REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 01-A-22

Subject: Council on Medical Service Sunset Review of 2012 House Policies

Presented by: Asa C. Lockhart, MD, Chair

Referred to: Reference Committee G

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for review and specifying the procedures to follow:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification; or (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

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RECOMMENDATION

1 The Council on Medical Service recommends that the House of Delegates policies that are
2 listed in the appendix to this report be acted upon in the manner indicated and the
3 remainder of this report be filed.

APPENDIX – Recommended Actions

Policy #	Title	Text	Recommendation
D-165.957	State Options to Improve Coverage for the Poor	Our AMA (1) urges national medical specialty societies, state medical associations, and county medical societies to become actively involved in and support state-based demonstration projects to expand health insurance coverage to low-income persons; and (2) encourages state governments to maintain an inventory of private health plans and design an easily accessible, consumer-friendly information clearinghouse for individuals, families, and small businesses on available plans for expanding health insurance coverage. (CMS Rep. 1, A-05; Reaffirmed in lieu of Res. 105, A-12)	Rescind. Superseded by Policies D-165.942 and H-165.839, which state: Empowering State Choice D-165.942 Our AMA will advocate that state governments be given the freedom to develop and test different models for covering the uninsured, provided that their 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. Health Insurance Exchange Authority and Operation H-165.839 1. Our American Medical Association adopts the following principles for the operation of health insurance exchanges: A) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features. B) Any benefits standards implemented for plans participating in the exchange and/or to determine minimum creditable coverage for an individual mandate should be designed with input from

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			patients and actively practicing physicians. C) Physician and patient decisions should drive the treatment of individual patients. D) Actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options. E) Regulations addressing physician participation in public, private or non-profit health insurance options in the exchange that impact physician practice should ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process. F) Any necessary federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices. 2. Our AMA: (A) supports using the open marketplace model for any health insurance exchange, with strong patient and physician protections in place, to increase competition and maximize patient choice of

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			health plans, (B) will advocate for the inclusion of actively practicing physicians and patients in health insurance exchange governing structures and against the categorical exclusion of physicians based on conflict of interest provisions; (C) supports the involvement of state medical associations in the legislative and regulatory processes concerning state health insurance exchanges; and (D) will advocate that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information.
D-165.974	Achieving Health Care Coverage for All	Achieving Health Care Coverage for All -- Our American Medical Association joins with interested medical specialty societies and state medical societies to advocate for enactment of a bipartisan resolution in the US Congress establishing the goal of achieving health care coverage through a pluralistic system for all persons in the United States consistent with relevant AMA policy. (Res. 733, I-02; Modified: CCB/CLRPD Rep. 4, A-12)	Rescind. Superseded by Policy H-165.838, which states: 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

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			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 American Medical Association 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 American Medical Association 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 American Medical Association 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

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			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

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			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

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			should be part of any national health system reform.
D-185.985	Patient Access to Therapeutics	Our AMA will work with other interested parties to ensure that payment for prescription medications and durable medical equipment not be denied based solely on the use of a properly suffixed institutional Drug Enforcement Agency number or similar identifier. (Res. 121, A-12)	Retain. Still relevant.
D-260.995	Improvements to Reporting of Clinical Laboratory Results	1. Our AMA will: (a) make its involvement with the Office of the National Coordinator for Health Information Technology and its Health Information Technology Policy and Standards Committees a high priority; and (b) become involved in and/or provide input into policies involving electronic transmission of clinical laboratory results. 2. Our AMA will encourage the College of American Pathologists, Health Level 7, the National Institute for Standards and Technology, and the Agency for Healthcare Research and Quality to urgently address usability and standardization of laboratory report results for physicians and non-physician practitioners to ensure patient safety. 3. Our AMA will support the continued efforts of relevant national medical specialty societies, such as the American College of Radiology, the American Osteopathic College of Radiology and other like organizations whose members generate reports electronically to clarify terminology and work in consultation with physicians likely to be end users toward producing a standardized format with appropriate standard setting bodies for the presentation of radiology results, including clearly identifiable diagnoses and test results. 4. Our AMA will report back to the House of Delegates on progress with regard to medical record and reporting standardization. (BOT Rep. 16, I-06; Modified: CMS Rep. 2, I-12)	Retain-in-part. The following subsection was accomplished and should be rescinded. 4. Our AMA will report back to the House of Delegates on progress with regard to medical record and reporting standardization.
D-285.965	Small Businesses and Health Reform	Our AMA will: (1) advocate that stop-loss coverage of self-insured plans have minimum attachment points that are high enough to ensure the adequacy	Retain. Still relevant.

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		and financial security of health insurance coverage of enrollees, and be provided by stop-loss insurers that are legitimate and financially secure and solvent; and (2) encourage states to monitor the rate at which small employers self-insure, and the impact of such self-insurance on the viability and purchasing power on SHOP exchanges. (CMS Rep. 6, A-12)	
D-290.980	Medicare-Medicaid Dual Eligible Demonstration Program	1. Our AMA will advocate that the Centers for Medicare & Medicaid Services and the states delay implementation of the Medicare-Medicaid dual eligible demonstration program for at least one year to allow beneficiaries and provider stakeholders to better understand and evaluate and comment on the "State Demonstrations to Integrate Care for Dual Eligible Individuals" initiative. 2. Because Medicare-Medicaid dual eligibles often have complex medical and social needs, our AMA will advocate to CMS and the states that established patient-provider relationships and current treatment plans will not be disrupted by the dual eligible Financial Alignment Initiative so as to preserve robust, patient-centered continuity of care. 3. Our AMA will advocate to CMS and the states that the Medicare-Medicaid dual eligibles Financial Alignment Initiative should operate as a true demonstration program, and therefore it should not enroll a majority of dual eligibles in any state, and there must be a rigorous evaluation plan to be consistent with the design of a demonstration that can provide useful information to policymakers. 4. Our AMA will advocate to CMS and states against automatically enrolling Medicare-Medicaid dual eligibles in a coordinated care program without their prior approval or consent. 5. Our AMA will work with CMS and the states to ensure that the Medicare-Medicaid dual eligibles Financial Alignment Initiative demonstrates potential ways of achieving efficiencies in organizing the care of dual eligibles, and any savings from coordination of care to dual eligibles should arise from	Retain-in-part. The following subsection is out-of-date and should be rescinded. The Centers for Medicare & Medicaid (CMS) has been implementing demonstration programs for dually eligible enrollees, including Financial Alignment Initiative demonstrations, since 2012. 1. Our AMA will advocate that the Centers for Medicare & Medicaid Services and the states delay implementation of the Medicare-Medicaid dual eligible demonstration program for at least one year to allow beneficiaries and provider stakeholders to better understand and evaluate and comment on the "State Demonstrations to Integrate Care for Dual Eligible Individuals" initiative.

