINE SERVICES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 118 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association study the issues of telemedicine and telehealth services, as well as issues associated with state-based licensure to aid in the development of national standards to facilitate support and portability of state licensure for telemedicine services with report back at I-14. (Directive to Take Action)

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 118 be adopted as amended.

HOD ACTION: Resolution 118 adopted as amended.

Resolution 118 asks that our AMA study the issues of telemedicine and telehealth services, as well as issues of state licensure, to aid in the development of national standards to facilitate state licensure for telemedicine services.

There was mixed testimony on this resolution. A member of the Council on Medical Service suggested that the focus of the study called for in Resolution 118 be narrowed to focus on state licensure for telemedicine, as Council on Medical Service Report 7 being considered at this meeting addressed the coverage of and payment for telemedicine services. A member of the Council on Medical Education suggested an amendment to remove the reference to national standards due to strong AMA policy in support of state licensure for telemedicine. In addition, the amendment suggested that the aim of the study should be to develop standards to support portability of state licensure for telemedicine services. Other speakers concurred with striking the reference to national standards. Accordingly, your Reference Committee recommends that Resolution 118 be adopted as amended.

(18) RESOLUTION 120 - USING NASCENT TECHNOLOGY IN LIEU OF FACE-TO-FACE INTERACTION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 120 be amended by addition and deletion to read as follows:
RESOLVED, That our American Medical Association work with the Centers for Medicare & Medicaid Services to enable the use of HIPAA-compliant telemedicine and video monitoring services including Skype to satisfy the face-to-face requirement in recommending certifying eligibility for Medicare home health care qualifications services.

(Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 120 be adopted as amended.

HOD ACTION: Resolution 120 adopted as amended.

Resolution 120 asks that our AMA work with the Centers for Medicare & Medicaid Services to enable the use of telemedicine and video monitoring services including Skype to satisfy the face-to-face requirement in recommending home care qualifications.

There was generally supportive testimony on Resolution 120. The sponsor of the resolution introduced an amendment to remove the reference in the resolution to Skype, as it is not HIPAA-compliant. While a speaker raised a concern that communications over the radio are not considered to be HIPAA-compliant, your Reference Committee notes that Resolution 120 only addresses the face-to-face encounter to certify eligibility for Medicare home health services. Your Reference Committee recommends that Resolution 120 be adopted as amended.

(19) RESOLUTION 126 - MEDICARE COVERAGE OF CONTINUOUS GLUCOSE MONITORING DEVICES FOR PATIENTS WITH INSULIN-DEPENDENT DIABETES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends adoption of Substitute Resolution 126.

RESOLVED, that our American Medical Association support efforts to achieve Medicare coverage of continuous glucose monitoring systems for patients with insulin-dependent diabetes. (New HOD Policy)

HOD ACTION: Substitute Resolution 126 adopted.

Resolution 126 asks that our AMA actively pursue all possible regulatory and legislative actions to achieve coverage for continuous glucose monitors (CGMs) under Medicare to help Medicare patients maintain control of their diabetes, improve their health and quality of life and prevent the costly debilitating complications of diabetes; and further, that our AMA work with all interested medical societies, patient groups, and other stakeholders to achieve coverage of CGMs under Medicare.
Testimony was limited but supportive of Resolution 126. Your Reference Committee is aware that the resolution’s sponsors have been advocating with CMS on this issue. In addition, legislation introduced in the Congress (H.R. 3710) would require Medicare to cover continuous glucose monitoring systems as durable medical equipment. Your Reference Committee recommends adoption of substitute language which establishes that the AMA supports efforts to achieve coverage of these devices.

(20) RESOLUTION 129 - CMS “TWO MIDNIGHT” POLICY

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 129 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association demand that the Centers for Medicare & Medicaid Services educate the public and produce documents develop tools for physicians and patients that outline the potential negative financial consequences impact of the “two midnight” policy. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 129 be adopted as amended.

HOD ACTION: Resolution 129 adopted as amended

Resolution 129 asks that our AMA demand that the Centers for Medicare & Medicaid Services educate the public and produce documents that outline the potential negative financial consequences of the “two midnight” policy.

