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The following is a preliminary report of actions taken by the House of Delegates at its 2013 Annual 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-13)

Report of Reference Committee A
Jerry L. Halverson, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Resolution 103 - Managed Care Contract Payment Should Be Above Medicare Fees
2. Resolution 109 - Comprehensive Dental Coverage (including dental implants) for Children with Orofacial Clefting
3. Resolution 114 - Oncofertility and Fertility Preservation Treatment
4. Resolution 121 - Need to Deactivate New Coding Edits that Bundle Evaluation and Management Codes and Codes for Immunization Services, Resulting in Decreased Immunization Rates for Children

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

5. Board of Trustees Report 14 - Direct-to-Consumer Advertising of Durable Medical Equipment
6. Council on Medical Service Report 3 - Payment Variations Across Outpatient Sites of Service
7. Council on Medical Service Report 5 - Delivery of Care and Financing Reform for Medicare and Medicaid Dually Eligible Beneficiaries
8. Resolution 102 - Patient Satisfaction Surveys and Quality Parameters as Criteria for Physician Reimbursement
9. Resolution 104 - Cost-Saving Public Coverage for Renal Transplant Patients
10. Resolution 106 - Surprise Fee in Patient Protection and Affordable Care Act (PPACA)
11. Resolution 107 - Medicare’s Non-Existent Relationship to Usual and Customary (U&C) Fees

12. Resolution 108 - Vaccines for Children Program and the New CPT Codes for Immunization Administration

13. Resolution 116 - Extending Medicaid Payment Increases to Primary Care Physicians to Include Obstetrician/Gynecologists

14. Resolution 117 - Observation Status and Medicare Part A Qualification In lieu of Resolution 111 - Medicare Long-Term Care Prior Hospitalization Requirement

15. Resolution 120 - Patient Access to Anti-Tuberculosis Medications

RECOMMENDED FOR REFERRAL

16. Resolution 112 - Unfair Medicare Payment Practice

17. Resolution 118 - Pap Testing Guidelines: HEDIS versus USPSTF

18. Resolution 119 - Place of Service Code for Observation Services


20. Resolution 115 - Medication Non-Adherence and Errors

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

21. Resolution 101 - Affordable Access for Low Income Individuals

22. Resolution 105 - Reducing the Cost of Prescription Drugs to Low Income Seniors

23. Resolution 110 - Language and Hearing Impaired Interpreter Services

24. Resolution 113 - Making Medicare Price Standardization Accurate
(1) RESOLUTION 103 – MANAGED CARE CONTRACT
PAYMENT SHOULD BE ABOVE MEDICARE FEES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that
Resolution 103 be adopted.

HOD ACTION: Resolution 103 adopted.

Resolution 103 asks that our AMA seek legislation and/or regulation to prevent managed
care companies from utilizing a physician payment schedule below the updated Medicare
professional fee schedule.

A preponderance of the testimony heard on Resolution 103 was supportive. The
resolution’s sponsor acknowledged the similarity of their request with existing AMA policy
(Policy D-400.990), which asks the AMA to use every means available to convince health
insurance companies and managed care organizations to immediately uncouple fee
schedules from Medicare conversion factors and to maintain a fair and appropriate
payment level. Your Reference Committee points to the AMA’s strategic focus area on
payment and care delivery, which builds upon ongoing legislative activities to shape
payment and delivery models that improve physician satisfaction.

The sponsor underscored the continued downward spiral of physician payment levels and
the trend among managed care companies to link physician payment to Medicare rates
plus or minus certain percentages. Multiple speakers also described insurers who have
uncoupled their fees from Medicare conversion factors in ways that negatively affect
physician payments. Because testimony on Resolution 103 was largely supportive, your
Reference Committee recommends that it be adopted.

(2) RESOLUTION 109 - COMPREHENSIVE DENTAL
COVERAGE (INCLUDING DENTAL IMPLANTS) FOR
CHILDREN WITH OROFACIAL CLEFTING

RECOMMENDATION:

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

HOD ACTION: Resolution 109 adopted.

Resolution 109 asks that our AMA advocate for appropriate funding for comprehensive
dental coverage (including dental implants) for children with orofacial clefting.

There was limited, yet unanimous positive testimony heard on Resolution 109. Speakers
urged the AMA to support comprehensive dental coverage to assist children with orofacial
clefting as this condition can be a tremendous burden for the children afflicted by this
disorder. Your Reference Committee notes that existing AMA Policy H-185.967[1]
supports insurance coverage for the treatment of a minor child's congenital or
developmental deformity or disorder due to trauma or malignant disease. Given
supportive testimony and consistency with existing AMA policy, your Reference Committee recommends that Resolution 109 be adopted.

(3) RESOLUTION 114 - ONCOFERTILITY AND FERTILITY PRESERVATION TREATMENT

RECOMMENDATION:

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

HOD ACTION: Resolution 114 adopted.

Resolution 114 asks that our AMA support payment for and lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary oncologic treatments as determined by a licensed physician.

Your Reference Committee heard extensive, impassioned testimony on Resolution 114. Many speakers supported the adoption of Resolution 114 as written stating that providing fertility preservation treatment is the standard of care although patients are often not able to obtain this care because health insurers are not covering such treatment. One speaker highlighted a series of adverse health conditions that have resulted from oncology care, which are all covered by health insurers. Therefore, it was urged that oncofertility and fertility preservation treatment should be covered as well. Given supportive testimony, your Reference Committee recommends that Resolution 114 be adopted.

(4) RESOLUTION 121 - NEED TO DEACTIVATE NEW CODING EDITS THAT BUNDLE EVALUATION AND MANAGEMENT CODES AND CODES FOR IMMUNIZATION SERVICES, RESULTING IN DECREASED IMMUNIZATION RATES FOR CHILDREN

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 121 be adopted.

HOD ACTION: Resolution 121 adopted.

Resolution 121 asks that AMA Policy H-60.969, Childhood Immunizations, be reaffirmed and that our AMA work with the American Academy of Family Physicians and the American Academy of Pediatrics to strongly encourage CMS to deactivate coding edits that cause a decrease in immunization rates for children, and to make these edit deactivations retroactive to January 1, 2013.

The sponsors of Resolution 121 expressed concern about the Center for Medicare and Medicaid Services’ National Correct Coding Initiative, which has resulted in the bundling of all evaluation and management services with immunization codes. The unintended consequence of this bundling of services has resulted in making it more difficult for physicians caring for children to provide preventive medicine, specifically immunizations.
Several speakers expressed strong concerns about barriers that make it difficult to administer immunizations. Given supportive testimony, your Reference Committee recommends that Resolution 121 be adopted.