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		better health outcomes and efficiencies gained by reducing duplicative, unnecessary, or inappropriate care. The Initiative should not be employed as a policy lever simply to reduce provider payment rates, which could significantly harm beneficiary access. Res. 123, A-12	
D-290.986	Capitation of Medicaid Funding for Guam and Other US Territorial Possessions	The AMA will support: (1) Repeal of 42 USC 1308(f) and to allow Guam and other Territorial Possessions and Island Nations to participate in the Medicaid program on the same terms as the States, without capitation of matching funds; (2) Amending 42 USC 1396(d)(b)(2) by striking "50 per centum" and by inserting in lieu thereof: "determined in the same manner as such percentage is determined for the States under this subsection"; this will allow the Territories to participate in the Medicaid program on the same terms as the States; and (3) Federal legislative language introduced during the 107th Congress that has provisions equivalent to those included in H.R. 5126, introduced during the last Congress by Virgin Islands Delegate Donna Christensen, MD. (BOT Action in response to referred for decision Res. 215, I-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmation A-12)	Retain-in-part. The following subsection is out-of-date and should be rescinded. (3) Federal legislative language introduced during the 107th Congress that has provisions equivalent to those included in H.R. 5126, introduced during the last Congress by Virgin Islands Delegate Donna Christensen, MD.
D-330.918	Appropriateness of National Coverage Decisions	1. Our AMA will work with the national medical specialty societies and the Centers for Medicare and Medicaid Services (CMS) and their intermediaries to identify outdated coverage decisions that create obstacles to clinically appropriate patient care. 2. Our AMA will work with CMS to suspend recovery actions for technologies and treatments for which sufficient comparative effectiveness research or other quality evidence exists to update a National Coverage Determination (NCD) or Local Coverage Determination (LCD) to reflect the available scientific evidence and contemporary practice. (Sub. Res. 120, A-11; Reaffirmed in lieu of Res. 125, A-12)	Retain. Still relevant.

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D-373.995	Shared Decision Making Resource Centers	Our AMA will advocate for full funding for section 3506 of the Affordable Care Act. (Res. 812, I-12)	Retain. Still relevant.
D-385.959	Billing Codes for Filling Out Forms	Our AMA will lobby the Centers for Medicare & Medicaid Services and other national payers to reimburse those physicians who utilize billing code 99080 for filling out various forms requested by patients. (Res. 803, I-12)	Retain. Still relevant.
D-390.956	MedPAC Recommendations from June 15, 2011	1. Our AMA will oppose any policy that applies a payment reduction to professional component of diagnostic services where multiple imaging studies are interpreted by the same practitioner during the same session and will oppose any policy that reduces the physician work component of imaging and other diagnostic tests that are ordered and interpreted by the same practitioner. 2. Our AMA will: (A) actively support legislation to repeal the 25 percent multiple procedure payment reduction (MPPR) recently implemented by the Centers for Medicare & Medicaid Services (CMS) as part of its 2012 Fee Schedule; and (B) work to prevent further broadening of CMS MPPR proposals until thoroughly studied by CMS. (BOT action in response to referred for decision Res. 124, A-11; Appended: Res. 214, A-12)	Retain-in-part. The following subsection is out-of-date and should be rescinded. 2. Our AMA will: (A) actively support legislation to repeal the 25 percent multiple procedure payment reduction (MPPR) recently implemented by the Centers for Medicare & Medicaid Services (CMS) as part of its 2012 Fee Schedule; and (B) work to prevent further broadening of CMS MPPR proposals until thoroughly studied by CMS.
D-410.992	Evidence-Based Utilization of Services	Our AMA supports physician-led, evidence based, efforts to improve appropriate utilization of medical services and will educate member physicians, hospitals, health care leaders and patients about the need for physician-led, evidence based, efforts to improve appropriate utilization of medical services. Res. 815, I-12	Rescind. Superseded by Policy H-285.931. The Critical Role of Physicians in Health Plans and Integrated Delivery Systems H-285.931 Our AMA adopts the following organizational principles for physician involvement in health plans and integrated delivery systems (IDS): (1) Practicing physicians participating in a health plan/IDS must: (a) be involved in the selection and removal of their leaders who are involved in governance or who serve on a

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			council of advisors to the governing body or management; (b) be involved in the development of credentialing criteria, utilization management criteria, clinical practice guidelines, medical review criteria, and continuous quality improvement, and their leaders must be involved in the approval of these processes; (c) be accountable to their peers for professional decisions based on accepted standards of care and evidence-based medicine; (d) be involved in development of criteria used by the health plan in determining medical necessity and coverage decisions; and (e) have access to a due process system. (2) Representatives of the practicing physicians in a health plan/IDS must be the decision-makers in the credentialing and recredentialing process. (3) To maximize the opportunity for clinical integration and improvement in patient care, all of the specialties participating in a clinical process must be involved in the development of clinical practice guidelines and disease management protocols. (4) A health plan/IDS has the right to make coverage decisions, but practicing physicians participating in the health plan/IDS must be able to discuss treatment alternatives with their patients to enable them to make informed decisions. (5) Practicing physicians and patients of a health plan/IDS should have access to a

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			timely, expeditious internal appeals process. Physicians serving on an appeals panel should be practicing participants of the health plan/IDS, and they must have experience in the care under dispute. If the internal appeal is denied, a plan member should be able to appeal the medical necessity determination or coverage decision to an independent review organization. (6) The quality assessment process and peer review protections must extend to all sites of care, e.g., hospital, office, long-term care and home health care. (7) Representatives of the practicing physicians of a health plan/IDS must be involved in the design of the data collection systems and interpretation of the data so produced, to ensure that the information will be beneficial to physicians in their daily practice. All practicing physicians should receive appropriate, periodic, and comparative performance and utilization data. (8) To maximize the opportunity for improvement, practicing physicians who are involved in continuous quality improvement activities must have access to skilled resource people and information management systems that provide information on clinical performance, patient satisfaction, and health status. There must be physician/manager teams to identify, improve and document cost/quality relationships that demonstrate value. (9) Physician representatives/leaders must communicate key policies

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			and procedures to the practicing physicians who participate in the health plan/IDS. Participating physicians must have an identified process to access their physician representative. (10) Consideration should be given to compensating physician leaders/representatives involved in governance and management for their time away from practice. Our AMA aggressively advocates to private health care accreditation organizations the incorporation of the organizational principles for physician involvement into their standards for health plans, networks and integrated delivery systems.
D-410.993	Need to Include Assessment of Economic Impact in Practice Guidelines	Our AMA will continue to monitor the methodological guidance, data collection, and data synthesis applied to evaluating the economic impact of implementing guidelines into clinical practice. (BOT Rep. 13, A-12)	Retain. Still relevant.
H-35.996	Status and Utilization of New or Expanding Health Professionals in Hospitals	(1) The services of certain new health professionals, as well as those professionals assuming an expanded medical service role, may be made available for patient care within the limits of their skills and the scope of their authorized practice. The occupations concerned are those whose patient care activities involve medical diagnosis and treatment to such an extent that they meet the three criteria specified below: (a) As authorized by the medical staff, they function in a newly expanded medical support role to the physician in the provision of patient care. (b) They participate in the management of patients under the direct supervision or direction of a member of the medical staff who is responsible for the patient's care. (c) They make entries on patients' records, including progress notes, only to the extent established by the medical staff.	Retain. Still relevant.

