DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2024 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 (I-24)

Final Report of Reference Committee J

Shawn Baca, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 5 – Protecting the Health of Incarcerated People
2. Council on Medical Service Report 2 – Unified Financing Health Care System
3. Council on Medical Service Report 3 – Time-Limited Patient Care
4. Resolution 804 – Improving Public Assistance for People with Disabilities
5. Resolution 808 – Requirement to Communicate Covered Alternatives for Denied Medications
6. Resolution 812 – Advocate for Therapy Cap Exception Process
7. Resolution 813 – Insurance Coverage for Pediatric Positioning Chairs
8. Resolution 822 - Resolution On Medicare Coverage for Non-Emergent Dialysis Transport
9. Resolution 824 – Ophthalmologists Required to Be Available for Level I & II Trauma Centers
10. Resolution 825 – Transparency of Facility Fees for Hospital Outpatient Department Visits

RECOMMENDED FOR ADOPTION AS AMENDED

11. Board of Trustees Report 13 – AMA/Specialty Society RVS Update Committee
12. Board of Trustees Report 15 – Published Metrics for Hospitals and Hospital Systems
13. Council on Medical Service Report 1 – Nonprofit Hospital Charity Care Policies
14. Council on Medical Service Report 4 – Biosimilar Coverage Structures
15. Resolution 805 – Coverage for Sexual Assault Survivors
16. Resolution 810 – Immediate Digital Access to Updated Medication Formulary for Patients
17. Resolution 811 – AMA Practice Expense Survey Geographic Analysis
18. Resolution 815 – Addressing the Crisis of Pediatric Hospital Closures and Impact on Care
19. Resolution 818 – Payment for Pre-Certification/Preauthorization Procedures
20. Resolution 820 – State Medicaid Coverage of Home Sleep Testing
21. Resolution 821 – Patient Access to Asthma Medications
22. Resolution 823 – Reining in Medicare Advantage – Institutional Special Needs Plans

RECOMMENDED FOR REFERRAL

23. Resolution 803 – Healthcare Savings Account Reform
24. Resolution 807 – Expanded Pluralism in Medicaid

25. Resolution 809 – Minimum Requirements for Medication Formularies
26. Resolution 817 – ACA Subsidies for Undocumented Immigrants

RECOMMENDED FOR REFERRAL FOR DECISION

27. Resolution 814 – Legislation for Physician Payment for Prior Authorization

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

28. Resolution 801 – Reimbursement for Managing Portal Messages
29. Resolution 802 – Address Physician Burnout with Inbox Management Resources and Increased Payment
30. Resolution 819 – Establishing a New Office-Based Facility Setting to Pay Separately from the Medicare Physician Fee Schedule for the Technical Reimbursement of Physician Services Using High-Cost Supplies
31. Resolution 826 – Renewing Expansion of Premium Tax Credits

RECOMMENDED FOR ADOPTION

(1) BOT REPORT 5: PROTECTING THE HEALTH OF INCARCERATED PATIENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the Recommendations in Board of Trustees Report 5 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 5 adopted and the remainder of the Report filed.

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 202-I-23, and that the remainder of the report be filed.

That our American Medical Association reaffirm existing AMA Policies H-430.986, "Health Care While Incarcerated;" H-430.997, "Standards of Care for Inmates of Correctional Facilities;" and D-430.997, "Support for Health Care Services to Incarcerated Persons." (Reaffirm HOD Policy)

Your Reference Committee heard supportive testimony on Board of Trustees Report 5. One delegation suggested amending the report by addition of two new recommendations, but there was no other support for these amendments in the testimony online and minimal support in-person. The Board of Trustees addressed the proffered amendments and spoke against them citing that they are based on an Executive Order from the current Administration and it cannot be guaranteed that this Executive Order is continued by the incoming Administration. Additionally, the Board highlighted that the AMA should support the health of all inmates, not just those in for-profit facilities. All other testimony supported adoption of the recommendations as written. Therefore, your Reference Committee recommends that the recommendations in Board of Trustees Report 5 be adopted and the remainder of the report be filed.

(2) CMS REPORT 2 – UNIFIED FINANCING HEALTH CARE SYSTEM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the Recommendations in Council on Medical Service Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 2 be adopted and the remainder of the Report filed.

The Council on Medical Service recommends that the following recommendations be adopted in lieu of the second resolve clause of Resolution 818-I-23, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) continue monitoring federal and state health reform proposals, including the development of state plans and/or waiver applications seeking program approval for unified financing. (Directive to Take Action)

2. That our AMA reaffirm Policy D-165.942, which advocates that state governments be given the freedom to develop and test different models for covering the uninsured, provided that proposed alternatives a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care, b) ensure and maximize patient choice of physician and private health plan, and c) include reforms that eliminate denials for pre-existing conditions. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-165.838, which upholds the AMA's commitment to achieving enactment of health system reforms that include health insurance for all Americans, expand choice of affordable coverage, assure that health care decisions remain in the hands of patients and their physicians, and are consistent with pluralism, freedom of choice, freedom of practice, and universal access. (Reaffirm HOD Policy)

Your Reference Committee heard supportive testimony on Council on Medical Service Report 2. Notably, members of the Council on Medical Service, Council on Legislation, and Board of Trustees spoke in favor of the report's recommendation to continue monitoring federal and state health reform proposals, including waiver applications seeking approval for unified financing, and against a proposed new recommendation asking our AMA support federal waivers that permit states to develop and test unified financing systems. The authors of the proffered new recommendation stated that AMA support for a new waiver program is needed because states that may want to implement unified financing reforms are not currently permitted to reallocate and repurpose federal Medicaid or Affordable Care Act funding to provide universal coverage. A member of the Council on Medical Service countered that it would be premature to support unified financing waivers, given the lack of data and design details, including how physicians will be paid under such systems. An amendment similar in intent to the recommendation offered online was proffered in person. Because in-person testimony was similar to testimony in the online reference committee, your Reference Committee recommends that the recommendations in Council on Medical Service Report 2 be adopted and the remainder of the report filed.

(3) CMS REPORT 3 – TIME-LIMITED PATIENT CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the Recommendations in Council on Medical Service Report 3 be <u>adopted</u> and the remainder of the report be <u>filed</u>.

HOD ACTION: Recommendations in Council on Medical Service Report 3 <u>adopted</u> and the remainder of the Report <u>filed</u>.

The Council on Medical Service recommends that the following recommendations be adopted in lieu of the second resolve clause of Resolution 818-I-23, and that the remainder of the report be filed.

1.That our American Medical Association (AMA) support efforts to ensure that physicians are able to exercise autonomy in the length of patient care visits free from undue influence from

outside entities such as, but not limited to, payers, administrators, and health care systems. (New HOD Policy)

2. That our AMA support efforts to incorporate patient complexities and social determinants of health in calculating appropriate amounts of expected patient care time. (New HOD Policy)

3. That our AMA reaffirm Policy H-70.976 which monitors and seeks to prevent attempts by third-party payers to institute policies that impose time and diagnosis limits. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy D-225.977 that details support for employed physician involvement in self-governance and leadership. (Reaffirm HOD Policy)
5. That our AMA reaffirm Policy H-405.957 that describes AMA efforts to study, promote, and educate on physician well-being and to prevent physician burnout. (Reaffirm HOD Policy)

6. Rescind Policy D-450.951, as having been completed with this report. (Rescind HOD Policy)

Your Reference Committee heard supportive testimony for Council on Medical Service Report 3. Testimony indicated the importance of ensuring that physicians have autonomy in their practice and do not face undue time pressures in caring for patients. Additionally, support was expressed for the Council's recommendations presented in this report. All in-person testimony expressed support for the adoption of this item. Therefore, your Reference Committee recommends that the recommendations in Council on Medical Service Report 3 be adopted and the remainder of the report filed.

(4) RESOLUTION 804 – IMPROVING PUBLIC ASSISTANCE FOR PEOPLE WITH DISABILITIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 804 be <u>adopted</u>.

HOD ACTION: Resolution 804 <u>adopted</u>.

RESOLVED, that our American Medical Association support appropriate increased asset limits, income cutoffs, and benefits that are indexed to increase at least by inflation for public assistance programs such as Supplemental Security Income (SSI) (New HOD Policy); and be it further

RESOLVED, that our AMA support eliminating the marriage penalty for SSI benefits, such that married couples do not receive fewer benefits or have more restrictive eligibility requirements than they would have as individuals. (New HOD Policy)

Online testimony on Resolution 804 was overwhelmingly supportive. An amendment was proffered, but testimony expressed serious concern that the amended language could increase confusion around the intent of the resolution. Additional testimony expressed support for the breadth of the original resolution. No additional testimony was provided in-person. Therefore, your Reference Committee recommends that Resolution 804 be adopted.

(5) RESOLUTION 808 – REQUIREMENT TO COMMUNICATE COVERED ALTERNATIVES FOR DENIED MEDICATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 808 be <u>adopted</u>.

HOD ACTION: Resolution 808 be <u>adopted</u>.