(5) BOARD OF TRUSTEES REPORT 14 - DIRECT-TO-CONSUMER ADVERTISING OF DURABLE MEDICAL EQUIPMENT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 2b in Board of Trustees Report 14 be amended by addition and deletion to read as follows:

(b) whenever feasible list the actual criteria (or a summary thereof) from the appropriate source, such as the applicable Certificate of Medical Necessity, DME Information Form (DIF), “Dear Physician Letter” from DME Contractor Medical Directors, Local Coverage Determination or associated policy article; and

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 3 in Board of Trustees Report 14 be amended by addition and deletion to read as follows:

That our AMA recommend that DME companies stop coercive acts which push inappropriately influence physicians to sign these prescriptions for their patients.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 14 be adopted as amended and that the remainder of the report be filed.

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

Board of Trustees Report 14 recommends that policies H-330.945 Durable Medical Equipment Requirements, H-330.955 Prescription of Durable Medical Equipment and H-330.960 Cost of Medically Related Services and Supplies be reaffirmed.

Board of Trustees Report 14 also recommends that Resolution 505-A-12 be amended by deletion to read as follows and adopted: That our AMA pursue legislation or regulation as appropriate to require that direct-to-consumer advertising and any other media for durable medical equipment and other medical supplies: (a) include a disclaimer statement to the effect that eligibility for and coverage of the illustrated product is subject to specific criteria and that only a physician can determine if a patient meets those criteria; (b) whenever
feasible list the actual criteria (or a summary thereof) from the appropriate Certificate of Medical Necessity; (c) note that patients who knowingly obtain DME or other supplies without meeting the eligibility criteria and the physicians who inappropriately certify such patients may be subject to civil and/or criminal penalties for fraud; and, (d) refrain from statements to the effect that only a physician order or signature is required to obtain the desired items. In addition, the report suggests that our AMA recommend that DME companies stop coercive acts which push physicians to sign these prescriptions for their patients.

Your Reference Committee commends the Board on its examination of durable medical equipment (DME) and supplies sales, direct-to-consumer advertising of these products and federal oversight activities of medical devices. Testimony on this report was generally supportive. Your Reference Committee believes that the report’s recommendations address the adverse effects of direct-to-consumer advertising of DME and supplies. Moreover, the report includes compelling information in support of the recommendations. Suggested edits to the body of the report, but not to the report’s recommendations, were submitted by the U.S. Food and Drug Administration. An amendment to Recommendation 2b accounting for a range of sources of criteria was well-received and is recommended by your Reference Committee. Your Reference Committee also concurs with a minor amendment to Recommendation 3 that was suggested in online testimony. Accordingly, your Reference Committee recommends that Board of Trustees Report 14 be adopted as amended.

(6) COUNCIL ON MEDICAL SERVICE REPORT 3 – PAYMENT VARIATIONS ACROSS OUTPATIENT SITES OF SERVICE

RECOMMENDATION A:

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

1. That our AMA work with states to advocate that third party payers be required to:
   a. Assess equal or lower facility coinsurance for lower-cost sites of service (hospital outpatient department, ambulatory surgical center, or office-based facility);
   b. Publish and routinely update pertinent information related to patient cost-sharing; and
   c. Allow their plan’s participating physicians to perform outpatient procedures at an appropriate site of service as chosen by the physician and the patient. (Directive to Take Action)
Mr. Speaker, your Reference Committee recommends that Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.


Council on Medical Service Report 3 recommends that our AMA reaffirm Policies H-330.925, H-240.993 and D-330.997, which support equitable Medicare payments across outpatient settings, and reaffirm Policy H-165.846, which supports mechanisms to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing, out-of-pocket limits and lifetime benefit caps, and excluded services. Council on Medical Service Report 3 also recommends that our AMA work with states to advocate that third party payers be required to: (a) assess equal or lower facility coinsurance for lower-cost sites of service (hospital outpatient department, ambulatory surgical center, or office-based facility); (b) publish and routinely update pertinent information related to patient cost-sharing; and (c) allow their plan’s participating physicians to perform outpatient procedures at an appropriate site of service as chosen by the physician and the patient.

Your Reference Committee heard testimony that was supportive of Council on Medical Service Report 3. Testimony noted that a variety of factors may justify higher payments to hospital outpatient departments, such as hospital requirements to meet Joint Commission accreditation standards and Medicare Conditions of Participation. Alternatively, physician offices are not required to meet these standards. An additional comment suggested that our AMA explore whether higher payments in certain settings are justified by patient safety concerns. Your Reference Committee discussed possible reasons for higher payments to hospital outpatient departments, including hospitals’ 24-hour access and the proximity of outpatient departments to hospital emergency departments. Your Reference Committee concludes that data are not yet available to substantiate whether pay disparities for services performed across outpatient settings are in fact justifiable. Furthermore, there is no comprehensive evidence base to help patients determine the optimal location to have a particular outpatient procedure performed.

Testimony also acknowledged the importance of cost transparency to help patients understand that the amount of their cost-sharing may differ, depending on the site of service. Your Reference Committee clarified that transparency regarding costs is important but does not inform patients about actual quality of care. Additional testimony noted that the payment disparities discussed in the Council’s report have led many cardiologists to migrate to the hospital setting, thereby increasing costs of certain outpatient cardiac procedures. Speakers also expressed concern that physician payments across sites of service will be equalized at the lowest possible level.

Substitute language for Recommendation 3a was offered out of concern that the recommendation as written does not sufficiently hold patients accountable to make quality and cost-effective choices. Testimony was supportive of this language, and your Reference Committee therefore recommends incorporating the substitute language into Recommendation 3a and adopting Council on Medical Service Report 3 as amended.
Council on Medical Service Report 5 - Delivery of Care and Financing Reform for Medicare and Medicaid Dually Eligible Beneficiaries

Recommendation A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1a of Council on Medical Service Report 5 be amended by addition and deletion to read as follows:

1. That our American Medical Association (AMA) adopt the following principles on the delivery of care and financing reform for Medicare and Medicaid dually eligible beneficiaries:

   a. Various approaches to integrated delivery of care should be promoted under demonstrations such as primary care physician-led patient-centered medical homes with adequate payment to physicians, provision of care management and mental health resources.

Recommendation B:

Mr. Speaker, your Reference Committee recommends that Council on Medical Service Report 5 be adopted as amended and the remainder of the report be filed.

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

Council on Medical Service Report 5 recommends that our AMA adopt the following principles on the delivery of care and financing reform for Medicare and Medicaid dually eligible beneficiaries: a. Various approaches to integrated delivery of care should be promoted under demonstrations such as primary care medical homes with adequate payment to physicians, provision of care management and mental health resources; b. Customized benefits and services from health plans are necessary according to each beneficiary’s specific medical needs; c. Care coordination demonstrations should not interfere with the established patient-physician relationships in this vulnerable population; d. Delivery and payment reform for dually eligible beneficiaries should involve actively practicing physicians and take into consideration the diverse patient population and local area resource; e. States with approved financial alignment demonstration models should provide education and counseling to beneficiaries on options for receiving Medicare and Medicaid benefits; f. Conflicting payment rules between the Medicare and Medicaid programs should be eliminated; g. Medicare and Medicaid benefit plans and the delivery of benefits should be coordinated and h. Care plans for beneficiaries should be streamlined among all clinical providers and social service agencies.