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		Thus this statement covers regulation of such categories as the new physician-support occupations generically termed physician assistants, nurse practitioners, and those allied health professionals functioning in an expanded medical support role. (2) The hospital governing authority should depend primarily on the medical staff to recommend the extent of functions which may be delegated to, and services which may be provided by, members of these emerging or expanding health professions. To carry out this obligation, the following procedures should be established in medical staff bylaws: (a) Application for use of such professionals by medical staff members must be processed through the credentials committee or other medical staff channels in the same manner as applications for medical staff membership and privileges. (b) The functions delegated to and the services provided by such personnel should be considered and specified by the medical staff in each instance, and should be based upon the individual's professional training, experience, and demonstrated competency, and upon the physician's capability and competence to supervise such an assistant. (c) In those cases involving use by the physician of established health professionals functioning in an expanded medical support role, the organized medical staff should work closely with members of the appropriate discipline now employed in an administrative capacity by the hospital (for example, the director of nursing services) in delineating such functions. (BOT Rep. G, A-73; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified:CMS Rep. 6, A-10; Reaffirmation A-12)	
H-70.924	Litigation Center Cases to Combat Automatic Downcoding and/or Recoding	The Litigation Center continues to initiate or support lawsuits that seek redress from insurers who engage in inappropriate or inaccurate downcoding and/or recoding practices. (BOT Rep. 31, A-02; Reaffirmed:CMS Rep. 4,	Retain. Still relevant.

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H-70.925	CPT Editorial Panel Representation	(1) The CPT Editorial Panel shall be kept at a size compatible with its functioning as an efficient and effective editorial board and should not be subject to the requirement of formal slotted seats for individual specialty societies. (2) While the role of the CPT Advisory Committee as clinical and technical experts to the CPT Editorial Panel is important, necessary, and currently of satisfactory composition, the need to expand as the practice of medicine changes or the scope of the CPT code set changes should be regularly evaluated. (BOT Rep. 34,	Retain. Still relevant.
H-155.966	Controlling Cost of Medical Care	The AMA urges the American Hospital Association and all hospitals to encourage the administrators and medical directors to provide to the members of the medical staffs, house staff and medical students the charges for tests, procedures, medications and durable medical equipment in such a fashion as to emphasize cost and quality consciousness and to maximize the education of those who order these items as to their costs to the patient, to the hospital and to society in general. (Sub. Res. 75, I-81; Reaffirmed: CLRPD Rep. F, I-91; Res. 801, A-93; CMS Rep. 12, A-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 5, A-12)	Retain. Still relevant.
H-155.998	Voluntary Health Care Cost Containment	(1) All physicians, including physicians in training, should become knowledgeable in all aspects of patient-related medical expenses, including hospital charges of both a service and professional nature. (2) Physicians should be cost conscious and should exercise discretion, consistent with good medical care, in determining the medical necessity for hospitalization and the specific treatment, tests and ancillary medical services to be provided a patient. (3) Medical staffs, in cooperation with hospital administrators, should embark now upon a concerted effort to educate physicians, including house staff officers, on all aspects of hospital charges, including specific medical	Retain. Still relevant.

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		tests, procedures, and all ancillary services. (4) Medical educators should be urged to include similar education for future physicians in the required medical school curriculum. (5) All physicians and medical staffs should join with hospital administrators and hospital governing boards nationwide in a conjoint and across-the-board effort to voluntarily contain and control the escalation of health care costs, individually and collectively, to the greatest extent possible consistent with good medical care. (6) All physicians, practicing solo or in groups, independently or in professional association, should review their professional charges and operating overhead with the objective of providing quality medical care at optimum reasonable patient cost through appropriateness of fees and efficient office management, thus favorably moderating the rate of escalation of health care costs. (7) The AMA should widely publicize and disseminate information on activities of the AMA and state, county and national medical specialty societies which are designed to control or reduce the costs of health care. (Res. 34, A-78; Reaffirmed: CLRPD Rep. C, A-89; Res. 100, I-89; Res. 822, A-93; Reaffirmed: BOT Rep. 40, I-93; CMS Rep. 12, A-95; Reaffirmed: Res. 808, I-02; Modified: CMS Rep. 4, A-12)	
H-160.913	Medicaid Patient-Centered Medical Home Models	Our AMA: (1) recognizes that the physician-led medical home model, as described by Policy H-160.919, has demonstrated the potential to enhance the value of health care by improving access, quality and outcomes while reducing costs; and (2) will work with state medical associations to explore, and where feasible, implement physician-led Medicaid patient-centered medical home models based on the unique needs of the physicians and patients in their states. (CMS Rep. 3, A-12)	Retain. Still relevant.
H-160.914	Support of Multilingual Assessment Tools for	Our AMA will encourage the publication and validation of standard patient assessment tools in multiple languages. (Res. 703, A-12)	Retain. Still relevant.

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	Medical Professionals		
H-165.832	Basic Health Program	1. Our AMA supports the adoption of 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans to limit patient churn and promote the continuity and coordination of patient care. 2. Our AMA adopts the following principles for the establishment and operation of state Basic Health Programs: A. State Basic Health Programs (BHPs) should guarantee ample health plan choice by offering multiple standard health plan options to qualifying individuals. Standard health plans offered within a BHP should provide an array of choices in terms of benefits covered, cost-sharing levels, and other features. B. Standard health plans offered under state BHPs should offer enrollees provider networks that have an adequate number of contracted physicians and other health care providers in each specialty and geographic region. C. Standard health plans offered in state BHPs should include payment rates established through meaningful negotiations and contracts. D. State BHPs should not require provider participation, including as a condition of licensure. E. Actively practicing physicians should be significantly involved in the development of any policies or regulations addressing physician payment and practice in the BHP environment. F. State medical associations should be involved in the legislative and regulatory processes concerning state BHPs. G. State BHPs should conduct outreach and educational efforts directed toward physicians and their patients, with adequate support available to assist physicians with the implementation process. (CMS Rep. 5, A-12)	Retain. Still relevant.