RESOLVED, that our American Medical Association advocate that Medicare, Medicaid, and all other insurers provide covered alternatives to the patient and the patient's prescribing physician at the time that coverage for a medication is denied. (Directive to Take Action)

Your Reference Committee heard overwhelmingly supportive testimony of Resolution 808. This item was suggested for reaffirmation; however, testimony indicated that the full ask of the resolution is not covered by existing policy. Testimony indicated the importance of placing the onus of identifying alternative, covered medications on payers and not physicians or their patients. All in-person testimony expressed support for the adoption of this item. Based on the supportive testimony, your Reference Committee recommends that Resolution 808 be adopted.

(6) RESOLUTION 812 – ADVOCATE FOR THERAPY CAP EXCEPTION PROCESS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 812 be <u>adopted</u>.

HOD ACTION: Resolution 812 <u>adopted</u>.

RESOLVED, that our American Medical Association actively advocate for all health plans with therapy caps or thresholds to include an exception process. This process should, at a minimum, follow the Medicare standard for therapy cap exceptions, ensuring that patients can access the necessary services to restore functional abilities and enhance quality of life. (Directive to Take Action)

Online testimony for Resolution 812 was overwhelmingly supportive, stressing the importance of ensuring that patients are not harmed by therapy caps and are able to access the necessary services. The author provided in-person testimony in support of the Reference Committee recommendation. Due to the supportive testimony, your Reference Committee recommends Resolution 812 be adopted.

(7) RESOLUTION 813 – INSURANCE COVERAGE FOR PEDIATRIC POSITIONING CHAIRS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 813 be adopted.

HOD ACTION: Resolution 813 adopted.

RESOLVED, that our American Medical Association advocate that private and public insurance companies pay for a physician prescribed positioning chair for children who need support for sitting for daily activities in the home, in addition to the wheelchair that the patient uses for all mobility in the home and community. (Directive to Take Action)

Online testimony was unanimously in favor of Resolution 813, outlining the importance of ensuring that children with disabilities are able to receive positioning chairs as they can support both physical health and engagement with their community. The author provided in-person testimony in support of the Reference Committee recommendation. Due to the overwhelmingly supportive testimony, your Reference Committee recommends Resolution 813 be adopted.

(8) RESOLUTION 822 – RESOLUTION ON MEDICARE COVERAGE FOR NON-EMERGENT DIALYSIS TRANSPORT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 822 be adopted.

HOD ACTION: Resolution 822 adopted.

RESOLVED, that our American Medical Association advocate for Medicare coverage of non-emergent medical transportation specifically for patients requiring dialysis treatment (Directive to Take Action); and be it further

RESOLVED, that our AMA partner with Center for Medicare and Medicaid Services (CMS) to develop policies to ensure financial assistance for non-emergent medical transportation for dialysis treatments and to transplant centers for kidney transplant evaluation and related care for Medicare beneficiaries. (Directive to Take Action)

Your Reference Committee heard limited, but supportive, online testimony of Resolution 822, which indicated that it may be covered by existing AMA policy. However, the preponderance of in-person testimony supported adoption rather than reaffirmation. Therefore, your Reference Committee has changed its recommendation from reaffirmation to adoption of Resolution 822.

(9) RESOLUTION 824 – OPHTHALMOLOGISTS REQUIRED TO BE AVAILABLE FOR LEVEL I & II TRAUMA CENTERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 824 be adopted.

HOD ACTION: Policy H-130.948 reaffirmed in lieu of Resolution 824.

RESOLVED, that our American Medical Association work with the American College of Surgeons and the American Trauma Society to specifically name Ophthalmology as a requirement for Level I & II Trauma Centers (Directive to Take Action); and be it further

RESOLVED, that our AMA work with the American College of Surgeons and the American Trauma Society to ensure that during the verification process it has to be insisted that there is availability of Ophthalmology Trauma coverage. (Directive to Take Action)

Your Reference Committee heard mixed but mostly supportive testimony on this resolution. The authors and two additional delegations supported adoption, and another delegation testified against adoption. Through testimony it was revealed that Resolution 824 was submitted to address an optometrist being called first from the emergency department, rather than an ophthalmologist. The authors conceded that their issue had been addressed but encouraged adoption of the resolution to prevent this situation from happening again. The delegation speaking in favor of not adoption testified that the processes outlined in this resolution are already in place within the American College of Surgeons guidelines ("Grey Book"), rendering this resolution unnecessary. Your Reference Committee believes this is ultimately a scope issue, and it is in the best interest of patients to be treated by an ophthalmologist when care is needed at a Level I and/or Level II Trauma Center. Therefore, your Reference Committee recommends that Resolution 824 be adopted.

(10) RESOLUTION 825 – TRANSPARENCY OF FACILITY FEES FOR HOSPITAL OUTPATIENT DEPARTMENT VISITS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 825 be adopted.

HOD ACTION: Resolution 825 adopted.

RESOLVED, that our American Medical Association advocate for legislation or regulation that mandates the proactive transparency of the added costs to the consumer for health care services rendered at hospital outpatient department designated clinics (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate the additional costs of facility fees over professional services be stated upon scheduling of such services, noting the two are separate and additive charges, as well as prominently displayed at the point of service (Directive to Take Action)

Testimony was limited but supportive of Resolution 825. Speakers noted that transparency empowers patients to make good decisions about their care. Your Reference Committee recommends that Resolution 825 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(11) BOT REPORT 13: AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 in Board of Trustees Report 13 by addition and deletion.

1. That our American Medical Association (AMA) ~~support the continued efforts of the AMA/Specialty Society RVS Update Committee (RUC) to identify extant data to utilize within the ongoing process to improve the Resource Based Relative Value Scale (RBRVS). (New HOD Policy)~~ collaborate with relevant parties to support the AMA/Specialty Society RVS Update Committee (RUC) and RUC Research Subcommittee's study on how usable extant data, including electronic data, can be collected in order to compare the accuracy of a mixed methodology approach against the current survey methodology. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 13 be adopted as amended and the remainder of the report be filed.

> **HOD ACTION: Recommendations in Board of Trustees Report 13 be adopted as amended and the remainder of the report filed.**

The Board of Trustees recommends that the following be adopted in lieu of Resolution 821-I-23, and the remainder of the report be filed.

1. That our American Medical Association (AMA) support the continued efforts of the AMA/Specialty Society RVS Update Committee (RUC) to identify extant data to utilize within the ongoing process to improve the Resource Based Relative Value Scale (RBRVS). (New HOD Policy)

2. That our AMA reaffirm Policy D-400.983, which supports the RUC and its ability to implement methodological improvements. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-400.959, which supports the RUC's efforts to improve the validity of the RBRVS through development of methodologies for assessing the relative work of new technologies. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-400.969, which calls on the Centers for Medicare & Medicaid Services to adopt the recommendations of the RUC for work relative values for new and revised Current Procedural Terminology (CPT®) codes, and strongly supports the use of the RUC

process as the principal method of refining and maintaining the Medicare RBRVS. (Reaffirm HOD Policy)

Your Reference Committee heard mixed testimony on Board of Trustees (BOT) Report 13. Testimony supportive of the recommendations as written described the AMA/Specialty Society RVS Update Committee (RUC) process as collaborative, transparent, and striving for continuous improvement in the accuracy of the valuation recommendations it makes to the Centers for Medicare & Medicaid Services.

Critics of BOT Report 13 stated that the recommendations support existing RUC efforts but do not fulfill the intent of referred Resolution 821-I-23, which sought to encourage the use of more comprehensive data sources, beyond physician surveys, in determining relative value units (RVUs). Two delegations spoke against Recommendation 4, which recommends reaffirming Policy H-400.969. These delegations also testified in strong support of proffered substitute Recommendation 1, which asks our AMA to fund a pilot study aimed at modernizing the RUC's process by utilizing extant databases from institutions and systems that own these data, such as Epic, Cerner, and Kaiser, to compare the accuracy of this mixed methodology approach against the current survey methodology.

Testimony opposed to substitute Recommendation 1 emphasized that AMA staff have already explored the use of electronic health record (EHR) data with Epic and Oracle (formerly Cerner) and determined that physician time data that could be utilized by the RUC are not available. Additional testimony against the substitute language cautioned that extant data, such as EHRs and operating logs, frequently fail to capture the nuances and intensity of certain specialty services, highlighting neurosurgery and labor management as examples of care that is not fully captured in such data sources. Testimony further questioned the scope and potential costs of the pilot called for in substitute Recommendation 1.

Your Reference Committee also heard testimony supportive of substitute Recommendation 1. Your Reference Committee notes that the RUC operates independently of our AMA. We recommend compromise language that addresses the intent of the proffered substitute recommendation while recognizing that our AMA plays a supportive role to the RUC and does not offer competing recommendations. Accordingly, your Reference Committee recommends that BOT Report 13 be adopted as amended and the remainder of the report be filed.

(12) BOT REPORT 15: PUBLISHED METRICS FOR HOSPITALS AND HOSPITAL SYSTEMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Recommendation in Board of Trustees Report 15 be <u>amended by addition</u> to read as follows:

That our AMA research <u>and develop</u> useful metrics that hospitals and hospital systems can use to improve physicians' experience, engagement, and work environment <u>in a manner accessible to physicians</u>.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Recommendation in Board of Trustees Report 15 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 15 adopted as amended and the remainder of the report be filed.