Council on Medical Service Report 5 also recommends that our AMA reaffirm Policy D-290.978, which calls for the Centers for Medicare & Medicaid Services to require all states to develop forms and related processes to facilitate “opting out” of managed care programs by dually eligible beneficiaries.
eligible individuals, and that those forms and directives be available no less than 120 days before the implementation date of a state’s dually eligible managed care program.

Your Reference Committee heard supportive testimony on Council on Medical Service Report 5. A speaker acknowledged that the report provides a good summary of some of the issues and solutions for providing health care services for Medicare and Medicaid dually eligible beneficiaries.

Amendments were proposed for consideration. Testimony provided information that there are National Committee for Quality Assurance standards for specialty medical homes as well as primary care medical homes. Therefore, it was suggested that Recommendation 1a be amended to read “patient-centered medical homes” rather than “primary care medical homes.” In addition, an amendment was suggested to include “physician-led” at the beginning of “patient-centered medical homes,” which was supported by the Council on Medical Service. Your Reference Committee concurs with these amendments.

In addition, testimony suggested that recommendation 1f be more explicit so that the administration of the dually eligible population takes into consideration physician payments, medical office administration and patient empowerment. A speaker suggested amending the recommendation to read “Conflicting payment rules between the Medicare and Medicaid programs should be eliminated in a manner that benefits the physician-patient team.” Your Reference Committee considered this amendment, but felt that the suggested new language was too vague and questioned what examples of benefiting the physician-patient team would apply in this situation.

A concern was raised that this report may allow for any willing provider provisions. A member of the Council on Medical Service testified that the report does not advocate for any willing provider provisions since it is focused on not disrupting continuity of care of dually eligible patients when possible. It is not designed to allow any willing provider to care for any patient, but rather to support the long term patient-physician relationships that have already been established in this vulnerable population. As such, your Reference Committee recommends that Council on Medical Service Report 5 be adopted as amended.

(8) RESOLUTION 102 - PATIENT SATISFACTION SURVEYS AND QUALITY PARAMETERS AS CRITERIA FOR PHYSICIAN PAYMENT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 102 be amended by addition and deletion to read as follows:
RESOLVED, That our American Medical Association work with the Centers for Medicare & Medicaid Services (CMS) and non-government payers to ensure that subjective criteria, such as patient satisfaction surveys, be used only as an adjunctive and not a determinative measure of physician quality for the purpose of physician reimbursement payment (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 102 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work with CMS and non-government payers to ensure that reimbursement physician payment determination, when incorporating quality parameters, only consider measures that are under the direct control of the physician. (Directive to Take Action)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 102 be adopted as amended.

HOD ACTION: Resolution 102 adopted as amended.

Resolution 102 asks that our AMA work with CMS and non-government payers to ensure that subjective criteria, such as patient satisfaction surveys, be used only as an adjunctive and not a determinative measure of physician quality for the purpose of physician reimbursement and that reimbursement determination, when incorporating quality parameters, only consider measures that are under the direct control of the physician.

Testimony on Resolution 102 was mixed. Several amendments were proposed, such as replacing the term "reimbursement" with “payment” in both resolves. Your Reference Committee concurs with this suggested language change. In addition, your Reference Committee notes that existing AMA policy is consistent with the requests in Resolution 102. Policy H-406.991[5] advocates that physician-profiling programs may rank individual physician members of a medical group but should not use those individual rankings for placement in a network or for payment purposes. Policy H-450.966 advocates that regarding the development and evaluation of quality and performance standards, standards and measures should recognize and adjust for factors that are not within the direct control of those being measured. Given the minor amendments and consistency with AMA policy, your Reference Committee recommends that Resolution 102 be adopted as amended.
Resolution 104 asks that our AMA support private and public mechanisms that would extend insurance coverage for the full spectrum of renal transplant care for the life of the transplanted organ and offer technical assistance to individual state and specialty societies when those societies lobby state or federal legislative or executive bodies to implement evidence-based cost-saving policies within public health insurance programs.

Mixed, yet mostly supportive testimony was heard on Resolution 104. Speakers in favor of Resolution 104 identified the cost savings that would occur by covering a lifelong immunosuppressive regimen in order to prevent failure of a kidney transplant. Furthermore, it was cautioned that discontinuing this treatment in the midst of care would result in poor health outcomes. Opposing testimony highlighted that our AMA does not support life-long public support for other health care conditions and urged consistency with existing policy.

The first resolve requests AMA support for extending coverage for the “full spectrum” of renal transplant care. Your Reference Committee is concerned that this language is too broad and could include any type of treatments. Therefore, your Reference Committee recommends
replacing “full spectrum” with “evidence-based treatment.” In addition, the second resolve asks our AMA to offer technical assistance to state and specialty societies when these entities lobby to implement evidence-based cost-saving policies within public health insurance programs. Your Reference Committee is aware that our AMA is available to provide this service and therefore suggests additional language supporting our AMA to continue this service. As such, your Reference Committee recommends that Resolution 104 be adopted as amended.

(10) RESOLUTION 106 - SURPRISE FEE IN PATIENT PROTECTION AND AFFORDABLE CARE ACT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 106 be amended by addition to read as follows:

RESOLVED, That our American Medical Association advocate that any proposed assessment on ‘issuers of insurance’ (scheduled to commence in 2014 for a 3-year period), intended to fund a ‘risk adjustment program’ to cushion insurers against any actual uncertainties surrounding the health status of the uninsured, not be passed along to consumers be taken from administrative and medical management costs. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 106 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 106 be changed to read as follows:

TRANSITIONAL REINSURANCE FEES UNDER THE AFFORDABLE CARE ACT

HOD ACTION: Resolution 106 adopted as amended with a change in title.

Resolution 106 asks that our AMA advocate that any proposed assessment on ‘issuers of insurance’ (scheduled to commence in 2014 for a 3-year period), intended to fund a ‘risk adjustment program’ to cushion insurers against any actual uncertainties surrounding the health status of the uninsured, not be passed along to consumers.