Testimony was supportive of Resolution 129. Speakers described concerns about Medicare’s two-midnight policy and also spoke about the AMA’s advocacy on this issue which has resulted in the policy’s enforcement being delayed. Testimony also pointed to the need for tools for both patients and physicians that explain hospital admissions policy and what it means to be assigned to hospital observation status versus inpatient status. Your Reference Committee appreciates the testimony on Resolution 129 but does not believe it would be productive for the AMA to “demand” action from CMS. Instead, your Reference Committee recommends that the resolution be adopted as amended.
(21) RESOLUTION 102 - CRITICAL ACCESS HOSPITAL NECESSARY PROVIDER DESIGNATION
RESOLUTION 133 - ECONOMIC VIABILITY OF RURAL SOLE COMMUNITY HOSPITALS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolutions 102 and 133 be referred.

HOD ACTION: Resolution 102 adopted. Resolution 133 referred.

Resolution 102 asks that our AMA call on the Centers for Medicare & Medicaid Services to support individual states in their development of rural health networks; oppose the elimination of the state-designated Critical Access Hospital (CAH) “necessary provider” designation; and pursue steps to require the federal government to fully fund its obligations under the Medicare Rural Hospital Flexibility Program.

Resolution 133 asks that our AMA study the complex economic factors that threaten the viability of Sole Community Hospitals, and develop recommendations for advocacy and new policies addressing this urgent concern, with a report back by the 2015 Annual Meeting.

Testimony on Resolutions 102 and 133 described the value of critical access hospitals (CAHs) and sole community hospitals (SCHs), which enable rural patients to access hospital services and also provide economic benefits to rural America as large employers. Speakers also emphasized that many rural hospitals are basically on life support due to funding cuts and increased costs. Your Reference Committee is unsure whether those who testified are familiar with the report by the Office of the Inspector General at HHS, which is the subject of Resolution 102 and recommends changes to the CAH program. Therefore, your Reference Committee is hesitant to adopt new policy on CAHs without additional study. Because Resolution 133 recommends that the AMA study issues related to SCHs, your Reference Committee recommends referral of both resolutions to study the economic viability of rural hospitals and the need for new or updated AMA policy on Medicare designations for rural hospitals.

(22) RESOLUTION 108 - MODERNIZING TRICARE PAYMENT POLICIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 108 be referred.

HOD ACTION: Resolution 108 referred with report back at I-14.

Resolution 108 asks that our AMA help to insure the continued access of our nation’s military dependents and retirees to the services of civilian physicians by actively
pursuing the modernization of Tricare policies to reflect standard fair payment policies to
physicians, specifically with regard to a) accepting the “incident to” Medicare model for
payment for mid-level provider services, if under the general supervision of a physician,
b) paying for treatment of mental health conditions, regardless of the specialty of the
treating physician, and c) covering the copayment of a Medicare patient who receives
transition of care services (CPT 99495, 99496) by a physician. Resolution 108 also asks
that a progress report on these discussions be presented to this House, if possible at the
2014 Interim Meeting, but no later than the 2015 Annual Meeting.

Testimony on Resolution 108 was limited and mixed. The resolution’s sponsor spoke
about access problems associated with Tricare and the need to modernize Tricare
payment policies so they are in line with other payment policies. Testimony from another
speaker contradicted some of the specific information referenced in Resolution 108.
Your Reference Committee believes that concerns about Tricare coverage and patient
access to care are legitimate and worthy of further study. Your Reference Committee
therefore recommends that Resolution 108 be referred.

(23) RESOLUTION 112 - MINIMUM INSURANCE BENEFITS
FOR PATIENTS WITH CHRONIC PAIN

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that
Resolution 112 be referred.

HOD ACTION: Resolution 112 referred.

Resolution 112 asks that our AMA and interested stakeholders advocate for a minimum
set of health insurance benefits for people in pain severe enough to require ongoing
therapy; advocate for an interdisciplinary clinical approach that recognizes the
interdependency of treatment methods in the treatment of chronic pain; and recommend
and provide expertise for legislation to require that all payers offer coverage for a
comprehensive, interdisciplinary pain program, which would include such care modalities
as cognitive-behavioral therapy, for patients who have disabling pain and have failed
more conservative therapy. Resolution 112 also asks that our AMA advocate for parity in
coverage for people with pain, similar to that accorded people with mental-health
disorders [MHPAEA 2008].