That our AMA research and develop useful metrics that hospitals and hospital systems can use to improve physicians' experience, engagement, and work environment in a manner accessible to physicians with report back to the House of Delegates no later than Annual 2026.

The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 802-I-23, and the remainder of the report be filed:

1) That our American Medical Association (AMA) support that all nonprofit hospitals be required to screen patients for charity care eligibility and other financial assistance program eligibility prior to billing. (New HOD Policy)

2) That our AMA support efforts to encourage debt collectors to ensure a patient has been screened for financial assistance eligibility before pursuing that patient for outstanding debt, provide an appeals process for those patients not screened previously or deemed ineligible, and require the hospital to reassume the debt account if an appeal is successful. (New HOD Policy)

3) That our AMA support development of minimum standards for nonprofit hospital financial assistance eligibility programs which are publicly accessible. (New HOD Policy)

4) That our AMA support a standardized definition of what is considered a "community benefit" when evaluating community health improvement activities. (New HOD Policy)

5) That our AMA support the development of a transparent, publicly available, standardized data set on community benefit including consideration of charity care-to-expense ratios. (New HOD Policy)

6) That our AMA support expansion of governmental oversight of nonprofit hospitals and enforcement of federal and/or state guidelines and standards for community benefit requirements including the ability to enact penalties and/or loss of tax-exempt status. (New HOD Policy)

7) That our AMA reaffirm existing Policy H-155.958, which states that the AMA will encourage hospitals to adopt, implement, monitor, and publicize policies on patient discounts, charity care, and fair billing and collection practices and make access to those programs readily available to eligible patients. (Reaffirm HOD Policy)

Online testimony on Council on Medical Service Report 1 was overwhelmingly supportive. An amendment was proffered to ensure that the language in the report recommendations were more

proactive and actionable. This amendment received supportive testimony. The author provided in-person testimony in support of the Reference Committee recommendation. Your Reference Committee recommends that the recommendations in Council on Medical Service Report 1 be adopted as amended and the remainder of the report filed.

(13) CMS REPORT 1 – NONPROFIT HOSPITAL CHARITY CARE POLICIES

RECOMMENDATION A:

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

1. **That our American Medical Association (AMA) ~~support~~ advocate that all nonprofit hospitals be required to screen patients for charity care eligibility and other financial assistance program eligibility prior to billing. (New HOD Policy)**
2. **That our AMA ~~support efforts~~ advocate to encourage debt collectors to ensure a patient has been screened for financial assistance eligibility before pursuing that patient for outstanding debt, provide an appeals process for those patients not screened previously or deemed ineligible, and require the hospital to reassume the debt account if an appeal is successful. (New HOD Policy)**
3. **That our AMA ~~support~~ advocate for the development of minimum standards for nonprofit hospital financial assistance eligibility programs which are publicly accessible. (New HOD Policy)**
4. **That our AMA ~~support~~ advocate for a standardized definition of what is considered a "community benefit" when evaluating community health improvement activities. (New HOD Policy)**
5. **That our AMA ~~support~~ advocate for the development of a transparent, publicly available, standardized data set on community benefit including consideration of charity care-to-expense ratios. (New HOD Policy)**
6. **That our AMA ~~support~~ advocate for the expansion of governmental oversight of nonprofit hospitals and enforcement of federal and/or state guidelines and standards for community benefit requirements including the ability to enact penalties and/or loss of tax-exempt status. (New HOD Policy)**
7. **That our AMA reaffirm existing Policy H-155.958, which states that the AMA will encourage hospitals to adopt, implement, monitor, and publicize policies on patient discounts, charity care, and fair billing and collection practices and make access to those programs readily available to eligible patients. (Reaffirm HOD Policy)**

RECOMMENDATION B:

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

HOD ACTION: Recommendations in Council on Medical Service Report 1 adopted as amended and the remainder of the report be filed.

The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 802-I-23, and the remainder of the report be filed:

1) That our American Medical Association (AMA) support that all nonprofit hospitals be required to screen patients for charity care eligibility and other financial assistance program eligibility prior to billing. (New HOD Policy)

2) That our AMA support efforts to encourage debt collectors to ensure a patient has been screened for financial assistance eligibility before pursuing that patient for outstanding debt, provide an appeals process for those patients not screened previously or deemed ineligible, and require the hospital to reassume the debt account if an appeal is successful. (New HOD Policy)

3) That our AMA support development of minimum standards for nonprofit hospital financial assistance eligibility programs which are publicly accessible. (New HOD Policy)

4) That our AMA support a standardized definition of what is considered a "community benefit" when evaluating community health improvement activities. (New HOD Policy)

5) That our AMA support the development of a transparent, publicly available, standardized data set on community benefit including consideration of charity care-to-expense ratios. (New HOD Policy)

6) That our AMA support expansion of governmental oversight of nonprofit hospitals and enforcement of federal and/or state guidelines and standards for community benefit requirements including the ability to enact penalties and/or loss of tax-exempt status. (New HOD Policy)

7) That our AMA reaffirm existing Policy H-155.958, which states that the AMA will encourage hospitals to adopt, implement, monitor, and publicize policies on patient discounts, charity care, and fair billing and collection practices and make access to those programs readily available to eligible patients. (Reaffirm HOD Policy)

Online testimony on Council on Medical Service Report 1 was overwhelmingly supportive. An amendment was proffered to ensure that the language in the report recommendations were more proactive and actionable. This amendment received supportive testimony. The author provided in-person testimony in support of the Reference Committee recommendation. Your Reference Committee recommends that the recommendations in Council on Medical Service Report 1 be adopted as amended and the remainder of the report filed.

(14) CMS REPORT 4 – BIOSIMILAR COVERAGE STRUCTURES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Recommendation of Council on Medical Service Report 4 be amended by addition to read as follows:

That our American Medical Association (AMA):

(a) support the development and implementation of strategies to incentivize the use of lower cost biosimilars when safe, fiscally prudent for the patient and not financially disadvantageous to the clinical practice, clinically appropriate, and agreed upon as the best course of treatment by the patient and physician, and

(b) advocate to eliminate acquisition cost and reimbursement disparities for in-office biosimilar treatment across diverse treatment locations. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Recommendation of Council on Medical Service Report 4 be amended by addition to read as follows:

That our AMA support patient education regarding biosimilars and their safety and efficacy. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the Recommendations in Council on Medical Service Report 4 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 4 be adopted as amended and the remainder of the report filed.

The Council on Medical Service recommends that the following recommendations be adopted and the remainder of the report be filed.

1. That our American Medical Association (AMA) support the development and implementation of strategies to incentivize the use of lower cost biosimilars when safe, fiscally prudent for the patient, clinically appropriate, and agreed upon as the best course of treatment by the patient and physician. (New HOD Policy)

2. That our AMA support patient education regarding biosimilars and their safety. (New HOD Policy)

3. That our AMA reaffirm Policy H-110.987, which works to ensure that prescription medications are affordable and accessible to patients. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-110.997 which supports the freedom of physicians in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy D-125.989, which outlines efforts to ensure that physicians are able to transition patient to biosimilar medications with coverage from payers. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-125.972 which details efforts to encourage physician education related biosimilars. (Reaffirm HOD Policy)

Your Reference Committee heard testimony supportive of the Council on Medical Service Report 4. Testimony described the potential challenges around prescribing biosimilars, largely ensuring coverage from payers. Additionally, testimony outlined the need to ensure that patients have access to biosimilar medications when appropriate to limit cost-burdens on patients. Testimony proffered amendments to specify that physicians and physician offices would not face undue financial burdens as a result of biosimilar prescriptions. In-person testimony recommended minor amendments to the preliminary recommendation and adding efficacy education to patient education efforts mentioned in Recommendation 2. Due to the supportive testimony, both online and in-person, for the proffered amendments and report itself, your Reference Committee recommends that the recommendations in the Council on Medical Service Report 4 be adopted as amended and the remainder of the report filed.

(15) RESOLUTION 805 – COVERAGE FOR CARE FOR SEXUAL ASSAULT SURVIVORS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 805 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association amend policy H-80.999 "Sexual Assault Survivors" by addition as follows:

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing ~~physicians~~ clinicians involved in providing care to sexual assault survivors.

2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing ~~and prevention~~, drug testing for drug-facilitated assault, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence

collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention free of charge.

3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.

4. Our AMA will advocate for increased ~~post-pubertal~~ patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.

5. Our AMA will advocate at the state and federal level for (a) the timely processing of all sexual examination kits upon patient consent; (b) timely processing of "backlogged" sexual assault examination kits with patient consent; and (c) additional funding to facilitate the timely testing of sexual assault evidence kits.

6. Our AMA supports the implementation of a national database of Sexual Assault Nurse Examiner and Sexual Assault Forensic Examiner providers (Modify Current HOD Policy);

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 805 be amended by addition to read as follows:

RESOLVED, that our AMA advocate for federal and state efforts to reduce financial barriers that limit sexual assault survivor's ability to seek physical and mental health care and social services after sexual assault, including funds to cover emergency, acute inpatient, and follow up services including testing, medications, and counseling without out-of-pocket costs for any patient.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 805 be adopted as amended.

HOD ACTION: Resolution 805 adopted as amended.