Testimony received on Resolution 106 was mixed. Your Reference Committee acknowledges the sponsors’ concern that transitional reinsurance fees enacted under the ACA will be passed along to consumers. These fees, which will be imposed on insurers beginning in 2014, are intended to fund reinsurance payments that cover high-risk people in the individual market. Your Reference Committee heard testimony on the appropriateness of insulating patients from the costs of covering risk adjustment pools. Concerns regarding Resolution 106 largely focused on
the potential that physicians will ultimately bear the burden of these fees. In an effort to prevent
the reinsurance fees from being passed on to consumers or to physicians via payment
reductions, your Reference Committee recommends adding a clause at the end of the resolve
specifying that the transitional reinsurance fees “be taken from administrative and medical
management costs,” as suggested by one of the speakers. To clarify the fee program
addressed in the resolution, your Reference Committee also recommends that the title of
Resolution 106 be changed to Transitional Reinsurance Fees under the Affordable Care Act.

(11) RESOLUTION 107 - MEDICARE’S NON-EXISTENT
RELATIONSHIP TO USUAL AND CUSTOMARY (U&C)
FEES

RECOMMENDATION A:
Mr. Speaker, your Reference Committee recommends that
Resolution 107 be amended by addition and deletion to
read as follows:

RESOLVED, That our American Medical Association take
the position that there is no relationship between the
Medicare fee schedule and Usual, & Customary and
Reasonable Fees. (New HOD Policy)

RECOMMENDATION B:
Mr. Speaker, your Reference Committee recommends that
Resolution 107 be adopted as amended.

RECOMMENDATION C:
Mr. Speaker, your Reference Committee recommends that
the title of Resolution 7 be changed to read as follows:

MEDICARE’S NON-EXISTENT RELATIONSHIP TO
USUAL, CUSTOMARY AND REASONABLE (UCR) FEES

HOD ACTION: Resolution 107 be adopted as
amended with a change in title.

Resolution 107 asks that our AMA take the position that there is no relationship between the
Medicare fee schedule and usual and customary fees. Testimony on Resolution 107 was
supportive. It was suggested in the online testimony that “usual and customary” be defined for
those less familiar with these terms. Under Policy H-385.923, “usual” means a fee that the
physician usually charges to his/her private patients. “Customary” means the charge is within
the range of usual fees currently charged by physicians of similar training and experience for the
same service within the same limited geographic area. “Reasonable” is defined as a charge that
is usual and customary, and is justifiable considering the special circumstances of the case in
question, without regard to payments that have been discounted under governmental or non-
governmental health insurance plans or policies.

Our AMA has been consistent in its position that Medicare payment rates are significantly lower
than the cost to provide medical services. Your Reference Committee concurs that there is no relationship between the Medicare physician fee schedule and usual, customary and reasonable (UCR) fees. Testimony regarding this position was supportive. Your Reference Committee heard testimony offering an amendment to replace “fee schedule” with “payment schedule” but notes that the correct terminology is “Medicare fee schedule.” To be consistent with existing AMA policy, your Reference Committee also suggests adding the word “reasonable” to the resolution and its title, and recommends that Resolution 107 be adopted with these minor amendments.

(12) RESOLUTION 108 - VACCINES FOR CHILDREN PROGRAM AND THE NEW CPT CODES FOR IMMUNIZATION ADMINISTRATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 108 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association work with the American Academy of Pediatrics and other groups to convince the Centers for Medicare & Medicaid Services to allow state Medicaid agencies to pay physicians for using the new immunization administration codes (90460, 90461) to compassionately immunize eligible patients and to be paid fairly for their participation in the Vaccines for Children Program. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 108 be adopted as amended.

HOD ACTION: Resolution 108 adopted as amended.

Resolution 108 asks that our AMA work with the American Academy of Pediatrics and other groups to convince CMS to allow state Medicaid agencies to pay physicians for using the new immunization administration codes (90460, 90461) to compassionately immunize eligible patients and to be paid fairly for their participation in the Vaccines for Children Program.

Unanimous positive testimony was heard on Resolution 108. Your Reference Committee notes that Resolution 108 is consistent with AMA policy D-440.956, which advocates for improved financing mechanisms for vaccines, including the expansion of the Vaccines for Children Program. Your Reference Committee agrees that this is an important issue for our AMA to support. However, an amendment is suggested to strike the term “compassionately” since it appears unnecessary given that the services provided by physicians are naturally compassionate.
RESOLUTION 116 - EXTENDING MEDICAID PAYMENT INCREASES TO PRIMARY CARE PHYSICIANS TO INCLUDE OBSTETRICIAN/GYNECOLOGISTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends adoption of the following Substitute Resolution 116:

RESOLVED, That our AMA advocate for the extension of Medicaid payment increases to primary care physicians to include all physicians who furnish a substantial portion (60%) of their Medicare or Medicaid billings (allowable charges) for designated primary care services.

RESOLVED, That our AMA advocate for the continuation of the Affordable Care Act primary care rate increases after the expiration of such provision on December 31, 2014.

RECOMMENDATION B:

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

EXTENDING MEDICAID PAYMENT INCREASES

HOD ACTION: Resolution 116 referred.

Resolution 116 asks that our AMA advocate for the extension of Medicaid reimbursement rate increases to primary care physicians to include obstetrician/gynecologists.

Extensive mixed testimony was heard on Resolution 116. One speaker stated that extending the increase in Medicaid reimbursement rates for primary care physicians to include obstetricians/gynecologists would improve access to care for Medicaid-insured women. Concern was voiced about inadequate payment for all other physicians. Several speakers requested that other specialties, such as neurology, psychiatry and emergency medicine be included in the increased payment rates. Several amendments were suggested. Your Reference Committee considered these amendments and drafted a substitute resolution in response.

Your Reference Committee notes that Medicare uses a fee schedule to pay physicians for the services they furnish to beneficiaries. The ACA provides a 10 percent bonus payment on top of the fee schedule payment for select primary care services furnished by primary care physicians in calendar years 2011-2015. To qualify for the bonus, a physician must be self-designated in a primary care specialty (general internal medicine, family practice, pediatrics, and geriatrics) and a substantial portion (60 percent) of their Medicare billings, or allowable charges, must be for the designated primary care services (mainly, office-and other outpatient visits) on which a bonus payment is made. CMS will assess eligibility for the bonus by (1) checking a physician’s specialty self-designation to ensure that they are in general internal medicine or in another primary care specialty and (2) looking back on the percentage of designated primary care services furnished by the physician during an earlier time period.
Given supportive testimony and the fact that existing AMA policy supports a sufficient supply of primary care physicians, including obstetricians/gynecologists, your Reference Committee recommends that Substitute Resolution 116 be adopted.

(14) RESOLUTION 111 – MEDICARE LONG-TERM CARE PRIOR HOSPITALIZATION REQUIREMENT
RESOLUTION 117 - OBSERVATION STATUS AND MEDICARE PART A QUALIFICATION

RECOMMENDATION A:

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

RESOLVED, That our AMA advocate for Medicare Part A coverage for a patient’s direct admission to a skilled facility if directed by their physician and if the patient’s condition meets skilled nursing criteria. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 117 be adopted as amended in lieu of Resolution 111.