There was mixed testimony on this resolution, with speakers expressing support for a
comprehensive approach to treat chronic pain and the appropriate insurance coverage
of chronic pain treatment. Other speakers expressed concern with the level and scope
of insurance coverage for chronic pain highlighted in this resolution. A speaker also
suggested referral of this item. Your Reference Committee agrees that this is a complex
issue and that further study is needed, and therefore recommends that Resolution 112
be referred.
(24) RESOLUTION 113 - NETWORK ADEQUACY
RESOLUTION 125 - EXPANDING PATIENTS’ CHOICE IN THE EXERCISE OF HEALTH INSURANCE BENEFITS
RESOLUTION 130 - ENSURING AFFORDABLE CARE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolutions 113, 125 and 130 be referred.

HOD ACTION: Resolutions 113, 125 and 130 referred.

Resolution 113 asks that our AMA study the issue of network adequacy, including the impact on access to and quality of care, with a report back by the 2014 Interim Meeting; advocate for adherence to existing statutory and regulatory measures designed to ensure network adequacy, and work with state medical societies to advocate for the same in states where measures do not currently exist; and support the right of patients and physicians to seek appropriate recourse when and if harmed by inadequate networks.

Resolution 125 asks that our AMA study the growing problem of restrictions on a patient’s ability to use their health insurance benefits with the providers of their choice; and report back to the House of Delegates on the extent of the problem, with recommended strategies to more effectively engage the public on the problem, and to address the issue with both state and federal government.

Resolution 130 asks that our AMA advocate for regulation and legislation to provide that insurers give reasonable credit for out of network expenses based on Fair Health toward a participant’s annual deductibles and out of pocket maximums.

There was supportive testimony on Resolutions 113 and 125. A member of the Council on Medical Service indicated that the issue of network adequacy is under study by the Council on Medical Service, and welcomed referral of Resolutions 113 and 125 so that the issues raised in the resolution can be included in its report for the 2014 Interim Meeting on network adequacy, narrow networks and access to care. Testimony on Resolution 130 was limited to the sponsor. As the treatment of out-of-network expenses is directly related to narrow networks and network adequacy, your Reference Committee believes that the issue of Resolution 130 would also benefit from further study by the Council on Medical Service. As such, your Reference Committee recommends that Resolutions 113, 125 and 130 be referred.

(25) RESOLUTION 114 - LUNG CANCER SCREENING TO BE CONSIDERED STANDARD CARE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 114 be referred.

HOD ACTION: Substitute Resolution 114 adopted.
RESOLVED, That our American Medical Association recommend that coverage of screening low-dose CT (LDCT) scans for patients at high risk for lung cancer by Medicare, Medicaid, and private insurance be a required covered benefit.

Resolution 114 asks that our AMA recommend that coverage of lung cancer screening for high risk patients by Medicare, Medicaid, and private insurance be a required covered benefit to ensure that everyone at risk has a fair and equitable opportunity to survive a lung cancer diagnosis.

Your Reference Committee heard mixed testimony on Resolution 114. Testimony in support of the resolution noted a reduction in morbidity and mortality associated with lung cancer resulting from the screening called for in Resolution 114. However, concerns were raised regarding the impact of the coverage of the lung cancer screening as called for in Resolution 114 on Medicare premium levels. Your Reference Committee notes that the U.S. Preventive Services Task Force recommended, with a “B” grade, annual screening for lung cancer with low-dose computed tomography in high-risk adults aged 55 to 80 years. However, the Medicare Evidence Development and Coverage Advisory Committee (MEDCAC) recently recommended against covering annual screenings for high-risk adults based on a lack of evidence to support the benefits of the screening. The final National Coverage Decision by Medicare has not yet been issued. With this discrepancy, your Reference Committee believes that the topic of Resolution 114 could benefit from further study, and accordingly recommends that Resolution 114 be referred.

(26) RESOLUTION 105 - SENIORS SLEEP

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 105 not be adopted.

HOD ACTION: Resolution 105 not adopted.

Resolution 105 asks that our AMA support the American Academy of Sleep Medicine in their efforts to add medical history questions discussing daytime sleepiness, snoring, and sleep breathing to the free Welcome to Medicare preventive service benefit provided to Medicare beneficiaries.