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H-165.845	State Efforts to Expand Coverage to the Uninsured	Our AMA supports the following principles to guide in the evaluation of state health system reform proposals: 1. Health insurance coverage for state residents should be universal, continuous, and portable. Coverage should be mandatory only if health insurance subsidies are available for those living below a defined poverty level. 2. The health care system should emphasize patient choice of plans and health benefits, including mental health, which should be value-based. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as references when considering if a given plan would provide meaningful coverage. 3. The delivery system should ensure choice of health insurance and physician for patients, choice of participation and payment method for physicians, and preserve the patient/physician relationship. The delivery system should focus on providing care that is safe, timely, efficient, effective, patient-centered, and equitable. 4. The administration and governance system should be simple, transparent, accountable, and efficient and effective in order to reduce administrative costs and maximize funding for patient care. 5. Health insurance coverage should be equitable, affordable, and sustainable. The financing strategy should strive for simplicity, transparency, and efficiency. It should emphasize personal responsibility as well as societal obligations. (CMS Rep. 3, I-07; Reaffirmed: Res. 239, A-12)	Rescind. Superseded by Policy D-165.942, which states: Our AMA will advocate that state governments be given the freedom to develop and test different models for covering the uninsured, provided that their 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.
H-165.904	Universal Health Coverage	Our AMA: (1) 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) seeks federal legislation that would require the federal government to provide financial support to any individuals, organizations, and institutions	Retain. Still relevant.

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		providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) 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)	
H-180.964	Health Care Coverage of Young Adults Under Their Parents' Family Policies	Our AMA encourages the health insurance industry, employers and health plans to make available to young adults who do not have health insurance extended family health expense coverage to age 28 that conforms to the following characteristics: (1) The option to extend coverage under the parents' family policy or plan from the usual cut-off age to age 28 should be available for a specified initial enrollment period beyond the usual cut-off age under the plan. (2) Enrollment in the family coverage other than during this initial period should be available without a preexisting condition limitation to those individuals (to age 28) seeking the coverage because of loss of previous insurance protection within a specified time after loss of the previous protection, and should be available with a preexisting condition limitation to those seeking the coverage for other reasons at any time. (3) Status as a full-time student should not be a requirement for extension of or first-time enrollment in the parents' coverage. (4) To the extent that premiums for such a plan are higher, the extended coverage should be made available as a separate extra-cost rider. (CMS Rep. 1, I-95; Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12)	Retain. Still relevant.
H-180.978	Access to Affordable Health Care	Our AMA (1) through its coalition with business and industry and its state federation, supports giving priority	Rescind. Superseded by Policies H-165.846 and H-165.825, which state:

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	Insurance through Deregulation of State Mandated Benefits	attention to a partial and rational deregulation of the insurance industry in order to expand access to affordable health care coverage; and (2) reaffirms its commitment to private health care insurance using pluralistic, free enterprise mechanisms rather than government mandated and controlled programs. (Res. 129, A-89; Reaffirmed: CLRPD Rep. 2, I-99; Reaffirmed: CMS Rep. 5, A-09; Reaffirmed: Res. 239, A-12)	Adequacy of Health Insurance Coverage Options H-165.846 1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options: A. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose. B. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage. C. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations. D. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services. 2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children. 3. Our AMA: (a) opposes the removal of categories from the essential health benefits (EHB) package and their

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			associated protections against annual and lifetime limits, and out-of-pocket expenses; and (b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses. Ensuring Marketplace Competition and Health Plan Choice H-165.825 Our AMA will: (1) support health plans offering coverage options for individuals and small groups competing on a level playing field, including providing coverage for pre-existing conditions and essential health benefits; (2) oppose the sale of health insurance plans in the individual and small group markets that do not guarantee: (a) pre-existing condition protections and (b) coverage of essential health benefits and their associated protections against annual and lifetime limits, and out-of-pocket expenses, except in the limited circumstance of short-term limited duration insurance offered for no more than three months; and (3) support requiring the largest two Federal Employees Health Benefits Program (FEHBP) insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation.
H-190.988	Medicare Claims Processing Accuracy	Our AMA will: (1) continue efforts to assure that Medicare carriers accurately process claims; (2) continue to pursue legislation to require local physician input on the adequacy of carrier performance; (3) continue to pursue legislation to allow individual physicians to request and receive an	Rescind. No longer relevant.

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		administrative law hearing to challenge carrier performance of administrative and other policy requirements; and (4) take other appropriate actions that will result in penalties for carriers that process claims inaccurately. (BOT Rep. C, A-92; Reaffirmed: Res. 712, A-02; Reaffirmed: CMS Rep. 4, A-12)	
H-210.989	Medicare Physician Reimbursement for Home Health Visits	It is the policy of the AMA: (1) to urge Congress and CMS to adjust reimbursement for physician home visits so that the payment made to physicians is consistent with the services involved in treating patients at home; and (2) that physician reimbursement should appropriately reflect the relative differences in the training and skill of physicians and other home health care providers. (Res. 109, A-91; Reaffirmation A-97: Reaffirmation I-99; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12)	Retain. Still relevant.
H-215.982	Interpretive Services	Our AMA encourages hospitals and pharmacies that serve populations with a significant number of non-English speaking or hearing-impaired patients to provide trained interpretive services. (BOT Rep. D, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11; Modified: Res. 702, A-12)	Rescind. Superseded by Policy H-160.924, which states: Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924 AMA policy is that: (1) further research is necessary on how the use of interpreters-- both those who are trained and those who are not--impacts patient care; (2) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (3) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services

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			with the understanding, however, of these tools' limitations-- to aid LEP patients' involvement in meaningful decisions about their care; and (4) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third-party payers and physicians shall not be required to participate in payment arrangements.
H-225.951	The Importance of Local Control of Hospitals	Our AMA will establish policy and advocate for local governing boards to continue to exist for individual hospitals within multi-hospital systems to ensure that community needs, the needs of local medical staff and patient care needs are met within those communities whenever possible. (Res. 719, A-12)	Retain. Still relevant.
H-225.964	Hospital Employed/Contracted Physicians Reimbursement	AMA policy states that: (1) all hospital employed/contracted physicians be prospectively involved if the hospital negotiates for them for capitation and global billing contracts; (2) hospital employed/contracted physicians be informed about the actual payment amount allocated to the physician component of the total hospital payment received by the contractual arrangement; and (3) all potential hospital/contracted physicians request a bona fide hospital plan which delineates the actual payment amount allocated to the employed or contracted physicians. (Sub. Res. 723, I-96; Reaffirmed: Res. 812, A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: BOT Rep. 4, I-12)	Retain. Still relevant.
H-225.973	Financial Arrangements Between	Our AMA: (1) opposes financial arrangements between hospitals and physicians that are unrelated to professional services, or to the time,	Retain. Still relevant.