HOD ACTION: Resolution 117 adopted as amended in lieu of Resolution 111.

Resolution 111 asks that our AMA work to eliminate the “three day” requirement for inpatient hospital admission prior to skilled nursing facility admission as a prerequisite for Medicare coverage and substitute other appropriate criteria that would allow for timely and appropriate skilled nursing facility placement of Medicare patients.

Resolution 117 asks that our AMA seek and/or support a requirement that a 72-hour hospital stay, either under inpatient status or under observation status, will qualify a patient for Medicare Part A coverage for skilled services after discharge.

Testimony heard on Resolution 111 supported reaffirmation of existing policy; however, some testimony favored adoption of this resolution out of concern that reaffirmation would not help eliminate the three-day inpatient hospital requirement for Medicare coverage of skilled nursing facility services. Testimony heard on Resolution 117 was very supportive. Multiple speakers emphasized that current federal observation care policy is archaic and problematic. Others spoke about the costs associated with hospitalizing patients for 72 hours for non-acute treatments to qualify for post-hospital skilled nursing facility care. It was repeatedly suggested that legislative and/or regulatory relief is very much needed, and that our AMA has had policies in place to eliminate the three-day stay for several years. There was discussion of requiring no hospital stay; however, your Reference Committee believes the resolution as amended captures the spirit and intent of Resolution 117.
Your Reference Committee points out that our AMA is actively working with Congress and the Centers for Medicare & Medicaid Services (CMS) on solutions to coverage problems associated with hospital observation stays and subsequent skilled nursing facility care. Our AMA is working in support of federal legislation (S 569; HR 1179) that would count observation care toward the three-day stay requirement. Our AMA has also repeatedly requested that CMS review its policy on the three-day stay requirement. Your Reference Committee recognizes similarities in intent between Resolutions 111 and 117 and existing AMA policy on the three-day hospital stay requirement. After hearing discussion of several amendments suggested during testimony, your Reference Committee recommends asking our AMA to continue to advocate that hospital stays of any duration, under either inpatient or observation status, will qualify a patient for Medicare Part A coverage of skilled nursing facility services after discharge. Your Reference Committee recommends that Resolution 117 be adopted as amended in lieu of Resolution 111.

(15) RESOLUTION 120 - PATIENT ACCESS TO ANTI-TUBERCULOSIS MEDICATIONS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 120 be amended by addition to read as follows:

RESOLVED, That our American Medical Association support state and federal policy to cover TB testing for individuals deemed to have a high risk for contracting TB infection and to provide anti-tuberculosis medications to patients with both active and latent TB free of charge or insurance co-pays or deductibles in order to prevent the transmission of this airborne infectious disease. (New HOD Policy)

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 support state and federal policy to provide anti-tuberculosis medications to patients with both active and latent TB free of charge or insurance co-pays or deductibles in order to prevent the transmission of this airborne infectious disease.

Your Reference Committee heard mostly supportive testimony on Resolution 120. While support was voiced for adopting this resolution, several concerns were raised. One speaker questioned if there were widespread issues with anti-tuberculosis medications not being covered for free. Another speaker felt that the resolution did not take into account the continuing emergence of drug resistance to common TB regimens, the challenge of drug shortages or the fact that TB is a global problem. In addition, it was cautioned that offering free medication for any condition should be carefully considered.

Your Reference Committee considered the issues raised in testimony, but notes that while most states provide free TB medications for both active and latent TB, there are a few states where this is the responsibility of the local health departments. In addition, your Reference Committee is aware that there has been a shortage of TB medications, which has caused some states to
either decrease the dosage to make it last longer or have temporarily restricted free TB medications to only high priority patients. Given the shortage of TB medications in addition to drug resistant TB, this is a growing problem that your Reference Committee believes needs to be further addressed. Your Reference Committee recommends additional language to include the coverage of testing for individuals deemed to have a high risk for contracting TB infection in order to increase the efforts to eliminate this disease.

(16) RESOLUTION 112 - UNFAIR MEDICARE PAYMENT PRACTICE

RECOMMENDATION:

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

HOD ACTION: Resolution 112 referred.

Resolution 112 asks that our AMA seek legislation to fairly compensate procedures across all service sites (physician office, ambulatory surgical centers, and hospital outpatient departments) to include a single formula for reimbursement that recognizes the different average resource costs to provide each procedure and a single update formula (such as the Consumer Price Index for all Urban Consumers) for all sites with an appropriate conversion factor that recognizes different average resource costs for the different sites.

Testimony on Resolution 112 was mixed, and included suggestions for referral. A member of the Council on Medical Service noted that Council on Medical Service Report 3-A-13 addresses payment variations across outpatient sites of service, and asked what additional information would be expected from referral. A concern was expressed that adopting the resolution as written will not increase payments for physicians in solo practice or those in rural or at-risk areas. Alternatively, the sponsors noted that hospital-based care is more expensive but may not produce better outcomes than outpatient facilities owned and operated by independent physicians. Your Reference Committee discussed the complexity associated with transitioning existing payment update formulas into a single update formula, as requested by the resolution. Your Reference Committee concurs that this is a complex issue worthy of further study and therefore recommends referral.

(17) RESOLUTION 118 - PAP TESTING GUIDELINES: HEDIS VERSUS USPSTF

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 118 be referred.

HOD ACTION: Resolution 118 referred.

Resolution 118 asks that our AMA urge third party payers not to withhold payment to physicians for preventive health services that fall under accepted guidelines, even if they differ from the payer’s own guidelines.

While testimony was supportive of the topic in general, concern was raised that physicians should practice according to the specific needs of each individual patient rather than according
to guidelines created by other entities. In addition several speakers felt that this was a complicated issue that deserved more consideration and therefore urged referral.

In addition, your Reference Committee had several concerns. First, the reference to “acceptable guidelines” is not defined in the resolve, which is preferable if adopting policy so that our AMA’s position is clear. In addition, the resolve is much broader than the subject of the resolution. Your Reference Committee suggests that the terminology “pap smear testing” should be in the resolve so that it reflects the resolution’s subject matter. Finally, referencing “guidelines” in the resolve is of concern as the guidelines could change and our AMA may not remain supportive. For these reasons, your Reference Committee recommends that Resolution 118 be referred.

(18) RESOLUTION 119 - PLACE OF SERVICE CODE FOR OBSERVATION SERVICES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 119 be referred.

HOD ACTION: Resolution 119 referred.

Resolution 119 asks that our AMA conduct a study of the impact on patient cost-sharing, physician payment, physician administrative cost, and the quality of care if a specific place-of-service code is created for observation services, consult with the AHA and other stakeholders in this study on place of service code for observation services and that based on the findings of the study our AMA and other interested stakeholders petition CMS to recognize a new place-of-service code for observation services.