Several speakers opposed Resolution 105. While acknowledging that sleep disorders, including obstructive sleep apnea, are prevalent among the Medicare population, your Reference Committee agrees with those who questioned whether the Welcome to Medicare visit is the appropriate time to screen for sleep disorders. Welcome to Medicare visits are intended to focus on a defined set of components and already include a plethora of questions which make these visits onerous for primary care physicians. Testimony further noted that it would be burdensome to screen every patient for sleep disorders as well as potentially intrusive into the practice of medicine. For these reasons, your Reference Committee recommends that Resolution 105 not be adopted.
(27) RESOLUTION 110 - SUPPORT A NATIONAL POLL OF
PHYSICIAN’S OPINION REGARDING A SINGLE PAYER
NATIONAL HEALTH PROGRAM, IMPROVED MEDICARE
FOR ALL

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that
Resolution 110 not be adopted.

HOD ACTION: Resolution 110 not adopted.

Resolution 110 asks that our AMA nationally survey physicians, asking the question,
“When considering the topic of health care reform, would you prefer to make
improvements to the current public/private system, or a single-payer system such as a
“Medicare for all” approach?” Resolution 110 also asks that our AMA disseminate the
survey results to physicians and the public.

There was mixed testimony on this resolution. Speakers in support of the resolution
noted that the poll outlined in the resolution could monitor changes in physician opinion
on health reform. Your Reference Committee also heard testimony regarding the
inclusiveness of the AMA House of Delegates, as it represents all state and specialty
societies. Several speakers raised concerns that Resolution 110 is inconsistent with
AMA policies that oppose a single payer system, instead favoring health system reform
alternatives that promote pluralism, freedom of choice, freedom of practice, and
universal access for patients. Your Reference Committee notes that Resolution 110 has
a fiscal note estimated to be between $35,000 and $68,000. Your Reference Committee
agrees with testimony that the intent of Resolution 110 is inconsistent with AMA policy.
As such, your Reference Committee recommends that Resolution 110 not be adopted.

(28) RESOLUTION 107 - SLEEP ILLNESS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that
Policies H-160.949 and D-440.943 be reaffirmed in lieu of
Resolution 107.

HOD ACTION: Policies H-160.949 and D-440.943 reaffirmed
in lieu of Resolution 107.

Resolution 107 asks that our AMA work with state and federal legislators, policymakers,
state and federal agencies, insurance companies, employers, and other providers to
require that patients receive a consultation with a physician and that the physician is
intricately involved in the testing, treatment, and long-term management of a patient’s
sleep illness.

Testimony on Resolution 107 was limited. Based on testimony from the sponsor, your
Reference Committee believes that the intent of the resolution relates to scope of
practice, or non-physician providers attempting to treat obstructive sleep apnea. The
AMA has policy that recognizes obstructive sleep apnea as a major public health issue (Policy D-440.943), and opposes allowing non-physicians to practice medicine (Policy H-160.949). Your Reference Committee recommends reaffirmation of these policies in lieu of Resolution 107.

D-440.943 Obstructive Sleep Apnea
Our AMA: (1) recognizes Obstructive Sleep Apnea (OSA) as a major public health issue; (2) encourages a national public education campaign by appropriate federal agencies and relevant advocacy groups; (3) encourages research into the association of OSA with metabolic, cardiovascular, respiratory, and other diseases; and (4) encourages that all physicians become knowledgeable about the diagnosis and management of OSA. (Res. 521, A-09)

H-160.949 Practicing Medicine by Non-Physicians
Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given; (2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers; (3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision; (4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision; and (5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine. (Res. 317, I-94; Modified by Res. 501, A-97; Appended: Res. 321, I-98; Reaffirmation A-99; Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00; Reaffirmed: CME Rep. 1, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Res. 208, I-10; Reaffirmed: Res. 224, A-11; Reaffirmed: BOT Rep. 9, I-11)

(29) RESOLUTION 111 - INCLUDING BARIATRIC SURGERY AS PART OF THE ESSENTIAL BENEFITS PLAN

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-185.964 and H-165.856 be reaffirmed in lieu of Resolution 111.

HOD ACTION: Substitute Resolution 111 adopted.
RESOLVED, That our American Medical Association, consistent with H-440.842 Recognition of Obesity as a Disease, work with national specialty and state medical societies to advocate for patient access to the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions). (Directive to Take Action)

Resolution 111 asks that our AMA advocate, in concert with national specialty societies and state medical societies, for coverage of bariatric surgery as part of the essential benefits package for health insurance plans sold through the state health insurance exchanges.