RESOLVED, that our American Medical Association amend policy H-80.999 “Sexual Assault Survivors” by addition as follows:

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.

2. Our AMA advocates for the legal protection of sexual assault survivors’ rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing and prevention, drug testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.

3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.

4. Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.

5. Our AMA will advocate at the state and federal level for (a) the timely processing of all sexual examination kits upon patient consent; (b) timely processing of “backlogged” sexual assault examination kits with patient consent; and (c) additional funding to facilitate the timely testing of sexual assault evidence kits.

6. Our AMA supports the implementation of a national database of Sexual Assault Nurse Examiner and Sexual Assault Forensic Examiner providers (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA advocate for federal and state efforts to reduce financial barriers that limit sexual assault survivors’ ability to seek physical and mental health care and social services after sexual assault. (Directive to Take Action)

Your Reference Committee heard supportive online testimony on Resolution 805, which indicated the importance of making sure that adequate coverage is provided for post-assault exams. Amendments were proffered to specify the intent of the resolution and clarify the covered portions of the care offered. Both online and in-person testimony supported the online amendments as well as an additional amendment offered during the in-person hearing. Therefore, your Reference Committee recommends that Resolution 805 be adopted as amended.

(16) RESOLUTION 810 – IMMEDIATE DIGITAL ACCESS TO UPDATED MEDICATION FORMULARY FOR PATIENTS AND THEIR PHYSICIANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 810 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association advocate for and support efforts for ~~the Centers for Medicare & Medicaid Services~~ payers to provide (or cause their associated carriers to provide) ~~hyperlink (such as a QR code) to~~ a digital, well-organized, and searchable formulary, including anticipated cost-sharing amounts and prior authorization requirements, that the patient or physician can easily access, with access instructions clearly included on the beneficiary's insurance card and/or online account webpage. ~~located on the insured's insurance card to all Medicare patients in such a manner that the patient can easily share and discuss covered medications with their prescribing physician during office appointments or other encounters.~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 810 be adopted as amended.

HOD ACTION: Resolution 810 adopted as amended.

RESOLVED, that our American Medical Association advocate for the Centers for Medicare & Medicaid Services to provide (or cause their associated carriers to provide) a hyperlink (such as a QR code) to a digital, well-organized, and searchable formulary located on the insured's insurance card to all Medicare patients in such a manner that the patient can easily share and discuss covered medications with their prescribing physician during office appointments or other encounters. (Directive To Take Action)

Your Reference Committee heard generally supportive testimony of Resolution 810; however, many testifiers suggested that the scope of the resolution be expanded beyond Medicare beneficiaries. A number of amendments to capture this expanded scope were proffered. Online testimony indicated the importance of ensuring that patients, along with their physicians, are able to view an accurate list of prescription medications included in their formulary. In-person testimony on Resolution 810 was largely supportive of the amended language, with some minor amendments to the proffered language. Additionally, a delegation proffered an amendment to ensure that the formulary included anticipated cost-sharing and prior authorization requirements. Testimony indicated concerns that the reference to specific types of technology (e.g., hyperlink and QR code) may be harmful should technology advance away from the referenced technology. Therefore, amendments were proffered to remove this portion of the resolution. Due to the overwhelming agreement in both online and in-person testimony to expand the scope of this resolution and

specify the access and formulary information your Reference Committee recommends Resolution 810 be adopted as amended.

(17) RESOLUTION 811 – AMA PRACTICE EXPENSE SURVEY GEOGRAPHIC ANALYSIS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 811 be deleted.

~~**RESOLVED, that our American Medical Association formally recognize that systemic bias in healthcare financing called "Structural Urbanism", has been a factor in leading to rural health disparities. (New HOD Policy)**~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 811 be amended by addition to read as follows:

RESOLVED, that our AMA review the results from its 2023-2024 Physician Practice Information Survey to determine whether the data can be used to generate statistically valid estimates of differences in physician practice expenses across practice geography (e.g., urban vs. rural, or region). (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the fourth Resolve of Resolution 811 be deleted.

~~**RESOLVED, that our AMA advocate for the Centers for Medicare and Medicaid Services use evidence rather than bias to determine if Geographic Practice Cost Indexes should continue to adjust physician payment regionally. (Directive to Take Action)**~~

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 811 be amended by addition of a new Resolve clause to read as follows:

RESOLVED, that our American Medical Association promote payment accuracy in the Medicare Geographic Practice Cost Index (GPCI). (New HOD Policy)

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 811 be amended by addition of a new Resolve clause to read as follows:

RESOLVED, that our AMA continue to strongly advocate for legislation to immediately improve physician shortages and access to care in rural areas, as long as the new funding is provided outside the budget neutrality limits in the Medicare Fee Schedule. (Directive to Take Action)

RECOMMENDATION F:

Madam Speaker, your Reference Committee recommends that Resolution 811 be adopted as amended.

HOD ACTION: Resolution 811 adopted as amended.

RESOLVED, that our American Medical Association formally recognize that systemic bias in healthcare financing called "Structural Urbanism", has been a factor in leading to rural health disparities (New HOD Policy); and be it further

RESOLVED, that our AMA in advocating for health equity for all Americans, point out that Medicare payment policies have played a role in the shortage of rural physicians and the poorer health outcomes in rural America (Directive to Take Action); and be it further

RESOLVED, that our AMA review the results from its 2023-2024 Physician Practice Information Survey to determine whether the data can be used to estimate differences in physician practice expenses across practice geography (e.g., urban vs. rural, or region) (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the Centers for Medicare and Medicaid Services use evidence rather than bias to determine if Geographic Practice Cost Indexes should continue to adjust physician payment regionally. (Directive to Take Action)

Testimony on Resolution 811 was mixed, with speakers both supportive of, and opposed to, current Medicare Geographic Practice Cost Index (GPCI) adjustments established for every Medicare payment locality. One commenter highlighted the AMA's recent study on structural urbanism (Board of Trustees Report 13-I-22), which addressed efforts to cultivate the rural workforce and highlighted current challenges with federal payment policies specific to volume, coverage, and access. Comments strongly supportive of Resolution 811 emphasized that rural communities are systemically disadvantaged in part because the payment adjustments do not reflect practice costs. Additional supportive testimony cited high costs incurred by rural practices, and the fact that there are fewer patients to share in these costs.

Opponents noted that the resolves, as written, would reduce Medicare payments to urban and suburban physicians and that CMS already adjusts the work GPCI to benefit rural physicians. Opponents also testified that the best available data does not support major changes to the GPCIs. Amendments were proffered to delete Resolves 1, 2 and 4, edit Resolve 3, and add new

resolve clauses that 1) promote payment accuracy in the Medicare GPCI, and 2) advocate for efforts aimed at improving physician shortages and access to care in rural areas, as long as the new funding is provided outside the budget neutrality limits in the Medicare Physician Payment Schedule.

Testimony also explained that the AMA's Physician Practice Information Survey was not intended to address geographic differences in practice costs. Commenters further asserted that the AMA's goal should be achieving Medicare payment increases that cover the practice costs of all physicians. Having heard both sides and in an attempt at compromise, your Reference Committee preliminarily recommended deleting the first and fourth resolves of Resolution 811; amending Resolve 3; and adding the two new resolves that were proffered in testimony. Because in-person testimony strongly supported our preliminary recommendation, your Reference Committee recommends that Resolution 811 be adopted as amended.

(18) RESOLUTION 815 – ADDRESSING THE CRISIS OF PEDIATRIC HOSPITAL CLOSURES AND IMPACT ON CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve clause in Resolution 815 be amended by addition to read as follows:

RESOLVED, that our American Medical Association recognize the closure of pediatric hospitals and units, including pediatric inpatient psychiatry units and hospitals, as a critical threat to children's health care access and quality (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve clause in Resolution 815 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~advocate for~~ support federal and state policies to support the financial viability and access to pediatric care delivery organizations, particularly inpatient care units (Directive to Take Action); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve clause in Resolution 815 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA work with interested ~~relevant~~ organizations to improve access to care and reduce health disparities arising from pediatric hospital and unit closures~~, for example the American Academy of Pediatrics, American Hospital Association, Children's Hospital Association, and National Rural~~

~~Health Association, to study the current and future projected impact of pediatric hospital and unit closures on health outcomes, access to care, and health disparities~~ (Directive to Take Action); and be it further

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the fourth Resolve clause in Resolution 815 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA work with interested organizations ~~build a national coalition with the American Hospital Association and other like-minded organizations~~ to increase awareness on the issue of pediatric hospital closures and to develop strategies to preserve access to high-quality pediatric emergency, inpatient, and critical care. (Directive to Take Action)

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 815 be adopted as amended.

HOD ACTION: Resolution 815 adopted as amended.