Testimony on Resolution 119 was limited to one comment in support of adoption. Your Reference Committee interprets this resolution as a call for a high-level AMA study on a complex issue (new place of service codes for observation services). As stated previously in this report, our AMA is working with Congress and CMS to advocate for solutions to Medicare coverage problems associated with hospital observation status. Your Reference Committee believes that our AMA should look into the use of new place-of-service codes for observation services before committing to the study called for in Resolution 119, and therefore recommends referral.

(19) RESOLUTION 122 - HEALTH INSURER CODE OF CONDUCT PRINCIPLES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 122 be referred.

HOD ACTION: Resolution 122 referred.

Resolution 122 asks that our AMA update the AMA Health Insurer Code of Conduct Principles and report back at the 2014 Annual Meeting.
Your Reference Committee heard limited, yet supportive testimony on Resolution 122. The sponsor highlighted the fact that the AMA Health Insurer Code of Conduct Principles were developed before health system reform legislation was adopted and therefore certain sections may no longer be relevant. The sponsor and a member of the Board of Trustees suggested that Resolution 122 be referred for additional consideration of appropriate updates. Therefore your Reference Committee recommends that Resolution 122 be referred.

(20) RESOLUTION 115 - MEDICATION NON-ADHERENCE AND ERRORS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 115 be referred.

HOD ACTION: Resolution 115 referred.

Resolution 115 asks that our AMA work with the Centers for Medicare & Medicaid Services or seek federal legislation to require Medicare to provide the option of prescribing, according to patient need, timed calendar blister packs to be filled locally with pharmacist counseling with no or minimal extra cost to the patient.

Testimony on Resolution 115 was mixed, and included comments on the costs of providing timed calendar blister packs as well as the potential cost savings from the use of blister packs if they prevent emergency room visits and hospitalizations. The sponsor spoke of senior citizens who, lacking blister packs and/or pharmacist counseling, may take medications incorrectly and end up in the hospital. The sponsor also testified that blister packs have been shown to increase medication adherence and save money on hospitalizations.

Your Reference Committee discussed the considerable expenses associated with having timed calendar blister packs filled locally with pharmacist counseling. Your Reference Committee is aware that current regulations require Medicare Part D plans to cover unit dose packaged drugs in the long-term care setting and believes further study is warranted before asking our AMA to advocate for broader Medicare coverage. Accordingly, your Reference Committee recommends that Resolution 115 be referred.

(21) RESOLUTION 101 - AFFORDABLE ACCESS FOR LOW INCOME INDIVIDUALS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-165.855, D-165.955 and H-165.848 be reaffirmed in lieu of Resolution 101.

HOD ACTION: Policies H-165.855, D-165.955 and H-165.848 be reaffirmed in lieu of Resolution 101.

Resolution 101 asks that our AMA adopt policy that all individuals under 400% FPL should be eligible for refundable tax credits to provide premium assistance for coverage of a qualified health plan and that the refundable tax credit for all individuals with incomes below 100% FPL
should be based on the exchange plan that covers the highest percentage of benefit costs and has the lowest out of pocket limits, and have a taxpayer’s applicable percentage (out of pocket limit) of 0%.

Your Reference Committee heard mostly supportive testimony on Resolution 101. However, one speaker acknowledged that AMA policy already addresses the issues asked for in this resolution. Concerns were raised that the ACA did not foresee the fact that some states would not expand Medicaid services. It was questioned what would happen to the individuals who live below 100 percent of the federal poverty level and may not have access to health insurance in the states that are not expanding Medicaid. Current AMA policies support this population having health insurance. A member of the Council on Medical Service testified in favor of reaffirmation and cautioned that the impact of the ACA will be realized in the future, but it is too early now to determine the outcome.

Policy H-165.855[1] advocates that states be allowed the option to provide health care coverage to their Medicaid beneficiaries who are nonelderly and nondisabled adults and children with premium tax credits that are refundable, advanceable, inversely related to income and administratively simple for patients, exclusively to allow patients and their families to purchase coverage through programs modeled after the state employee purchasing pool or the Federal Employee Health Benefits Program (FEHBP) with minimal or no cost-sharing obligations based on income. This policy also advocates that children qualified for Medicaid must also receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program benefits and have no cost-sharing obligations.

Policy D-165.955[2] advocates for individually selected and owned health insurance through the use of adequately funded federal tax credits as a preferred long-term solution for covering all Americans. Furthermore, Policy H-165.848[2] supports refundable advanceable tax credits in the form of a voucher to be provided on a sliding scale basis for the purchase of health care insurance for individuals living below 500% of the federal poverty level.

Given that existing AMA policy is broader in scope and more generous in suggested benefits, your Reference Committee was concerned that Resolution 101 would weaken existing policy. Therefore, your Reference Committee recommends that Policies H-165.855, D-165.955 and H-165.848 be reaffirmed in lieu of Resolution 101.

H-165.855 Medical Care for Patients with Low Incomes

It is the policy of our AMA that: (1) states be allowed the option to provide coverage to their Medicaid beneficiaries who are nonelderly and nondisabled adults and children with the current Medicaid program or with premium tax credits that are refundable, advanceable, inversely related to income, and administratively simple for patients, exclusively to allow patients and their families to purchase coverage through programs modeled after the state employee purchasing pool or the Federal Employee Health Benefits Program (FEHBP) with minimal or no cost-sharing obligations based on income. Children qualified for Medicaid must also receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program benefits and have no cost-sharing obligations. (2) in order to limit patient churn and assure continuity and coordination of care, there should be adoption of 12-month continuous eligibility across Medicaid, Children’s Health Insurance Program, and exchange plans. (3) to support the development of a safety net mechanism, allow for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical
care. (4) tax credit beneficiaries should be given a choice of coverage, and that a
mechanism be developed to administer a process by which those who do not choose a
health plan will be assigned a plan in their geographic area through auto-enrollment until
the next enrollment opportunity. Patients who have been auto-enrolled should be
permitted to change plans any time within 90 days of their original enrollment. (5) state
public health or social service programs should cover, at least for a transitional period,
those benefits that would otherwise be available under Medicaid, but are not medical
benefits per se. (6) as the nonelderly and nondisabled populations transition into
needing chronic care, they should be eligible for sufficient additional subsidization based
on health status to allow them to maintain their current coverage. (7) our AMA
encourages the development of pilot projects or state demonstrations, including for
children, incorporating the above recommendations. (Modify Current HOD Policy) (8)
our AMA should encourage states to support a Medicaid Physician Advisory
Commission to evaluate and monitor access to care in the state Medicaid program and
related pilot projects. (CMS Rep. 1, I-03; Reaffirmed in lieu of Res. 105, A-06;
Reaffirmation I-07; Modified: CMS Rep. 1, A-12)

D-165.955 Status Report on Expanding Health Care Coverage to all Individuals, with an
Emphasis on the Uninsured