There was mixed testimony on this resolution. Supportive testimony underscored the importance of insurance coverage of bariatric surgery, in light of Policy H-440.842 that recognizes obesity as a disease. Additional speakers noted the cost of obesity to society, and the likelihood for obese persons to have other comorbidities. However, a member of the Council on Medical Service testified that the Council presented CMS Report 2 at the 2011 Annual Meeting on essential health care benefits, which stressed that the essential health benefits package needs to be flexible to enable patient choice in health plan and the respective benefits covered while still offering meaningful coverage.

The Council also testified that AMA has policy that supports minimizing, not adding, benefit mandates to allow markets to determine benefit packages and permit a wide choice of coverage options. There was additional testimony in support of our AMA continuing to minimize benefit mandates, stating their direct correlation to health plan costs. Your Reference Committee concurs that our AMA should continue its efforts to minimize benefit mandates to allow for patients to have ample choice of health plan and coverage options, and therefore recommends that Policies H-185.964 and H-165.856 be reaffirmed in lieu of Resolution 111.

H-185.964 Status Report on the Uninsured
Our AMA opposes new health benefit mandates unrelated to patient protections, which jeopardize coverage to currently insured populations. (CMS Rep. 2, A-99; Reaffirmed: CMS Rep. 5, A-09)

H-165.856 Health Insurance Market Regulation
Our AMA supports the following principles for health insurance market regulation:
... (10) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically: (a) Legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed; (b) Benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and (c) Any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed. (CMS Rep. 7, A-03; Reaffirmed: CMS Rep. 6, A-05; Reaffirmation A-07; Reaffirmed: CMS Rep. 2, I-07; Reaffirmed: BOT Rep. 7, A-09; Res. 129, A-09; Reaffirmed: CMS Rep. 9, A-11; Reaffirmed in lieu of Res. 811, I-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed in lieu of Res. 125, A-12; Reaffirmed: Res. 239, A-12)
RESOLUTION 131 - ALTERNATIVES TO VALUE BASED MODIFIERS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies D-390.954 and D-450.961 be reaffirmed in lieu of Resolution 131.


Resolution 131 asks that our AMA continue to advocate for alternative mechanisms for calculating a value-based modifier (VBM) for all physicians in conjunction with efforts to identify relevant episodes of care that could be used in the calculation. Resolution 131 also asks that our AMA advocate for policy efforts that would provide an option for all physicians involved in hospital patient care to tie the VBM to their hospital’s performance in the hospital value-based purchasing program, if they so choose, as it is a mechanism that appropriately measures the direct health care team physicians’ value in the hospital care setting.

Your Reference Committee heard mixed testimony on this resolution. Speakers voiced concerns with advocating for alternative mechanisms for calculating a value-based modifier as called for in the first resolve, as existing policy advocates that the value-based payment modifier be repealed or significantly modified. In addition, your Reference Committee notes that Policy D-450.961 also addresses the intent of this resolution. As such, your Reference Committee recommends that Policies D-390.954 and D-450.961 be reaffirmed in lieu of Resolution 131.

D-390.954 Hospital-Based Physicians and the Value-Based Payment Modifier
Our AMA will continue to advocate that the Value-Based Payment Modifier program be repealed or significantly modified. (CMS Rep. 3, I-13)

D-450.961 Hospital-Based Physicians and the Value-Based Payment Modifier
Our AMA encourages national medical specialty societies to pursue the development of relevant performance measures that demonstrate improved quality and lower costs, and work with the Centers for Medicare & Medicaid Services to have those measures incorporated into the Value-Based Payment Modifier program and other quality measurement and improvement programs. (CMS Rep. 3, I-13)

RESOLUTION 132 - DELAYS IN MEDICAID PAYMENT FOR PROVIDER SERVICES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends Policies H-385.921, H-190.959, H-190.981 and H-390.976 be reaffirmed in lieu of Resolution 132.
Resolution 132 asks that our AMA work to educate legislators and the public about the importance of maintaining financial viability for physician practices, especially as increased numbers of patients have access to insured care under the Affordable Care Act; assist states in investigating and resolving delays in payment for services provided under Medicaid; work with state and specialty societies to advocate for state level laws and regulations that ensure timely payment for services provided to Medicaid patients; and advocate with Congress and the Centers for Medicare & Medicaid Services for legislation or regulation to make permanent the requirement that medical services provided under Medicaid be reimbursed at rates no less than would be provided by Medicare.