RESOLVED, that our American Medical Association recognize the closure of pediatric hospitals and units as a critical threat to children's health care access and quality (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for federal and state policies to support the financial viability and access to pediatric care delivery organizations, particularly inpatient care units (Directive to Take Action); and be it further

RESOLVED, that our AMA work with relevant organizations, for example the American Academy of Pediatrics, American Hospital Association, Children's Hospital Association, and National Rural Health Association, to study the current and future projected impact of pediatric hospital and unit closures on health outcomes, access to care, and health disparities (Directive to Take Action); and be it further

RESOLVED, that our AMA build a national coalition with the American Hospital Association and other like-minded organizations to increase awareness on the issue of pediatric hospital closures and to develop strategies to preserve access to high-quality pediatric inpatient and critical care. (Directive to Take Action)

Your Reference Committee heard testimony supportive of Resolution 815. There were suggested amendments to the third and fourth resolves to broaden the language by changing to "all interested stakeholders" to encompass any organizations that may be interested in these efforts. In addition, there was an amendment proffered by the Council on Medical Service to the fourth resolve clause to remove the reference to building a national coalition, as it would be more appropriate for these efforts to be spearheaded by another organization and for the AMA to then

support these efforts. Finally, there were amendments proposed to include emergency and psychiatric care in addition to pediatric inpatient units. Your Reference Committee recommends amendments to broaden the language in the third and fourth resolves, add references to psychiatric and emergency care, and change the fourth resolve to working with interested organizations on these efforts, as opposed to the AMA building a national coalition, which may be more appropriate for another organization. The author of the original resolution testified in favor of the amendments proffered. Your Reference Committee recommends that Resolution 815 be adopted as amended.

(19) RESOLUTION 818 – PAYMENT FOR PRE-CERTIFIED/PREAUTHORIZED PROCEDURES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 818 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association support the position that the practice of retrospective denial of payment or payment recoupment for care which has been pre-certified by an insurer should be ~~banned~~ prohibited under federal statute, except when materially false or fraudulent information has knowingly been given to the insurer by the physician, hospital or ancillary service provider to obtain pre-certification (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 818 be amended by addition of a new Resolve clause to read as follows:

RESOLVED, that our AMA encourages legal action against health plans that engage in inappropriate post-service payment denials and payment recoupment. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 818 be adopted as amended.

HOD ACTION: Resolution 818 adopted as amended.

RESOLVED, that our American Medical Association support the position that the practice of retrospective denial of payment for care which has been pre-certified by an insurer should be banned, except when false or fraudulent information has knowingly been given to the insurer by the physician, hospital or ancillary service provider to obtain pre-certification (New HOD Policy); and be it further

RESOLVED, that our AMA continue to advocate for legislation, regulation, or other appropriate means to ensure that all health plans including those regulated by ERISA, pay for services that are pre-authorized, or pre-certified by such health plan, including services that are deemed pre-authorized or pre-certified because the physician participates in a "Gold Card" program operated by that health plan. (Directive to Take Action)

Your Reference Committee heard supportive testimony of Resolution 818. Testimony outlined the frustration and disruptions that can occur when payment for a procedure is retrospectively denied. Testimony proffered minor amendments to the first resolve clause in order to clarify the wording of the submitted resolution, these amendments received support in testimony. Additionally, testimony was offered to ensure that physicians are encouraged in taking legal action should they encounter post-service denials. In-person testimony was unanimously supportive of the amended language; therefore, your Reference Committee recommends that Resolution 818 be adopted as amended.

(20) RESOLUTION 820 – STATE MEDICAID COVERAGE OF HOME SLEEP TESTING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 820 be <u>amended by addition</u> to read as follows:

RESOLVED, that our American Medical Association support efforts to expand access to and insurance coverage of <u>physician-ordered</u> home sleep testing, including for Medicaid beneficiaries, for the purpose of identifying sleep apnea and related sleep conditions. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 820 be <u>adopted as amended</u>.

HOD ACTION: Resolution 820 <u>adopted</u>.

RESOLVED, that our American Medical Association support efforts to expand access to and insurance coverage of home sleep testing, including for Medicaid beneficiaries, for the purpose of identifying sleep apnea and related sleep conditions. (New HOD Policy)

Your Reference Committee heard supportive online testimony of Resolution 820, which expressed the need to ensure that all patients can access home sleep testing when needed. An online amendment was proffered to qualify that covered services are clinically appropriate; however, some testified that this may cause more hurdles to patient access. Therefore, your Reference Committee proffered the language "physician-ordered" to address concerns. Based on the supportive testimony for the revised amendment, your Reference Committee recommends that Resolution 820 be adopted as amended.

(21) RESOLUTION 821 – PATIENT ACCESS TO ASTHMA MEDICATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 821 be <u>amended by addition</u> to read as follows:

RESOLVED, that our American Medical Association supports efforts to ensure access to and insurance coverage, including Medicaid coverage, <u>and reduce cost-sharing</u> for metered-dose inhaler formulations for children and others who require it for optimal medication administration. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 821 be <u>adopted as amended</u>.

HOD ACTION: Resolution 821 <u>adopted as amended</u>.

RESOLVED, that our American Medical Association supports efforts to ensure access to and insurance coverage, including Medicaid coverage, for metered-dose inhaler formulations for children and others who require it for optimal medication administration. (New HOD Policy)

Online testimony on Resolution 821 was strongly supportive, with one proffered amendment to strengthen the resolution and ensure that patients are able to access affordable prescription medication. The author, as well as two additional delegations, supported the Reference Committee recommendation. Due to the overwhelmingly supportive testimony, your Reference Committee recommends that Resolution 821 be adopted as amended.

(22) RESOLUTION 823 – REINING IN MEDICARE ADVANTAGE - INSTITUTIONAL SPECIAL NEEDS PLANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the third Resolve clause of Resolution 823 be <u>deleted</u>.

~~**RESOLVED, that our AMA advocate for an overall ban on facility-owned I-SNPs. (Directive to Take Action)**~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 823 be <u>adopted as amended</u>.

HOD ACTION: Resolution 823 <u>adopted as amended</u>.

RESOLVED, that our American Medical Association add I-SNPs to its advocacy efforts related to Medicare Advantage plans (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for increased policies, rules, and general oversight over I-SNPs (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for an overall ban on facility-owned I-SNPs. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 823. The resolution was recommended for reaffirmation and testimony was provided opposing reaffirmation and in favor of adoption. During its review, the Reference Committee noted that the resolve clauses of Resolution 823 are contradictory. The Reference Committee believes that the resolution should not call for adding I-SNP plans to AMA advocacy efforts as well as calling for an outright ban on these plans. For this reason, your Reference Committee offers amendments to delete the third resolve in order to streamline and clarify the language of Resolution 823, while maintaining the spirit. The authors of this resolution testified in support of this amended language. Your Reference Committee recommends that Resolution 823 be adopted as amended.

RECOMMENDED FOR REFERRAL

(23) RESOLUTION 803 – HEALTHCARE SAVINGS ACCOUNT REFORM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 803 be referred.

HOD ACTION: Resolution 803 referred.

RESOLVED, that our American Medical Association advocate for revision of Health Savings Accounts to:
1. Permit contributions from family members, employers, or other designated individuals, not limiting contributions to only those on high deductible health insurance plans;
2. Permit contributions to the accounts of dependents, including children and spouses;
3. Permit contributions from Medicare and Medicaid enrollees;
4. Permit the payment of health, dental, and vision insurance premiums from Health Savings Accounts;
5. Permit the money spent by an employer on health insurance to be directed, in part, into an employee HSA, at the employee's discretion;
6. Prioritize permitting the transfer of funds between HSAs, including between spouses and family members; and
7. Ensure that the expansion of the role and functions of Health Savings Accounts is complementary to, and does not replace, health insurance. (Modify Current HOD Policy)

Testimony on Resolution 803 was mixed, with supportive comments touting the potential tax advantages of health savings accounts (HSAs) and opponents raising concerns about the implications of expanding HSAs, including potential adverse effects on the risk pool, equity concerns, and problems with high deductible plans.

Your Reference Committee preliminarily recommended that Resolutions 803 and 807 be considered together and referred for study. A majority of in-person testimony supported this recommendation, with one AMA section requesting that the study consider whether the AMA could support allowing leftover ACA premium tax credits (i.e., when a selected plan's premium is lower than the premium tax credit) to be deposited into an account for patients to use on health expenses, including HSAs. Accordingly, your Reference Committee recommends that Resolution 803 be referred.

(24) RESOLUTION 807 - EXPANDED PLURALISM IN MEDICAID

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 807 be referred.

HOD ACTION: Resolution 807 not adopted.

Resolution 807

RESOLVED, that our American Medical Association suggest Medicaid reform that introduces more pluralism for Medicaid beneficiaries (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for inclusion of choices of plan that allow Medicaid beneficiaries to directly benefit financially from using our healthcare system in a more cost-effective way (Directive to Take Action); and be it further

RESOLVED, that our AMA investigate whether the Health Savings Account (HSA) model could be adapted as one option in an expanded pluralistic system that would enable Medicaid beneficiaries to directly benefit from utilizing the healthcare system in a more cost-effective manner and, in doing so, offer Medicaid beneficiaries an opportunity to create generational wealth. (Directive to Take Action)

Testimony on Resolution 807 was mixed. A preponderance of the testimony opposed adoption of Resolve 3, with commenters noting that HSAs are not practical for many families covered by Medicaid. Testimony emphasized that tax-related recommendations for expanding HSAs should be reviewed by experts on that topic and that a study on the impact of HSAs on tax policy, health care financing, and patient outcomes would be very useful. Your Reference Committee preliminarily recommended that Resolutions 803 and 807 be considered together and referred for study. Accordingly, your Reference Committee recommends that Resolution 807 be referred.