1. Our AMA will continue to: (1) place a high priority on expanding health insurance
coverage for all; (2) pursue bipartisan support for individually selected and owned health
insurance through the use of adequately funded federal tax credits as a preferred long-
term solution for covering all; and (3) explore and support alternative means of ensuring
health care coverage for all. 2. Our AMA Board of Trustees will consider assisting
Louisiana, and other Gulf Coast States if they should desire, in developing and
evaluating a pilot project(s) utilizing AMA policy as a means of dealing with the
impending public health crisis of displaced Medicaid enrollees and uninsured individuals
as a result of the recent natural disasters in that region. (CMS Rep. 1, I-05)

H-165.848 Individual Responsibility To Obtain Health Insurance

1. Our AMA will support a requirement that individuals and families earning greater than
500% of the federal poverty level obtain, at a minimum, coverage for catastrophic health
care and evidence-based preventive health care, using the tax structure to achieve
compliance. 2. Upon implementation of a system of refundable, advanceable tax credits
inversely related to income or other subsidies to obtain health care coverage, our AMA
will support a requirement that individuals and families earning less than 500% of the
federal poverty level obtain, at a minimum, coverage for catastrophic health care and
evidence-based preventive health care, using the tax structure to achieve compliance.
(CMS Rep. 3, A-06; Modified: CMS Rep. 8, A-08; Reaffirmation A-10; Reaffirmed: CMS
Rep. 9, A-11)
RESOLUTION 105 - REDUCING THE COST OF PRESCRIPTION DRUGS TO LOW INCOME SENIORS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-110.990 and H-330.902 be reaffirmed in lieu of Resolution 105.


Resolution 105 asks that our AMA engage in a dialogue with appropriate stakeholders (i.e., state medical associations, national specialty societies, consumer organizations, patient advocacy groups, etc.), in support of the concepts in the “Senior Protection Plan,” that would reduce the excessive costs of prescription drugs incurred by low income seniors.

Mixed testimony was heard on Resolution 105. Supportive testimony agreed with conceptual support by our AMA for strategies to make medication more affordable. Opposing testimony raised a concern that the resolution could unintentionally shift costs to our country’s younger generations who are already paying for the seniors’ Medicare program. In addition, there was concern about what the “Senior Protection Plan” contains and if it would be appropriate for our AMA to support Resolution 105 without first reviewing this document.

Your Reference Committee agrees with being cautious about supporting a resolution containing a lengthy document before first reviewing its contents. Given that our AMA has policy supporting the consideration of personal income and means testing when determining cost-sharing and the subsidization of prescription drugs, your Reference Committee recommends that Policies H-110.990 and H-330.902 be reaffirmed in lieu of Resolution 105.

H-110.990 Cost Sharing Arrangements for Prescription Drugs

Our AMA: 1. believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients; 2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes; and 3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and out-of-pocket costs of individual prescription drugs prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient’s medical condition. (CMS Rep. 1, I-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 1, I-12)

H-330.902 Subsidizing Prescription Drugs for Elderly Patients

Our AMA strongly supports subsidization of prescription drugs for Medicare patients based on means testing. (Res. 122, A-03)
RESOLUTION 110 - LANGUAGE AND HEARING IMPAIRED
INTERPRETER SERVICES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies D-385.978, H-285.985 and H-160.924 be reaffirmed in lieu of Resolution 110.


Resolution 110 asks that our AMA work with CMS and other public and private entities to require the payment of interpreter services by all public and private payers.

Testimony was supportive of payment for interpreter services, but also acknowledged that our AMA has policy that sufficiently addresses this issue. A member of the Council on Medical Service (CMS) stated that AMA Policies D-385.978, H-285.985 and H-160.924 in addition to CMS Report 5-I-11, Interpreter Services and Payment Responsibilities, adequately address the requests in Resolution 110. The identified policies and report address the need for language interpretive services to be a covered benefit by all health plans, that physicians practicing in an office setting should not incur the costs for qualified interpreters and that physicians should not be required to participate in payment arrangements for interpreter services.

Regarding the requests for AMA advocacy, our AMA has been and continues to be active on this issue. Our AMA has long been involved in efforts to promote patient-centered communication and collaborate with multiple stakeholders to address critical issues in providing medical care to patients with limited English proficiency (LEP).

In 2010, the US Government Accountability Office released a report on LEP and interpreter services. Our AMA was interviewed for this report and made the case that LEP requirements are unfunded mandates. Importantly, as required by AMA policy, the AMA continues to monitor and weigh in on federal and congressional activity around LEP and interpreter services. Specifically, our AMA highlights the financial constraints as a factor that must be addressed in providing interpretation services for LEP patients. Our AMA has also participated in the development of the Ethical Force program, which is being actively promoted and includes a toolkit that organizations can use to assess their communication climate, including health literacy and language services.

Given that existing policy adequately addresses this issue and our AMA is actively advocating that LEP requirements are unfunded mandates for physicians, your Reference Committee recommends that Policies D-385.978, H-285.985 and H-160.924 be reaffirmed in lieu of Resolution 110.

D-385.978 Language Interpreters

Our AMA will: (1) continue to work to obtain federal funding for medical interpretive services; (2) redouble its efforts to remove the financial burden of medical interpretive services from physicians; (3) urge the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement; (4) consider the feasibility of a legal solution to the problem of funding
medical interpretive services; and (5) work with governmental officials and other
organizations to make language interpretive services a covered benefit for all health
plans inasmuch as health plans are in a superior position to pass on the cost of these
federally mandated services as a business expense. (Res. 907, I-03; Reaffirmed in lieu
of Res. 722, A-07; Reaffirmation A-09; Reaffirmation A-10; Reaffirmed: CMS Rep. 5, A-
11)
H-285.985 Discrimination Against Physicians by Health Care Plans
Our AMA: (1) will develop draft federal and model state legislation requiring managed
care plans and third party payers to disclose to physicians and the public, the selection
criteria used to select, retain, or exclude a physician from a managed care or other
provider plans; (2) will request an advisory opinion from the Department of Justice on
the application of the Americans with Disabilities Act of 1990 to selective contracting
decisions made by managed care plans or other provider plans; (3) will support
passage of federal legislation to clarify the Americans With Disabilities Act to assure that
coverage for interpreters for the hearing impaired be provided for by all health benefit
plans. Such legislation should also clarify that physicians practicing in an office setting
should not incur the costs for qualified interpreters or auxiliary aids for patients with
hearing loss unless the medical judgment of the treating physician reasonably supports
such a need; (4) encourages state medical associations and national medical specialty
societies to provide appropriate assistance to physicians at the local level who believe
they may be treated unfairly by managed care plans, particularly with respect to
selective contracting and credentialing decisions that may be due, in part, to a
physician's history of substance abuse; and (5) urges managed care plans and third
party payers to refer questions of physician substance abuse to state medical
associations and/or county medical societies for review and recommendation as
appropriate. (BOT Rep. 18, I-93; Appended by BOT Rep. 28, A-98; Reaffirmation A-99;
Reaffirmation A-00; Reaffirmed: BOT Rep. 6, A-10)