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	Hospitals and Physicians	skill, education and professional expertise of the physician; (2) opposes any requirement which states that fee-for-services payments to physicians must be shared with the hospital in exchange for clinical privileges; (3) opposes financial arrangements between hospitals and physicians that (a) either require physicians to compensate hospitals in excess of the fair market value of the services and resources that hospitals provide to physicians, (b) require physicians to compensate hospitals even at fair market value for hospital provided services that they neither require nor request, or (c) require physicians to accept compensation at less than the fair market value for the services that physicians provide to hospitals; (4) opposes financial arrangements between hospitals and pathologists that force pathologists to accept no or token payment for the medical direction and supervision of hospital-based clinical laboratories; and (5) urges state medical associations, HHS, the AHA and other hospital organizations to take actions to eliminate financial arrangements between hospitals and physicians that are in conflict with the anti-kickback statute of the Social Security Act, as well as with AMA policy. (CMS Rep. C, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed and Appended: CMS Rep. 2, I-02; Reaffirmed: CMS Rep. 4, A-12)	
H-285.923	Elimination of Mental Health and Chemical Dependency Carve-Outs	Our AMA opposes and will work to eliminate mental health and chemical dependency carve-outs. (Sub. Res. 702, I-00; Reaffirmed: CMS 7, A-02; Reaffirmed: CMS Rep. 4, A-12)	Rescind. Superseded by Policies H-185.974, D-180.998, H-95.914, D-110.987, and H- 385.915 which state: Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs H-185.974 Our AMA supports parity of coverage for mental illness, alcoholism, substance use, and eating disorders.

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			Insurance Parity for Mental Health and Psychiatry D-180.998 Our AMA in conjunction with the American Psychiatric Association and other interested organizations will develop model state legislation for the use of state medical associations and specialty societies to promote legislative changes assuring parity for the coverage of mental illness, alcoholism, and substance abuse. Opioid Mitigation H-95.914 Our AMA urges state and federal policymakers to enforce applicable mental health and substance use disorder parity laws. The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987 1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance. 2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight. 3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale. 4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those

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			related to discriminatory benefit design and mental health and substance use disorder parity. 5. Our AMA supports improved transparency of PBM operations, including disclosing: - Utilization information; - Rebate and discount information; - Financial incentive information; - Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy; - Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records; - Methodology and sources utilized to determine drug classification and multiple source generic pricing; and - Percentage of sole source contracts awarded annually. 6. Our AMA encourages increased transparency in how DIR fees are determined and calculated. Integrating Physical and Behavioral Health Care H-385.915 Our American Medical Association: (1) encourages private health insurers to recognize CPT codes that allow primary care

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			physicians to bill and receive payment for physical and behavioral health care services provided on the same day; (2) encourages all state Medicaid programs to pay for physical and behavioral health care services provided on the same day; (3) encourages state Medicaid programs to amend their state Medicaid plans as needed to include payment for behavioral health care services in school settings; (4) encourages practicing physicians to seek out continuing medical education opportunities on integrated physical and behavioral health care; and (5) promotes the development of sustainable payment models that would be used to fund the necessary services inherent in integrating behavioral health care services into primary care settings.
H-285.956	Mental Health "Carve-Outs"	Our AMA is opposed to mental health carve-outs. However, in order to protect the large number of patients currently covered by carve-out arrangements, the AMA advocates that all managed care plans that provide or arrange for behavioral health care adhere to the following principles, and that any public or private entities that evaluate such plans for the purposes of certification or accreditation utilize these principles in conducting their evaluations: (1) Plans should assist participating primary care physicians to recognize and diagnose the behavioral disorders commonly seen in primary care practice. (2) Plans should reimburse qualified participating physicians in primary care and other non-psychiatric physician specialties for the behavioral health services provided to plan enrollees. (3) Plans should utilize practice guidelines developed by physicians in the appropriate specialties, with local adaptation by plan physicians as	Rescind. Superseded by Policies H-185.974, D-180.998, H-95.914, D-110.987, and H- 385.915 which state: Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs H-185.974 Our AMA supports parity of coverage for mental illness, alcoholism, substance use, and eating disorders. Insurance Parity for Mental Health and Psychiatry D-180.998 Our AMA in conjunction with the American Psychiatric Association and other interested organizations will develop model state legislation for the use of state

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		appropriate, to identify the clinical circumstances under which treatment by the primary care physician, direct referral to psychiatrists or other addiction medicine physicians, and referral back to the primary care physician for care of behavioral disorders is indicated, and should pay for all physician care provided in conformance with such guidelines. In the absence of such guidelines, direct referral by the primary care physician to the psychiatrist or other addiction medicine physician should be allowed when deemed necessary by the referring physician. (4) Plans should foster continuing and timely collaboration and communication between primary care physicians and psychiatrists in the care of patients with medical and psychiatric comorbidities. (5) Plans should encourage a disease management approach to care of behavioral health problems. (6) Participating health professionals should be able to appeal plan-imposed treatment restrictions on behalf of individual enrollees receiving behavioral health services, and should be afforded full due process in any resulting plan attempts at termination or restriction of contractual arrangements. (7) Plans using case managers and screeners to authorize access to behavioral health benefits should restrict performance of this function to appropriately trained and supervised health professionals who have the relevant and age group specific psychiatric or addiction medicine training, and not to lay individuals, and in order to protect the patient's privacy and confidentiality of patient medical records should elicit only the patient information necessary to confirm the need for behavioral health care. (8) Plans assuming risk for behavioral health care should consider "soft" capitation or other risk/reward-sharing mechanisms so as to reduce financial incentives for undertreatment. (9) Plans should conduct ongoing assessment of patient outcomes and	medical associations and specialty societies to promote legislative changes assuring parity for the coverage of mental illness, alcoholism, and substance abuse. Opioid Mitigation H-95.914 Our AMA urges state and federal policymakers to enforce applicable mental health and substance use disorder parity laws. The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987 1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance. 2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight. 3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale. 4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity. 5. Our AMA supports improved transparency of PBM operations, including disclosing: - Utilization information;

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		satisfaction, and should utilize findings to both modify and improve plan policies when indicated and improve practitioner performance through educational feedback. (CMS Rep. 2, A-96; Modified: CMS Rep. 6, I-00; Reaffirmed: CMS Rep. 9, A-01; Reaffirmed Res. 702, I-01; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12)	- Rebate and discount information; - Financial incentive information; - Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy; - Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records; - Methodology and sources utilized to determine drug classification and multiple source generic pricing; and - Percentage of sole source contracts awarded annually. 6. Our AMA encourages increased transparency in how DIR fees are determined and calculated. Integrating Physical and Behavioral Health Care H-385.915 Our American Medical Association: (1) encourages private health insurers to recognize CPT codes that allow primary care physicians to bill and receive payment for physical and behavioral health care services provided on the same day; (2) encourages all state Medicaid programs to pay for physical and behavioral health care services provided on the

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			same day; (3) encourages state Medicaid programs to amend their state Medicaid plans as needed to include payment for behavioral health care services in school settings; (4) encourages practicing physicians to seek out continuing medical education opportunities on integrated physical and behavioral health care; and (5) promotes the development of sustainable payment models that would be used to fund the necessary services inherent in integrating behavioral health care services into primary care settings.
H-285.979	Managed Care Insurance Company Credentialing	The AMA: (1) supports the development and utilization by all health insurance plans and managed care organizations of both a uniform application form and a reapplication form; (2) will work with the centralized credentialing collection services established by state and county medical societies to implement the acceptance of uniform application and reapplication forms; (3) urges managed care organizations to recredential participating physicians no more frequently than every two years; (4) urges hospitals, managed care organizations and insurance companies to utilize state and county central credentialing services, where available, for purposes of credentialing plan physician applicants, and will identify all state and county central credentialing services and make this information available to all interested parties including hospital and managed care/physician credentialing committees; (5) supports state and county medical society initiatives to promulgate a uniform reappointment cycle for hospitals and managed care plans; and (6) opposes any legislative or regulatory initiative to mandate	Retain. Still relevant.