(25) RESOLUTION 809 – MINIMUM REQUIREMENTS FOR MEDICATION FORMULARIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 809 referred.

HOD ACTION: Resolution 809 referred.

RESOLVED, that our American Medical Association advocate that Medicare, Medicaid, and all other insurers create, maintain, and enforce a minimum formulary for all beneficiaries, regardless of their specific plan, that includes all commonly prescribed, inexpensive, generic medications unless there are reasonable safety or economic concerns regarding the medication. (Directive to Take Action)

Your Reference Committee heard limited but somewhat supportive testimony for the intent of Resolution 809. Testimony expressed the importance of ensuring that patients have access to the medications they are prescribed. The Council on Medical Service expressed concern

regarding the practicality of the resolution as written. Specifically, the Council outlined concerns about the vagueness of the wording surrounding the medications that would be required to be listed in the resolution. Your Reference Committee heard the concerns expressed by the Council on Medical Service and feel that the resolution, as currently written, was non-specific. Specifically, concerns around the vagueness of what minimum formulary requirements were to be enforced and which medications should be included in that formulary. In-person testimony was also limited but expressed the intent of the resolution and outlined that, if appropriately fleshed out, it could make for policy that would support physician practice and patient access to prescriptions. Due to the concerns raised by the Council online and the in-person testimony outlining the potential helpfulness of the resolution's intent your Reference Committee recommends that Resolution 809 be referred.

(26) RESOLUTION 817 – ACA SUBSIDIES FOR UNDOCUMENTED IMMIGRANTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 817 be referred.

HOD ACTION: Resolution 817 adopted.

RESOLVED, that our American Medical Association support federal and state efforts to provide subsidies for undocumented immigrants to purchase health insurance, including by extending eligibility for premium tax credits and cost-sharing reductions to purchase Affordable Care Act (ACA) plans. (New HOD Policy)

Testimony on Resolution 817 was mixed. Supportive comments spoke to the need to build on existing AMA policies (e.g., Policy H-165.823 and D-440.911) which already advocate that undocumented immigrants should be eligible for Affordable Care Act (ACA), Medicaid, and CHIP coverage. These commenters noted that the resolution would make subsidies available and ACA plans more affordable. Opposing testimony ranged from a suggestion that coverage gaps experienced by U.S. citizens should be addressed before ACA subsidies are extended to undocumented people to more general opposition to subsidies being given to this population.

Online testimony both strongly supported and opposed Resolution 817. Your Reference Committee preliminarily recommended reaffirmation of Policy H-165.823[4], which supports extending eligibility to purchase ACA coverage to undocumented immigrants and recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status, in lieu of Resolution 817. In-person testimony largely opposed reaffirmation and supported adoption of Resolution 817, although some speakers raised potential unintended consequences of both extending the subsidies to undocumented people, and not extending the subsidies to this population. Your Reference Committee believes that such unintended consequences should be explored before new policy is adopted and recommends that Resolution 817 be referred.

RECOMMENDED FOR REFERRAL FOR DECISION

(27) RESOLUTION 814 – LEGISLATION FOR PHYSICIAN PAYMENT FOR PRIOR AUTHORIZATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 814 be referred for decision.

HOD ACTION: Resolution 814 referred for decision.

RESOLVED, that our American Medical Association initiates prior authorization legislation aimed at Medicare Advantage plans, state Medicaid programs as well as commercial payers, via model legislation, that allows for fair reimbursement for physician's time and that of their office staff when dealing with prior authorization. (Directive to Take Action)

Your Reference Committee heard passionate and mixed testimony on Resolution 814. Testimony indicated the extreme frustration that prior authorization causes to physicians on a regular basis, and some suggested that payment for prior authorization could result in the diminishing of the practice itself. However, other testimony, including that from members, the Council on Legislation (COL), the Council on Medical Service (CMS), and the Board of Trustees (BOT), raised intense concern that payment for prior authorization would be viewed as legitimizing an invasive process that causes great harm to patients. Additionally, testimony provided by both CMS and COL indicated the extensive advocacy efforts that the AMA is undertaking to reform prior authorization (as noted in Board of Trustees Report 20-I-24) and expressed concern that the position of 814 could harm these efforts, especially the work of state medical associations with patient coalitions. Finally, CMS outlined findings from past reports that echoed the concerns that arose in testimony for Resolution 814. In reviewing testimony, your Reference Committee understood and sympathized with the legitimate concerns expressed regarding prior authorization and believes that the intent of this resolution, to be paid for administrative work related to prior authorization, is covered by the ongoing efforts of AMA campaigns and work by the BOT.

In-person testimony primarily focused on debate between referral for decision and referral. One individual reemphasized the merits of the resolution and the burden that prior authorization places on physicians. Proponents of referring Resolution 814 testified to the hurdles faced when dealing with prior authorization. However, those testifying in favor of referral for decision emphasized the extensive work that has been, and continues to be, done by the AMA on this topic. Testimony conveyed a desire to have a decision made on this issue in an expeditious manner. Additional testimony expressed concern that allocating resources to study an issue that has been studied extensively is not only duplicative but could harm other AMA efforts by reducing their resources.

Based on the significant concern expressed in the mixed online testimony, the expansive efforts being made by the AMA, and the in-person testimony outlining the need for an expeditious and resource-efficient outcome for this item your Reference Committee recommends that Resolution 814 be referred for decision.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(28) RESOLUTION 801 – REIMBURSEMENT FOR MANAGING PORTAL MESSAGES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-385.919, H-385.951, and H-270.962 be reaffirmed in lieu of Resolution 801.

HOD ACTION: Policies H-385.919, H-385.951, and H-270.962 reaffirmed in lieu of Resolution 801.

RESOLVED, that our American Medical Association immediately collaborate with payers to seek adequate reimbursement for professional time spent answering questions on the patient portal not related to a recent visit (Directive to Take Action); and be it further

RESOLVED, that our AMA continue to advocate for physicians to receive adequate compensation or seek relief from overreaching administrative tasks that take physicians' time away from direct patient care during our present climate of ever-increasing unpaid and unfunded mandates on their time. (Directive to Take Action)

Your Reference Committee heard testimony from four delegations supporting reaffirmation of existing policy in lieu of Resolution 801. Testimony from one delegation opposed Resolution 801 as written. In-person testimony did not oppose reaffirmation and therefore, your Reference Committee recommends that Policies H-385.919, H-385.951, and H-270.962 be reaffirmed in lieu of this resolution.

PAYMENT FOR ELECTRONIC COMMUNICATION, H-385.919
Our AMA will: (1) advocate that pilot projects of innovative payment models be structured to include incentive payments for the use of electronic communications such as Web portals, remote patient monitoring, real-time virtual office visits, and email and telephone communications; (2) continue to update its guidance on communication and information technology to help physicians meet the needs of their patients and practices; and (3) educate physicians on how to effectively and fairly bill for electronic communications between patients and their physicians.
(CMS Rep. 1, A-10; Reaffirmed in lieu of Res. 705, A-11; Reaffirmation: I-18)

REMUNERATION FOR PHYSICIAN SERVICES, H-385.951
1. Our American Medical Association actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.

2. It is our AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.

3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.

(Sub. Res. 814, A-96; Reaffirmation: A-02; Reaffirmation: I-08; Reaffirmation: I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmation: A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14; Reaffirmed: Res. 811, I-19; Reaffirmation: A-22; Reaffirmed: BOT Rep. 30, A-24)

UNFUNDED MANDATES, H-270.962

Our AMA vigorously opposes any unfunded mandates on physicians.

(Res. 217, A-03; Reaffirmed: CMS Rep. 4, A-13; Reaffirmation: A-16; Reaffirmed: BOT Rep. 16, A-19)

(29) RESOLUTION 802 – ADDRESS PHYSICIAN BURNOUT WITH INBOX MANAGEMENT RESOURCES AND INCREASED PAYMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-270.962, D-310.968, H-400.972, H-400.991, D-405.972, D-450.980, D-478.976, and D-478.995 be reaffirmed in lieu of Resolution 802.

HOD ACTION: Policies H-270.962, D-310.968, H-400.972, H-400.991, D-405.972, D-450.980, D-478.976, and D-478.995 reaffirmed in lieu of Resolution 802.

RESOLVED, that our American Medical Association develop additional inbox management resources (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for increasing the relative value unit for inbox management recognizing that it is asynchronous care that provides value and reduces overall health care costs (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for electronic health record tools that calculate physician time spent in the inbox. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 802. There was testimony in favor of reaffirming AMA policy in lieu of the resolution, testimony amending the resolution, and testimony opposing the resolution. All those that testified agreed with the spirit of the resolution, both in person and online. Therefore, your Reference Committee believes that reaffirmation will achieve the goal of this resolution and thus recommends that Policies H-270.962, D-310.968, H-400.972, H-400.991, D405.972, D-450.980, D-478.976, and D-478.995 be reaffirmed in lieu of Resolution 802.