There was supportive testimony on Resolution 132. Your Reference Committee notes that the AMA has been very active on this issue on both the state and national levels. Based on already existing policy, the AMA has sent several letters and has met with CMS officials concerning the delays and problems with Medicaid payments. In addition, the AMA has been involved in advocating with Congress to continue the increased Medicaid payments beyond 2014. The AMA also surveyed state medical societies about whether they were receiving payments. Your Reference Committee believes that existing AMA policies address the intent of Resolution 132, and therefore recommends that Policies H-385.921, H-190.959, H-190.981 and H-390.976 be reaffirmed in lieu of the resolution.


**H-385.921 Health Care Access for Medicaid Patients**

It is AMA policy that to increase and maintain access to health care for all, payment for physician providers for Medicaid, TRICARE, and any other publicly funded insurance plan must be at minimum 100% of the RBRVS Medicare allowable. (Res. 103, A-07; Reaffirmed: CMS Rep. 2, I-08; Reaffirmation A-12)

**H-190.959 Physician Reimbursement by Health Insurance and Managed Care Companies**

(1) Our AMA shall make it a top priority to seek regulatory and legislative relief to ensure that all health insurance and managed care companies pay for clean claims submitted electronically within fourteen days. (2) When electronic claims are deemed to be lacking information to make the claim complete, the health insurance and managed care companies will be required to notify the health care provider within five business days to allow prompt resubmission of a clean claim. (3) Our AMA shall advocate for heavy penalties to be imposed on health insurance and managed care companies, including their employees, that do not comply with laws and regulations establishing guidelines for claims payment. (Sub. Res. 713, A-02; Modified: Res. 714, A-03; Reaffirmation I-04)

**H-190.981 Required Timely Reimbursements by all Health Insurers**

Our AMA will prepare and/or seek sponsorship of legislation calling for all health insurance entities and third party payers—inclusive of not-for-profit organizations and health maintenance organizations—to pay for "clean" claims when filed electronically within 14 days and paper claims within 30 days, with interest accruing thereafter. These time periods should be considered ceilings, not floors.
or fixed differentials between paper and electronic claims. (Sub. Res. 112, A-95; Modified: BOT Rep. 17, I-00; Reaffirmation A-02; Reaffirmed: Res. 815, I-02; Reaffirmation I-04)

H-390.976 Delayed Payment of Medical Insurance Claims
Our AMA (1) expresses its concern and displeasure about CMS's practice of slowing payment of Medicare claims, which places an unwarranted financial burden upon the elderly and the practitioners and facilities which serve senior citizens; (2) supports model state legislation to establish incentives and/or penalties among private and public third party payers to rectify the problem of delayed insurance reimbursements; and (3) believes that reasonable interest should begin on uncontroverted claims not later than 30 days following receipt of a claim by the payer. (Sub. Res. 20, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed by Res. 138, A-98; Reaffirmation I-04; Reaffirmed: CMS Rep. 5, A-10)

(32) BOARD OF TRUSTEES REPORT 17 – TUBAL LIGATION AND VASECTOMY CONSENTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 17 be filed.

HOD ACTION: Board of Trustees Report 17 filed.

Board of Trustees Report 17, an informational report, concludes that there is ample evidence to support of advocating for changing Medicaid’s sterilization waiting period policy, in accord with AMA policy.

Your Reference Committee heard limited testimony on Board of Trustees Report 17. A member of the Board of Trustees introduced the report, and summarized Policy D-75.994 adopted at the 2013 Interim Meeting. Additional speakers reiterated the importance of advocating for the implementation of Policy D-75.994. Your Reference Committee concurs with the conclusion outlined by the Board of Trustees in its report that there is ample evidence to support advocating for changing Medicaid’s sterilization waiting period policy. Accordingly, your Reference Committee recommends that Board of Trustees Report 17 be filed.
Mr. Speaker, this concludes the report of Reference Committee A. I would like to thank John Bizon, MD, Steven J. Fleischman, MD, Candace E. Keller, MD, Jonathan D. Leffert, MD, Janice Tildon-Burton, MD, Harsh K. Trivedi, MD, and all those who testified before the Committee.

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