H-285.985 Discrimination Against Physicians by Health Care Plans

Our AMA: (1) will develop draft federal and model state legislation requiring managed
care plans and third party payers to disclose to physicians and the public, the selection
criteria used to select, retain, or exclude a physician from a managed care or other
provider plans; (2) will request an advisory opinion from the Department of Justice on
the application of the Americans with Disabilities Act of 1990 to selective contracting
decisions made by managed care plans or other provider plans; (3) will support
passage of federal legislation to clarify the Americans With Disabilities Act to assure that
coverage for interpreters for the hearing impaired be provided for by all health benefit
plans. Such legislation should also clarify that physicians practicing in an office setting
should not incur the costs for qualified interpreters or auxiliary aids for patients with
hearing loss unless the medical judgment of the treating physician reasonably supports
such a need; (4) encourages state medical associations and national medical specialty
societies to provide appropriate assistance to physicians at the local level who believe
they may be treated unfairly by managed care plans, particularly with respect to
selective contracting and credentialing decisions that may be due, in part, to a
physician's history of substance abuse; and (5) urges managed care plans and third
party payers to refer questions of physician substance abuse to state medical
associations and/or county medical societies for review and recommendation as
appropriate. (BOT Rep. 18, I-93; Appended by BOT Rep. 28, A-98; Reaffirmation A-99;
Reaffirmation A-00; Reaffirmed: BOT Rep. 6, A-10)
H-160.924 Use of Language Interpreters in the Context of the Patient-Physician Relationship

AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care; (2) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (3) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid LEP patients' involvement in meaningful decisions about their care; and (4) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements. (BOT Rep. 8, I-02; Reaffirmation I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation A-09; Reaffirmed: CMS Rep. 5, A-11)

(24) RESOLUTION 113 - MAKING MEDICARE PRICE STANDARDIZATION ACCURATE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies D-450.964, H-400.984, H-400.988 and H-400.966 be reaffirmed in lieu of Resolution 113.


Resolution 113 asks that our AMA advocate with the Centers for Medicare & Medicaid Services, MedPAC, and Congress to ban the use of proxies of non-physician incomes that have been used to adjust prices (spending) for the Quality and Resource Use Reports (QRUR) and Value-Based Payment Modifier (VBPM), and that no price adjustment/standardization of physician spending shall be performed, as the actual amount paid to physicians is the most accurate data for QRUR and VBPM.

Testimony on Resolution 113 was limited. The sponsor spoke against reaffirmation and in favor of an amendment asking our AMA to testify before Congress and in comments to CMS and MedPAC on inaccurate price adjustment or price standardization methodology. A member of the Council on Medical Service pointed to Policy D-450.964 as an appropriate policy to reaffirm in lieu of Resolution 113.

Your Reference Committee acknowledges the concerns expressed by some states regarding the data sources and methodologies used to calculate the Geographic Practice Cost Index (GPCI). Your Reference Committee also recognizes the significant challenges involved in developing consensus on the use of GPCIs or potential improvements to them. Furthermore, your Reference Committee points to our AMA’s recent work on GCPI-related issues as exemplified in Council on Medical Service Reports 4-A-11 and Council on Medical Service...
Report 1-I-11. Numerous policies guide AMA advocacy on geographic variation, including Policies H-400.984, H-400.988 and H-400.966. Policy D-450.964 directs our AMA to continue to work with the Centers for Medicare & Medicaid Services to improve the design, content and performance indicators included in the QRURs for physicians, so that the reports reflect the quality and cost data associated with these physicians in calculating VBPMs. Therefore, your Reference Committee recommends that these policies be reaffirmed in lieu of Resolution 113.

D-450.964 Medicare Quality and Resource Use Reports

Our AMA will: (1) continue to work with the Centers for Medicare & Medicaid Services to improve the design, content, and performance indicators included in the Quality and Resource Use Reports (QRURs) for physicians, so that the reports reflect the quality and cost data associated with these physicians in calculating Value-Based Payment Modifiers (VBM); and (2) continue to advocate, educate and seek to delay implementation of the VBM program. (Res. 810, I-12)

H-400.984 Geographic Practice Costs

1. Our AMA will work to ensure that the most current, valid and reliable data are collected and applied in calculating accurate geographic practice cost indices (GPCIs) and in determining geographic payment areas for use in the new Medicare physician payment system. 2. Our AMA supports the use of physician office rent data, along with other practice expense data, to measure geographic variation in rent costs and to determine the proportion of overall costs that relate to rental expense. These data should be obtained through new or existing data sources that are accurate, standardized, verifiable and include per unit costs in physician offices. (Sub. Res. 25, A-90; Modified: Sunset Report, I-00; Reaffirmation A-09; Modified: CMS Rep. 4, A-11; Reaffirmed and Appended: CMS Rep. 1, I-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-12; Reaffirmation: I-12)

H-400.988 Medicare Reimbursement, Geographical Differences

The AMA reaffirms its policy that geographic variations under a Medicare payment schedule should reflect only valid and demonstrable differences in physician practice costs, especially liability premiums, with other non-geographic practice cost index (GPCI) -based adjustments as needed to remedy demonstrable access problems in specific geographic areas. (Sub. Res. 82, A-89; Reaffirmed: BOT Rep. DD, I-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-06; Reaffirmation I-07; Reaffirmation A-08; Reaffirmation A-09; Reaffirmed: BOT Action in response to referred for decision Res. 212, A-09; Modified: CMS Rep. 4, A-11; Reaffirmed: CMS Rep. 1, I-11; Reaffirmed in lieu of Res. 122, A-12)

H-400.966 Medicare Payment Schedule Conversion Factor

(1) The AMA will aggressively promote the compilation of accurate data on all components of physician practice costs and the changes in such costs over time, as the basis for informed and effective advocacy with Congress and the Administration concerning physician payment under Medicare. (2) The AMA will work aggressively with CMS, the Bureau of Labor Statistics, and other appropriate federal agencies to improve the accuracy of such indices of market activity as the Medicare Economic Index and the medical component of the Consumer Price Index. (CMS Rep. B, I-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 6, I-08; Reaffirmed: CMS Rep. 1, I-11;
1 Reaffirmation: I-12)
Mr. Speaker, this concludes the report of Reference Committee A. I would like to thank R. Dale Blasier, MD, Brooks F. Bock, MD, Jesse M. Ehrenfeld, MD, Sally J. Trippel, MD, Michael A. Wasylik, MD, David Welsh, MD, and all those who testified before the Committee.

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