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		accreditation for CVOs by the NCQA or any other agency until a fair, equitable, reasonable and appropriately inclusive process for such accreditation exists. (Sub. Res. 703, A-94; Amended in lieu of Res. 705, I-94; Amended by Res. 716, I-96; Reaffirmed: Res. 809, I-02; Reaffirmed: CMS Rep. 4, A-12)	
H-290.975	State and Federal Medicaid Physician Advisory Bodies	Our AMA supports the creation of state Medicaid Physician Advisory Commissions that would advise states on payment policies, utilization of services, and other relevant policies impacting physicians and patients. (BOT Rep. 13, I-02; Modified: CMS Rep. 4, A-12)	Rescind. Superseded by Policy H-165.855[8], which states: Medical Care for Patients with Low Incomes H-165.855 It is the policy of our AMA that: … (8) our AMA should encourage states to support a Medicaid Physician Advisory Commission to evaluate and monitor access to care in the state Medicaid program and related pilot projects.
H-330.889	Strengthening Medicare for Current and Future Generations	1. It is the policy of our AMA that a Medicare defined contribution program should include the following: a. Enable beneficiaries to purchase coverage of their choice from among competing health insurance plans, which would be subject to appropriate regulation and oversight to ensure strong patient and physician protections. b. Preserve traditional Medicare as an option. c. Offer a wide range of plans (e.g., HMOs, PPOs, high-deductible plans paired with health savings accounts), as well as traditional Medicare. d. Require that competing private health insurance plans meet guaranteed issue and guaranteed renewability requirements, be prohibited from rescinding coverage except in cases of intentional fraud, follow uniform marketing standards, meet plan solvency requirements, and cover at least the actuarial equivalent of the benefit package provided by traditional Medicare e. Apply risk-adjustment methodologies to ensure that affordable private health insurance coverage options are available for sicker beneficiaries and those with higher	Rescind. Superseded by Policy H-330.896, which states: Strategies to Strengthen the Medicare Program H-330.896 Our AMA supports the following reforms to strengthen the Medicare program, to be implemented together or separately, and phased-in as appropriate: 1. Restructuring beneficiary cost-sharing so that patients have a single premium and deductible for all Medicare services, with means-tested subsidies and out-of-pocket spending limits that protect against catastrophic expenses. The cost-sharing structure should be developed to provide incentives for appropriate utilization while discouraging unnecessary or inappropriate patterns of care. The use of preventive services should also be encouraged. Simultaneously, policymakers will need to consider modifications to Medicare supplemental

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		projected health care costs. f. Set the amount of the baseline defined contribution at the value of the government's contribution under traditional Medicare. g. Ensure that health insurance coverage is affordable for all beneficiaries by allowing for adjustments to the baseline defined contribution amount. In particular, individual defined contribution amounts should vary based on beneficiary age, income and health status. Lower income and sicker beneficiaries would receive larger defined contributions. h. Adjust baseline defined contribution amounts annually to ensure that health insurance coverage remains affordable for all beneficiaries. Annual adjustments should reflect changes in health care costs and the cost of obtaining health insurance. i. Include implementation time frames that ensure a phased-in approach. 2. Our AMA will advocate that any efforts to strengthen the Medicare program ensure that mechanisms are in place for financing graduate medical education at a level that will provide workforce stability and an adequate supply of physicians to care for all Americans. 3. Our AMA will continue to explore the effects of transitioning Medicare to a defined contribution program on cost and access to care. (CMS Rep. 5, I-12)	insurance (i.e., Medigap) benefit design standards to ensure that policies complement, rather than duplicate or undermine, Medicare's new cost-sharing structure. 2. Offering beneficiaries a choice of plans for which the federal government would contribute a standard amount toward the purchase of traditional fee-for-service Medicare or another health insurance plan approved by Medicare. All plans would be subject to the same fixed contribution amounts and regulatory requirements. Policies would need to be developed, and sufficient resources allocated, to ensure appropriate government standard setting and regulatory oversight of plans. 3. Restructuring age-eligibility requirements and incentives to match the Social Security schedule of benefits
H-330.890	Decoupling Social Security from Medicare	Our AMA supports abrogation of any connection between Medicare and Social Security benefits. (Res. 221, I-12)	Retain. Still relevant.
H-330.908	CMS Required Diabetic Supply Forms	Our AMA requests that CMS change its requirement so that physicians need only re-write prescriptions for glucose monitors every twelve months, instead of a six month requirement, for Medicare covered diabetic patients and make the appropriate diagnosis code sufficient for the determination of medical necessity. (Sub. Res. 102, A-00; Reaffirmation and Amended: Res. 520, A-02; Modified: CMS Rep. 4, A-12)	Retain. Still relevant.

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H-335.970	Medicare Integrity Program	Our AMA strongly urges CMS to adhere to the following principles during the implementation of the Medicare Integrity Program (MIP): (1) continue support for physician development of local medical review policy through strong Carrier Advisory Committees; (2) provide access to a Medical Director in each state; (3) provide a mechanism for close surveillance and monitoring of the performance of the MIP contractors to assure their accountability to questions and concerns raised by patients and physicians about coverage and other issues; (4) continue due process and appeals mechanisms for physicians; and (5) initiate a widespread and comprehensive effort to educate physicians about all aspects of the MIP. (CMS Rep. 4, A-97; Reaffirmed: CMS Rep. 1, A-99; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12)	Rescind. Policy is out-of-date. Medicare Integrity Program is no longer active.
H-383.997	Hospital-Based Physician Contracting	(1) It is the policy of the AMA that agreements between hospitals and hospital-based physicians should adhere to the following principles: (a) Physicians should have the right to negotiate and review their own portion of agreements with managed care organizations. (b) Physicians should have the right to set the parameters and acceptable terms for their contracts with managed care plans in advance of contract negotiations. (c) Physicians representing all relevant specialties should be involved in negotiating and reviewing agreements with managed care organizations when the agreements have an impact on such issues as global pricing arrangements, risks to the physician specialists, or expectations of special service from the specialty. (d) Physicians should have the opportunity to renegotiate contracts with the hospital whenever the hospital enters into an agreement with a managed care plan that materially impacts the physician unfavorably. (e) The failure of physicians to reach an agreement with managed care	Retain-in-part. The publications listed in subsection 3 are out-of-print, making the subsection out-of-date. Subsection 3 should be rescinded. (3) Our AMA encourages physicians to avail themselves of the contracting resources available through their relevant specialty societies, as well as the AMA Model Medical Services Agreement, and the Young Physician Section pamphlet entitled “Contracts: What You Need to Know,” to evaluate and respond to contract proposals.