UNFUNDED MANDATES, H-270.962
Our AMA vigorously opposes any unfunded mandates on physicians. (Res. 217, A-03; Reaffirmed: CMS Rep. 4, A-13; Reaffirmation: A-16; Reaffirmed: BOT Rep. 16, A-19)

PHYSICIAN AND MEDICAL STUDENT BURNOUT, D-310.968

1. Our American Medical Association recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to:
    a. address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight.
    b. develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of

demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.

(CME Rep. 8, A-07; Modified: Res. 919, I-11; Modified: BOT Rep. 15, A-19; Reaffirmation; A-22)

PHYSICIAN PAYMENT REFORM, H-400.972

1. It is the policy of our American Medical Association to take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but not limited to:
    a. Reduction of allowances for new physicians.
    b. The non-payment of EKG interpretations.
    c. Defects in the Geographic Practice Cost Indices and area designations.
    d. Inappropriate Resource-Based Relative Value Units.
    e. The deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system.
    f. The need for restoration of the RBRVS conversion factor to levels consistent with the statutory requirement for budget neutrality.
    g. The inadequacy of payment for services of assistant surgeons.
    h. The loss of surgical-tray benefit for many outpatient procedures (Reaffirmed by Rules & Credentials Cmt., A-96);
2. Seek an evaluation of:
    a. Stress factors (i.e., intensity values) as they affect the calculation of the Medicare Payment Schedule, seeking appropriate, reasonable, and equitable adjustments.
    b. Descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and payment levels and to seek adjustments so that the resulting values and payment levels appropriately pertain to the elderly and often infirm patients.
3. Evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment Schedule and to ascertain that the concept for the work component continues to be an appropriate part of a resource-based relative value system.
4. Seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors.
5. Seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with preoperative office visits, concomitant office procedures, and/or future procedures.
6. Seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992.
7. Seek the elimination of regulations directing patients to points of service.
8. Support further study of refinements in the practice cost component of the RBRVS to ensure better reflection of both absolute and relative costs associated with individual services, physician practices, and medical specialties, considering such issues as data adequacy, equity, and the degree of disruption likely to be associated with any policy change.

9. Take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs.
10. Support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of 1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare geographic practice costs indices (GPCIs) and work with CMS and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect actual physician costs, including gross receipt taxes.
11. Request that CMS refine relative values for particular services on the basis of valid and reliable data and that CMS rely upon the work of the AMA/Specialty Society RVS Updating Committee (RUC) for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations.
12. Pursue aggressively recognition and CMS adoption for Medicare payment schedule conversion factor updates of an index providing the best assurance of increases in the monetary conversion factor reflective of changes in physician practice costs, and to this end, to consider seriously the development of a "shadow" Medicare Economic Index.
13. Continue to implement and refine the Payment Reform Education Project to provide member physicians with accurate and timely information on developments in Medicare physician payment reform.
14. Take steps to assure all relative value units contained in the Medicare Fee Schedule are adjusted as needed to comply with ever-increasing federal and state regulatory requirements.

(Sub. Res. 109, A-92; Reaffirmed: I-92; Reaffirmed by CMS Rep. 8, A-95 and Sub. Res. 124, A-95; Reaffirmation A-99 and Reaffirmed; Res. 127, A-99; Reaffirmation: A-02; Reaffirmation: A-06; Reaffirmation: I-07; Reaffirmed: BOT Rep. 14, A-08; Reaffirmation: A-09; Reaffirmed: CMS Rep. 01, A-19; Reaffirmed: Res. 212, I-21)

GUIDELINES FOR THE RESOURCE-BASED RELATIVE VALUE SCALE, H-400.991

1. Our American Medical Association reaffirms its current policy in support of adoption of a fair and equitable Medicare indemnity payment schedule under which physicians would determine their own fees and Medicare would establish its payments for physician services using:
    a. An appropriate RVS based on the resource costs of providing physician services.
    b. An appropriate monetary conversion factor.
    c. An appropriate set of conversion factor multipliers.
2. Our AMA supports the position that the current Harvard RBRVS study and data, when sufficiently expanded, corrected and refined, would provide an acceptable basis for a Medicare indemnity payment system.

3. Our AMA reaffirms its strong support for physicians' right to decide on a claim-by-claim basis whether or not to accept Medicare assignment and its opposition to elimination of balance billing. (Reaffirmed: Sub. Res. 132, A-94)
4. Our AMA reaffirms its opposition to the continuation of the Medicare maximum allowable actual charge (MAAC) limits.
5. Our AMA promotes enhanced physician discussion of fees with patients as an explicit objective of a Medicare indemnity payment system.
6. Our AMA supports expanding its activities in support of state and county medical society-initiated voluntary assignment programs for low-income Medicare beneficiaries.
7. Our AMA reaffirms its current policy that payments under a Medicare indemnity payment system should reflect valid and demonstrable geographic differences in practice costs, including professional liability insurance premiums. In addition, as warranted and feasible, the costs of such premiums should be reflected in the payment system in a manner distinct from the treatment of other practice costs.
8. Our AMA believes that payment localities should be determined based on principles of reasonableness, flexibility and common sense (e.g., localities could consist of a combination of regions, states, and metropolitan and nonmetropolitan areas within states) based on the availability of high quality data.
9. Our AMA believes that, in addition to adjusting indemnity payments based on geographic practice cost differentials, a method of adjusting payments to effectively remedy demonstrable access problems in specific geographic areas should be developed and implemented.
10. Where specialty differentials exist, criteria for specialty designation should avoid sole dependence on rigid criteria, such as board certification or completion of residency training. Instead, a variety of general national criteria should be utilized, with carriers having sufficient flexibility to respond to local conditions. In addition to board certification or completion of a residency, such criteria could include, but not be limited to:
    a. Partial completion of a residency plus time in practice.
    b. Local peer recognition
    c. Carrier analysis of practice patterns. A provision should also be implemented to protect the patients of physicians who have practiced as specialists for a number of years.
11. Our AMA strongly opposes any attempt to use the initial implementation or subsequent use of any new Medicare payment system to freeze or cut Medicare expenditures for physician services in order to produce federal budget savings.
12. Our AMA believes that whatever process is selected to update the RVS and conversion factor, only the AMA has the resources, experience and umbrella structure necessary to represent the collective interests of medicine, and that it seek to do so with appropriate mechanisms for full participation from all of organized medicine, especially taking advantage of the unique contributions of national medical specialty societies.

BOT Rep. AA, I-88; Reaffirmed: I-92; Reaffirmed and Modified: CMS Rep. 10, A-03; Reaffirmation: A-06; Reaffirmed: CMS Rep. 01, A-16; Reaffirmed: Res. 212, I-21)

PHYSICIAN BURNOUT, D-405.972

1. Our American Medical Association will work with Centers for Medicare and Medicaid Services (CMS), The Joint Commission, and other accrediting bodies and interested stakeholders to add an institutional focus on physician wellbeing as an accreditation standard for hospitals, focusing on system-wide interventions that do not add additional burden to physicians.
2. Our AMA will work with hospitals and other stakeholders to determine areas of focus on physician wellbeing, to include the removal of intrusive questions regarding physician physical or mental health or related treatments on initial or renewal hospital credentialing applications.

(Res. 723, A-22; Reaffirmation: I-22)

PHYSICIAN TIME SPENT WITH PATIENTS AND WITH HOSPITAL DOCUMENTATION, D-450.980

Our AMA will:

(1) advocate for continued research into quality determinants--including time spent with patients--and lead the effort to develop and appropriately implement quality indicators, i.e., clinical performance measures;

(2) continue to work with accrediting bodies and government agencies to substantially reduce hospital paperwork; and

(3) continue to work with electronic health record (EHR) system developers to ensure that the perspectives of practicing physicians are adequately incorporated, to ensure the standardization and integration of clinical performance measures developed by physicians for physicians, and to ensure a seamless integration of the EHR into the day-to-day practice of medicine.

(BOT Action in response to referred for decision Res. 511, A-03; Reaffirmation: I-10; Reaffirmed: BOT Rep. 04, A-20)

INNOVATION TO IMPROVE USABILITY AND DECREASE COSTS OF ELECTRONIC HEALTH RECORD SYSTEMS FOR PHYSICIANS, D-478.976

1) Our AMA will: (A) advocate for CMS and the Office of the National Coordinator (ONC) to support collaboration between and among proprietary and open-source EHR developers to help drive innovation in the marketplace; (B) continue to advocate for research and physician education on EHR adoption and design best practices specifically concerning key features that can improve the quality, safety, and efficiency of health care regardless of proprietary or open-source status; and (C) through its partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs-open source and proprietary-to create more transparency and support more informed decision making in the selection of EHRs.

2) Our AMA will, through partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs--open source and proprietary--to create more transparency and formulate more formal decision making in the selection of EHRs.
3) Our AMA will work with AmericanEHR Partners to modify the current survey to better address the economics of EHR use by physicians including the impact of scribes.
4) Our AMA will make available the findings of the AmericanEHR Partners' survey and report back to the House of Delegates.
(BOT Rep. 23, A-13; BOT Rep. 24, A-13; Reaffirmed: BOT Rep. 17, A-15; Appended: Res. 603, I-16; Modified: BOT Rep. 20, A-17)

NATIONAL HEALTH INFORMATION TECHNOLOGY, D-478.995

1. Our American Medical Association will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA:
    a. Advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology.
    b. Advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue.
    c. Advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.
    d. Advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare & Medicaid Services:
    a. Support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices.
    b. Develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will
    a. seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery.
    b. work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic

health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.
8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.
9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.

(Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation: A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified: BOT Rep. 17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed: BOT Rep. 24, A-13; Reaffirmed in lieu of Res. 724, A-13; Appended: Res. 720, A-13; Appended: Sub. Res. 721, A-13; Reaffirmed: CMS Rep. 4, I-13; Reaffirmation I-13; Appended: BOT Rep. 18, A-14; Appended: BOT Rep. 20, A-14; Reaffirmation A-14; Reaffirmed: BOT Rep. 17, A-15; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmation I-15; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 227, A-17; Reaffirmed in lieu of: Res. 243, A-17; Modified: BOT Rep. 39, A-18; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 3, I-19; Reaffirmed: CMS Rep. 2, A-22; Reaffirmation: Res. 715, A-24)

(30) RESOLUTION 819 – ESTABLISHING A NEW OFFICE-BASED FACILITY SETTING TO PAY SEPARATELY FROM THE MEDICARE PHYSICIAN FEE SCHEDULE FOR THE TECHNICAL REIMBURSEMENT OF PHYSICIAN SERVICES USING HIGH-COST SUPPLIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-400.957 be <u>reaffirmed in lieu of</u> Resolution 819.

HOD Action: Policy H-400.957 <u>reaffirmed in lieu</u> of Resolution 819.

RESOLVED, that our American Medical Association study options to reform the Medicare Physician Fee Schedule by (1) removing high-cost supplies from the Medicare Physician Fee

Schedule by establishing a new office-based facility setting to pay separately for the technical reimbursement of physician services using high-cost supplies (2) removing high-cost radiation therapy equipment from the Medicare Physician Fee Schedule by establishing a new case rate model for radiation oncology. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 819. Testimony indicated support that the issues in the resolution are indeed important but are already being addressed at length by both the AMA and the RVS Update Committee (RUC). Testimony from RUC representatives outlined their own efforts to ensure that all physicians are paid for high-cost supplies in a fair and efficient manner. This resolution was suggested for reaffirmation, a position supported by RUC representatives. In-person testimony expressed support for the resolution as written and explained that reimbursement for high-cost supplies can be a challenge for many physicians. However, RUC members and leadership, along with the Council on Medical Service, expressed that efforts are ongoing to ensure that these needs are met. Your Reference Committee was compelled by this testimony and therefore recommends that Policy H-400.957 be reaffirmed in lieu of Resolution 819.

MEDICARE REIMBURSEMENT OF OFFICE-BASED PROCEDURES
H-400.957

1. Our American Medical Association will encourage CMS to expand the extent and amount of reimbursement for procedures performed in the physician's office, to shift more procedures from the hospital to the office setting, which is more cost effective.
2. Our AMA will seek to have the RBRVS practice expense RVUs reflect the true cost of performing office procedures.
3. Our AMA will work with CMS to develop consistent regulations to be followed by carriers that include reimbursement for the costs of disposable supplies and surgical tray fees incurred with office-based procedures and surgery. (Sub. Res. 103, I-93; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmation A-04Reaffirmation I-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: CMS Rep. 3, A-14; Reaffirmed in lieu of Res. 216, I-14; Reaffirmed: CMS Rep. 04, I-18; Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19; Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19; Reaffirmation: A-22)

(31) RESOLUTION 826 – RENEWING THE EXPANSION OF PREMIUM TAX CREDITS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policies H-165.824, H-185.948, and H-165.904 be <u>reaffirmed in lieu of</u> the first resolved clause of Resolution 826.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policies H-165.828 and H-165.838 <u>reaffirmed in lieu of</u> the second resolved clause of Resolution 826.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third resolved clause of Resolution 826 be adopted.

HOD Action: Policy H-165.824, H-185.948, and H-165.904 reaffirmed in lieu of Resolved 1 of Resolution 826; Policies H-165.828 and H-165.838 reaffirmed in lieu of Resolved 2 of Resolution 826; and Resolved 3 of Resolution 826 adopted as amended.

RESOLVED, that our AMA ~~will immediately initiate or substantially invest in a focused grassroots campaign to~~ support extending Affordable Care Act tax credit enhancement from the American Rescue Plan Act and the Inflation Reduction Act.

RESOLVED, that our American Medical Association (AMA) reaffirm that expanding coverage and protecting access to care is a top AMA priority; and be it further

RESOLVED, that our AMA will monitor and oppose efforts to rollback affordable and quality health insurance coverage at the federal level; and be it further

RESOLVED, that our AMA will immediately initiate or substantially invest in a focused grassroots campaign to support extending Affordable Care Act tax credit enhancement from the American Rescue Plan Act and the Inflation Reduction Act.

Your Reference Committee heard passionate testimony regarding Resolution 826. Testimony outlined that many individuals who utilize tax credit enhancements from the Affordable Care Act (ACA) for health insurance will lose coverage if the enhanced tax credits are not extended. While all testimony supported the importance of ensuring that individuals have access to affordable health insurance, some testimony indicated concern with the wording, not the intent, of first two resolved clauses. Your Reference Committee feels that the first and second Resolved clauses are adequately addressed in policies that express the AMA's strong intent to ensure that health insurance coverage is available in a manner that keeps health care access affordable to Americans and to protect against any rollback in the quality or affordability of care.

Additional testimony indicated that the AMA is participating in a coalition (Keep Americans Covered - https://americanscovered.org/) that aims to ensure that these tax credits are extended and to keep health care affordable. Since the AMA is already involved in a coalition of patients, consumers, physicians, hospitals, health insurers, and employers working together to extend the tax credits, your Reference committee believes that the adoption of the third Resolved clause of this resolution would enshrine current efforts in policy.

Therefore, your Reference Committee recommends that Policies H-165.824, H-185.948, and H-165.904 be reaffirmed in lieu of the first Resolved clause of Resolution 826, Policies H-165.828 and H-165.838 be reaffirmed in lieu of the second Resolved clause of Resolution 826, and the third Resolved clause of Resolution 826 be adopted.

IMPROVING AFFORDABILITY IN THE HEALTH INSURANCE EXCHANGES H-165.824

1. Our American Medical Association will:
   a. support adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits.
   b. support expanding eligibility for premium tax credits up to 500 percent of the federal poverty level.
   c. support providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income.
   d. encourage state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections.
2. Our AMA supports:
   a. eliminating the subsidy "cliff", thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL).
   b. increasing the generosity of premium tax credits.
   c. expanding eligibility for cost-sharing reductions.
   d. increasing the size of cost-sharing reductions. (CMS Rep. 02, A-18; Appended: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 3, I-21)

HEALTH INSURANCE FOR CHILDREN H-185.948
Our AMA supports requiring all children to have adequate health insurance as a strategic priority. (Res. 610, I-08; Reaffirmed: CMS Rep. 01, A-18)

UNIVERSAL HEALTH COVERAGE H-165.904
1. Our American Medical Association seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories.
2. Our AMA seeks federal legislation that would require the federal government to provide financial support to any individuals, organizations, and institutions providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform.
3. Our AMA continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans (Sub. Res. 138, A-94; Appended: Sub. Res. 109, I-98; Reaffirmation A-02; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 1, A-22)

HEALTH INSURANCE AFFORDABILITY H-165.828
1. Our American Medical Association supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage

by lowering the threshold that determines whether an employee's premium contribution is affordable to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage in Affordable Care Act (ACA) marketplaces.

2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the eligibility of family members of workers for premium tax credits and cost-sharing reductions based on the affordability of family employer-sponsored coverage and household income.
3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy.
4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible.
5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.
6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.
7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.
8. Our AMA supports the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace. (CMS Rep. 8, I-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmation: A-17; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed in lieu of: Res. 101, A-19; Reaffirmed: CMS Rep. 01, I-20; Reaffirmed: CMS Rep. 2, I-20Modified: CMS Rep. 3, I-21Appended: Res. 701, I-21)

HEALTH SYSTEM REFORM H-165.838

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
    a. Health insurance coverage for all Americans.

b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps.
c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials.
d. Investments and incentives for quality improvement and prevention and wellness initiatives.
e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care.
f. Implementation of medical liability reforms to reduce the cost of defensive medicine.
g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens.

2. Our AMA advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
3. Our AMA House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.
4. Our AMA supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.
5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.
6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.
8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
    a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services.
    b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system.

c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted.
d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate.
e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another.
f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest.

9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.
10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.
11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.
12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.
13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.(Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed in lieu of: Res. 805, I-17; Reaffirmed: CMS Rep. 03, A-18; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 3, I-21Reaffirmation: A-22; Reaffirmed: CMS Rep. 02, I-23\

Madam Speaker, this concludes the report of Reference Committee J. I would like to thank Barbara Arnold, MD, FACS; Clarence Chou MD, DLFAPA, DLFAACAP; Michael Cromer, MD, FAAFP; Mary Krebs, MD, FAAFP; Samantha Thomas, BS, Roxanne Tyroch, MD, FACP, and all those who testified before the Committee.

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