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		organizations should not constitute a breach of its agreement with the hospital, nor serve as grounds for termination. (f) Physicians should seek a provision that allows them to opt out from managed care plans that pose unacceptable professional liability risks. (g) Physicians should seek a provision to refuse to contract with, to modify contracts with, and/or to terminate contracts with managed care plans that are showing financial instability, or should seek a guarantee from the hospital that the plan will make timely payments. (h) Physicians should receive advance notice of the hospital's intent to enter into any package or global pricing arrangements involving their specialties, and have the opportunity to advise the hospital of their revenue needs for each package price. (i) Physicians should have the opportunity to request alternative dispute resolution mechanisms to resolve disputes with the hospital concerning managed care contracting. (j) If the hospital negotiates a package pricing arrangement and does not abide by the pricing recommendations of the physicians, then the physicians should be entitled to a review of the hospital's actions and to opportunities to seek additional compensation. (k) Physicians should be entitled to information regarding the level of discount being provided by the hospital and by other participating physicians. (2) Our AMA urges physicians who believe hospitals are negotiating managed care contracts on their behalf without appropriate input, and who feel coerced into signing such contracts, to contact the AMA/State Medical Society Litigation Center, their state medical association, and/or legal counsel. (3) Our AMA encourages physicians to avail themselves of the contracting resources available through their relevant specialty societies, as well as the AMA Model Medical Services Agreement, and the Young Physician Section pamphlet entitled "Contracts:	

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		What You Need to Know," to evaluate and respond to contract proposals. (CMS Rep. 3, A-00; Reaffirmed: BOT Rep. 13, I-06; Reaffirmed: BOT Rep. 4, I-12)	
H-385.922	Payment Terminology	It is AMA policy to change the terminology used in compensating physicians from "reimbursement" to "payment." (Res. 138, A-07; Reaffirmation A-12)	Retain. Still relevant.
H-385.958	Payment for Services Not Authorized by Health Plans	Our AMA advocates that all health plan contracts contain a provision to permit the direct billing of patients for medical services for which authorization was denied by a health plan, which the rendering physician, based upon reasonable evidence, determines to be essential for the welfare of the patient and for which prior patient consent was obtained. (Sub. Res. 705, I-93; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12)	Retain. Still relevant.
H-385.961	Medicare Private Contracting	Our AMA will: (1) continue to pursue legal and administrative efforts to permit patients to contract privately with their physicians in appropriate circumstances; and (2) support repeal of the restrictions placed on private contracts between physicians and Medicare beneficiaries to ensure that there is no interference with Medicare beneficiaries' freedom to choose a physician to provide covered services and give priority to this goal as a legislative objective. (BOT Rep. OO, A-93; Reaffirmed: Sub. Res. 132, A-94; Appended: Res. 203, I-98; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation I-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation A-02; Reaffirmation A-04; Reaffirmation A-08; Reaffirmed: CMS Rep. 5, I-12)	Rescind. Superseded by Policy D-380-997, which states: 1. It is the policy of the AMA: (a) that any patient, regardless of age or health care insurance coverage, has both the right to privately contract with a physician for wanted or needed health services and to personally pay for those services; (b) to pursue appropriate legislative and legal means to permanently preserve that patient's basic right to privately contract with physicians for wanted or needed health care services; (c) to continue to expeditiously pursue regulatory or legislative changes that will allow physicians to treat Medicare patients outside current regulatory constraints that threaten the physician/patient relationship; and (d) to seek immediately suitable cases to reverse the limitations on patient and physician rights to contract privately that have

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			been imposed by CMS or the private health insurance industry. 2. Our AMA strongly urge CMS to clarify the technical and statutory ambiguities of the private contracting language contained in Section 4507 of the Balanced Budget Act of 1997. 3. Our AMA reaffirms its position in favor of a pluralistic health care delivery system to include fee-for-service medicine, and will lobby for the elimination of any restrictions and physician penalties for provision of fee-for-service medicine by a physician to a consenting patient, including patients covered under Medicare
H-385.984	Fee for Services When Fulfilling Third Party Payer Requirements	The AMA believes that the attending physician should perform without charge simple administrative services required to enable the patient to receive his benefits. When more complex administrative services are required by third parties, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage, it is the right of the physician to be recompensed for his incurred administrative costs. (CMS Rep. J, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation I-08; Reaffirmation A-10; Reaffirmed: CMS Rep. 3, I-12)	Rescind. Superseded by Policy H-285.943, which states that the AMA (1) opposes managed care contract provisions that prohibit physician payment for the provision of administrative services; (2) encourages physicians entering into: (a) capitated arrangements with managed care plans to seek the inclusion of a separate capitation rate (per member per month payment) for the provision of administrative services, and (b) fee-for-service arrangements with managed care plans to seek a separate case management fee or higher level of payment to account for the provision of administrative services; and (3) supports the concept of a time-based charge for administrative duties (such as phone precertification, utilization review activities, formulary review, etc.), to be assessed to the various insurers.

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H-385.985	Denial of Payment for Medical Services Based Solely on Fiscal Considerations	Our AMA: (1) affirms that medical judgment as to the need for an assistant in any surgical procedure, or the need to provide any form of medical care, should be made by the physician based on what is best for the health and welfare of the patient and not on fiscal restraints or considerations; and (2) opposes any law, rule or regulation, or any decision by a third party carrier which denies payment for medical services due solely to fiscal considerations and which does not have as its primary purpose the health and safety of the patient. (Res. 12, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: BOT Rep. 32, A-99; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12)	Retain. Still relevant.
H-390.845	Mandatory Physician Enrollment in Medicare	Our AMA supports every physician's ability to choose not to enroll in Medicare and will seek the right of patients to collect from Medicare for covered services provided by unenrolled or disenrolled physicians. (Res. 223, I-12)	Retain. Still relevant.
H-390.846	Three-Day Payment Window Rule	Our AMA will: (1) work with the Centers for Medicare & Medicaid Services (CMS) to request a further delay in implementation of the 3-day Payment Window rule beyond the current delay of July 1, 2012; (2) thoroughly investigate all legislative and regulatory actions taken by Congress and CMS associated with the 3-Day Payment Window during this delay and determine whether additional legislative and/or regulatory actions are warranted to include overturning the current rule; and (3) work with other appropriate stakeholders to continue seeking a delay or modification of the three-day payment window rule; encourage CMS to clarify to whom and how this rule applies; and communicate the specifics about this rule to the physician community. (Res. 226, A-12)	Rescind. This policy was accomplished in 2012 and is out-of-date.
H-390.874	Repayment of Medicare Overpayments Made in Error	1. The AMA will request CMS to require Medicare carriers to be financially responsible for repayment to CMS of any overpayments made by the carrier to physicians where physicians could not reasonably be aware that the payments were overpayments or in	Rescind. Subsection 1 is superseded by Policy H-390.880, and Subsection 2 is out-of-date. Interest Rates Charged and Paid by CMS H-390.880

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		error and where the physicians relied on calculations by the carrier. 2. Our AMA will: (A) communicate to the US Department of Health and Human Services (DHHS) its strong objection to the proposed plan to collect overpayment of Medicare services within 60 days of discovery, regardless of how this might affect the cash flow and the solvency of a medical practice; and (B) express to DHHS its strong objection to the proposed rule which would require practices or auditors to report any overpayments that were discovered within ten years of the date the funds were received instead of the current six-year requirement, due to the burden this would place on physicians' practices, which in essence is another unfunded mandate. (Res. 224, I-93; Reaffirmed: CMS Rep. 10, A-03; Appended: Res. 212, A-12)	1. (A) Our AMA will (1) determine if the recent interest rate changes implemented by CMS comply with current Medicare laws; (2) seek to ensure that CMS's interest charges do not exceed legal limits; and (3) work with CMS to ensure parity in interest rates assessed against physicians by CMS and interest rates paid to physicians by CMS. (B) If an agreement cannot be reached with CMS, the AMA will seek legislation to correct this situation. 2. Our AMA supports amending federal Medicare law to require that interest on both overpayments and underpayments to providers attaches upon notice of the error to the appropriate party in either instance.
H-40.969	CHAMPUS Payment	(1) The AMA urges the Department of Defense to raise to at least Medicare levels those CHAMPUS maximum allowable charges (CMACs) that are presently below Medicare allowable charges. (2) The AMA urges the Department of Defense to eliminate price controls and encourage competition under TRICARE through true pluralism in the health plan choices available to beneficiaries, consistent with AMA Policy H-165.890, which proposes advocating transformation of the current Medicare program through an invigorated marketplace. Consistent with Policy H-165.890, this approach should use a defined contribution by CHAMPUS, regardless of the health plan chosen. (3) Until TRICARE introduces a contracting approach that increases competition and sets physician payments through the marketplace, the AMA urges the Department of Defense to assure that all TRICARE programs pay physicians at a minimum of CMAC levels, consistent with Policy H-40.972. (BOT Rep. 1, I-96; Reaffirmed: CMS Rep. 8,	Rescind. Superseded by Policy D-40.991, which states: Our AMA: 1. Encourages state medical associations and national medical specialty societies to educate their members regarding TRICARE, including changes and improvements made to its operation, contracting processes and mechanisms for dispute resolution. 2. Encourages the TRICARE Management Activity to improve its physician education programs, including those focused on non-network physicians, to facilitate increased civilian physician participation and improved coordination of care and transfer of clinical information in the program. 3. Encourages the TRICARE Management Activity and its contractors to continue and strengthen their efforts to

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		A-06; Reaffirmed: CMS Rep. 2, I-08; Reaffirmation A-12)	recruit and retain mental health and addiction service providers in TRICARE networks, which should include providing adequate reimbursement for mental health and addiction services. 4. Strongly urges the TRICARE Management Activity to implement significant increases in physician payment rates to ensure all TRICARE beneficiaries, including service members and their families, have adequate access to and choice of physicians. 5. Strongly urges the TRICARE Management Activity to alter its payment formula for vaccines for routine childhood immunizations, so that payments for vaccines reflect the published CDC retail list price for vaccines. 6. Continues to encourage state medical associations and national medical specialty societies to respond to requests for information regarding potential TRICARE access issues so that this information can be shared with TRICARE representatives as they develop their annual access survey. 7. Continues to advocate for changes in TRICARE payment policies that will remove barriers to physician participation and support new, more effective care delivery models, including: (a) establishing a process to allow midlevel providers to receive 100 percent of the TRICARE allowable cost for services rendered while practicing as part of a physician-led health care team, consistent with state law; and (b) paying for

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			transitional care management services, including payment of copays for services provided to TRICARE for Life beneficiaries receiving primary coverage through Medicare. 8. Continues to advocate for improvements in the communication and implementation of TRICARE coverage policies to ensure continued patient access to necessary services, including: (a) consistently approving full payment for services rendered for the diagnosis and treatment of common mental health conditions, regardless of the specialty of the treating physician; and (b) clarifying policies with respect to coverage for age appropriate doses of vaccines that have been recommended and adopted by the Advisory Committee on Immunization Practices.
H-440.903	Public Health Care Benefits	Our AMA actively lobby the federal and state governments to restore and maintain funding for public health care benefits for all legal immigrants. (Res. 219, A-98; Reaffirmation A-02; Reaffirmed: BOT Rep. 19, A-12)	Retain-in-part. Update language from "legal" to "lawfully present," as follows: Our AMA actively lobby the federal and state governments to restore and maintain funding for public health care benefits for all ~~legal~~ lawfully present immigrants.
H-480.961	Teleconsultations and Medicare Reimbursement	Our AMA demands that CMS reimburse telemedicine services in a fashion similar to traditional payments for all other forms of consultation, which involves paying the various providers for their individual claims, and not by various "fee splitting" or "fee sharing" reimbursement schemes. (Res. 144, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07; Reaffirmed in lieu of Res. 805, I-12; Reaffirmed in lieu of Res. 806, I-12)	Rescind. Superseded by Policies H-480.937 and H-480.946. Addressing Equity in Telehealth H-480.937 Our AMA: (1) recognizes access to broadband internet as a social determinant of health; (2) encourages initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for

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			historically marginalized and minoritized populations; (3) encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations; (4) supports efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities; (5) encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth; (6) supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically

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			marginalized, minoritized and underserved populations; (7) supports efforts to ensure payers allow all contracted physicians to provide care via telehealth; (8) opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians; and (9) will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person. Coverage of and Payment for Telemedicine H-480.946 1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles: a) A valid patient-physician relationship must be established before the provision of telemedicine services, through: - A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or - A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or - Meeting standards of establishing a patient-physician relationship

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			included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology. Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services. b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services. c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board. d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services. e) The delivery of telemedicine services must be consistent with state scope of practice laws. f) Patients receiving telemedicine services must have access to the licensure and board certification

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			qualifications of the health care practitioners who are providing the care in advance of their visit. g) The standards and scope of telemedicine services should be consistent with related in-person services. h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes. i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine. j) The patient's medical history must be collected as part of the provision of any telemedicine service. k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient. l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record. m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.

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			2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information. 3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine. 4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine. 5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models. 6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service. 7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines.