REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-A-26

Subject: Council on Medical Service Sunset Review of 2016 House Policies

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee G

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association 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; and (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to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.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.

RECOMMENDATION

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

APPENDIX – Recommended Actions

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POLICY #	Title	Text	Recommendation
D-120.949	Ensuring the Safe and Appropriate Use of Compounded Medications	Our AMA will: (1) monitor ongoing federal and state evaluations and investigations of the practices of compounding pharmacies; (2) encourage the development of regulations that ensure safe compounding practices that meet patient and physician needs; and (3) report back on efforts to establish the necessary and appropriate regulatory oversight of compounding pharmacy practices.	Retain. Policy is relevant.
D-155.995	Containing Catastrophic Care Costs	Our AMA will: (1) in order to ensure that quality of care is not compromised, encourage physicians and the medical profession to become more engaged in the development and implementation of cost-containment policies and strategies, particularly those directed toward high-cost patients; (2) support additional research into the characteristics of the five percent of the patient population with the highest health care costs; (3) support greater evaluation of the use of disease management, case management, pay-for-performance, and end-of-life care programs for high-cost patients, so that their cost-containment impact and projected future savings can be better assessed; and (4) continue to inform the medical profession and the general public regarding issues impacting catastrophic care costs and the complexities therein.	Retain. Policy is relevant.
D-160.924	Hospital Discharge Communications	Our AMA will develop model guidelines for physicians to improve communications to other physicians, hospital staff and patients, and promote these guidelines to payers, hospitals and patients.	Retain. Policy is relevant.
D-160.926	A Guide to Selecting a Physician-Led Integrated System	Our AMA, in collaboration with the Integrated Physician Practice Section and appropriate partners within the House of Medicine, will accomplish the following by the 2017 Annual Meeting: 1. Develop a guide for physicians considering joining or aligning with a physician-led integrated system that addresses, but is not limited to the following: A. various models of integrated systems; B. metrics that help determine the extent to which an integrated system fulfills the definition of, and performs as, an integrated system; C. how to determine an organization's quality commitment/record; D. how to know if a particular system is the right fit;	Sunset. Directive was accomplished.

POLICY #	Title	Text	Recommendation
		E. what does a physician stand to gain/lose when joining such a system; and 2. The guide should also provide information to physicians in or considering solo and small practice on how they can align through Independent Practice Associations, Accountable Care Organizations, Physician Hospital Organizations, and other models to help them with the imminent movement to risk-based contracting and value-based care.	
D-160.928	Hierarchical Condition Category Coding	Our AMA will continue to work with the Centers for Medicare and Medicaid Services to refine risk adjustment in all alternative payment models and Medicare Advantage plans, particularly to revise risk-adjustment processes, to allow hierarchical condition category (HCC) codes to automatically follow the beneficiary from year-to-year to reflect chronic conditions that will never change.	Retain. Policy is relevant.
D-160.945	Communication Between Hospitals and Primary Care Referring Physicians	Our AMA: (1) advocates for continued Physician Consortium for Performance Improvement? (PCPI) participation in the American College of Physicians (ACP), the Society of General Internal Medicine (SGIM), and the Society of Hospital Medicine (SHM) work to develop principles and standards for care transitions that occur between the inpatient and outpatient settings; (2) advocates for timely and consistent inpatient and outpatient communications to occur among the hospital and hospital-based providers and physicians and the patient's primary care referring physician; including the physician of record, admitting physician, and physician-to-physician, to decrease gaps that may occur in the coordination of care process and improve quality and patient safety; (3) will continue its participation with the Health Information Technology Standards Panel (HITSP) and provide input on the standards harmonization and development process; (4) continues its efforts with The Joint Commission, the Centers for Medicare & Medicaid Services, and state survey and accreditation agencies to develop accreditation standards that improve patient safety and quality; and (5) will explore new mechanisms to facilitate and incentivize communication and tran smission of data for timely coordination of care (via telephone, fax, e-mail, or face-to-face communication) between the hospital-based physician and the primary physician.	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
D-215.990	AMA Assistance for Members in Matters Pertaining to Physician-Hospital/Health System Relationships	1. As a benefit of membership our AMA will provide assistance, such as information and advice (but not legal opinions or representation), as appropriate to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other similar entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review, economic credentialing, and the denial of due process. 2. Our AMA encourages the Federation of Medicine and its members to provide assistance, such as information and advice (but not legal opinions or representation), as appropriate to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other similar entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.	Retain. Policy is relevant.
D-220.975	The Joint Commission Transparency	1. Our AMA Commissioners to The Joint Commission will be asked to advocate for a truly open and transparent comment process for all proposed changes to TJC standards. 2. It is AMA policy that: (a) all proposed changes to TJC standards resulting from field reviews be published along with clearly stated rationale(s) for each proposed change; (b) all proposed changes to TJC standards be published along with clearly stated identities of entity(ies) external to TJC that suggested the proposed changes to TJC; (c) all proposed changes to TJC standards that are modified by TJC as a result of comments received must provide clearly stated rationale(s) for each modified proposal, to include a clear and thorough analysis of the comment or comments upon which the modification(s) was based; and (d) all proposed changes to TJC standards that are adopted as final by TJC be published along with a clear and thorough analysis of all the field review.	Retain. Policy is relevant.
D-220.976	The Relationship Between The Joint Commission and Physicians	Our AMA will: (1) communicate to The Joint Commission (TJC) the concern regarding the unintended consequences of TJC's standards, and methods of communicating those standards to physicians; (2) advocate with TJC for direct communication to physicians' organizations about standards to be	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		adopted or modified, with at least six months available for open commentary and feedback; (3) advocate that this communication be timely and that it occur in print media as well as through e-mail; (4) advocate that TJC accreditation standards be made available to any licensed physician without hindrance; (5) advocate that TJC establish a process for any physician to provide feedback about TJC programs that affect that physician's practice; and (6) require that AMA TJC Commissioners meet with the Organized Medical Staff Section Governing Council to review TJC standards no less than twice per year.	
D-220.977	The Joint Commission - Evidence-Based Recommendations	Our AMA will: (1) work with The Joint Commission (TJC) to investigate the provision of a cost analysis for each new requirement; and (2) request that TJC provide an evidence-based evaluation to justify the expenditures for the recommendations it makes.	Retain. Policy is relevant.
D-225.975	De-Linkage of Medical Staff Privileges from Hospital Employment Contracts	Our AMA will develop resources to assist physicians transitioning from employment to independent practice.	Sunset. Directive was accomplished.
D-230.988	Fiduciary Credentialing	Our AMA will: (1) continue to encourage physicians who have experienced what they believe to be inappropriate hospital de-credentialing to contact their state medical association and the Litigation Center of the AMA and the State Medical Societies; and (2) explore the feasibility of participating in legal action designed to address arbitrary and abusive economic profiling of physicians.	Retain. Policy is relevant.
D-285.974	Possible Anti-Competitive and Ethical Implications of Integrated Hospital System Referral Expectations	Our AMA will continue to receive information on and monitor the issue of restrictions on referrals in all health care delivery settings.	Retain. Policy is relevant.
D-290.984	State Plan Amendments for Medicaid	Our AMA will: (1) promote mechanisms that provide the opportunity for public comment and legislative oversight prior to submission of the State Plan Amendments (SPAs) to the Centers for Medicare and Medicaid Services; and (2) serve as a repository of information relating to the outcomes of SPAs in different states, disseminate such information and educate	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		physicians about the impact of proposed changes to Medicaid via SPAs.	
D-315.983	Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data	Our AMA will continue to monitor the economic implications of the secondary sale and use of non-identifiable, aggregate data.	Retain. Policy is relevant.
D-330.909	Study the Costs of Administrative and Regulatory Burdens	Our AMA will perform or commission an analysis of the direct and indirect costs and documented benefits associated with significant administrative and regulatory requirements imposed by the Centers for Medicare & Medicaid Services~~, including but not limited to face-to-face documentation requirements, the Physician Quality Reporting System, and the Meaningful Use program~~.	Retain-in-part; amend by deletion as the policy is no longer limited to the Physician Quality Reporting System or the Meaningful Use program.
D-330.928	Strategies to Strengthen the Medicare Program	Our AMA: (1) will continue to study combining Parts A and B of the Medicare Trust Funds into a single program, and report back, clearly delineating the advantages and disadvantages of this action, including the effect on graduate medical education funding and of adding a means test to Medicare Part A; and (2) encourages the Centers for Medicare and Medicaid Services to explore the use of value-based, targeted benefit design to facilitate a more efficient and meaningful cost-sharing structure that will help align incentives for patients to seek appropriate and effective care.	Retain. Policy is relevant.
D-335.987	Erroneous Guidance by Medicare Carriers and Waiver of Audit and Refund Penalties	1. Our AMA will: (a) ask the Centers for Medicare and Medicaid Services to enforce the requirement that Medicare representatives who have given verbal guidance must immediately confirm that guidance in writing, requiring Medicare carriers to (i) closely monitor carrier representatives' compliance with the rule and (ii) penalize those representatives who do not comply; and (b) urge CMS to eliminate the rule that if a physician incurs a penalty having relied on erroneous guidance from a carrier representative, that penalty cannot be waived unless the physician's initial request was in	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		writing. 2. Whether or not CMS eliminates that rule, our AMA will ask CMS to require Medicare carriers to provide central e-mail and fax units, to which physicians can send all requests for coding and billing clarifications, and from which physicians can receive all carrier responses in "real time."	
D-345.986	Accurate Mental Status Reporting	Our American Medical Association encourages interested national medical specialty societies to develop recommendations regarding mental status information that should be transmitted when patients transition care settings.	Retain. Policy is relevant.
D-380.997	Private Contracting by Medicare Patients	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 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.	Retain-in-part; **rescind clause (2)**, as the Centers for Medicare & Medicaid Services has developed extensive regulatory guidelines that have eliminated the technical and statutory ambiguities of the private contracting language contained in Section 4507 of the Balanced Budget Act of 1997.
D-390.974	Modes of Participation in Medicare and Their Impact on the Patient, the Physician, and the US Congress	Our AMA will: (1) continue working to identify politically viable modifications to the statutory language on private contracting that will make opting out a more reasonable choice for practicing physicians; and (2) educate physicians on the different options for participating in the Medicare program and provid e our members with the tools and information necessary to analyze the impact on their patients, their practice	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		, and the US Congress, of their choice of the three modes of relating to the Medicare program by: (a) opting out of Medicare; or (b) caring for Medicare patients in a fee-for-service relationship, making the decision to "accept assignment" on the basis of mutual needs of the patient and the physician; or (c) continuing as a "participating physician" in the Medicare program understanding that the physician is subject to the continued anticipated reductions in direct reimbursement and the ultimate inability to directly negotiate any fees on behalf of their practice. This may give Congress the wrong impression that there is no problem with continued fee reductions.	
D-390.985	Medicare Balance Billing	Our AMA will work on behalf of physicians to regain the right to balance bill Medicare patients for the full reasonable fees as they determine appropriate.	Retain. Policy is relevant.
D-450.953	Development of Quality Measures with Appropriate Exclusions and Review Processes	Our AMA will provide input on the Severe Sepsis and Sepsis Shock: Management Bundle measure during the National Quality Forum's (NQF) review of the measure in 2017, and ask the Centers for Medicare and Medicaid Services to redesign the measure.	Sunset. Directive was for action at the 2017 NQF meeting.
D-478.971	Electronic Health Records and Meaningful Use	Our AMA: (1) will continue to work with the Centers for Medicare and Medicaid Services and other relevant stakeholders to allow for partial credit for eligible professionals in the Meaningful Use and Merit-Based Incentive payment programs; and (2) will compile and continue to educate physicians on the available guidance related to different types of EHRs, system downtime, and technology failures, including mitigation strategies, continuity training solutions, and contracting solutions.	Retain. Policy is relevant.
D-480.970	Access and Equity in Telemedicine Payments	Our AMA will advocate that the Centers for Medicare & Medicaid Services pay for telemedicine services for patients who have problems accessing physician specialties that are in short supply in areas that are not federally determined ?shortage? areas, if that area can show a shortage of those physician specialists.	Retain. Policy is relevant.
D-60.980	Emergency Medical Services for Children (EMSC) Program	Our AMA (1) recognizes the importance of Emergency Medical Services for Children ((EMSC)); (2) advocates for full funding for the (EMSC) program in Congress; and (3) advocates for continuous passage of (EMSC) reauthorization legislation in Congress.	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
D-70.957	Fixed Reimbursement to Physicians for Laboratory Services	Our AMA: (1) encourages physicians to become knowledgeable about the appropriate use of CPT modifier 26 in order to bill the professional component separately from the technical component for the interpretation of laboratory tests and clinical oversight of the laboratory; and (2) will advocate that Medicare and other third party payers provide appropriate coverage for the use of CPT modifier 26, as well as care plan oversight codes and prolonged services codes.	Retain. Policy is relevant.
D-70.958	Blended Payments	Our AMA will work with Congress to make it illegal for insurance companies to unilaterally change payments by "blending" levels.	Retain. Policy is relevant.
D-70.979	Preservation of ~~**Five**~~ Levels of Evaluation and Management Services	Our AMA will communicate to the Centers for Medicare and Medicaid Services and to private payers that the current levels of Evaluation and Management ser vices should be maintained and not compressed, with appropriate payment for each level.	Retain-in-part; **edit title to remove term "Five,"** as it is no longer accurate.
H-100.950	Addressing the Exploitation of Restricted Distribution Systems by Pharmaceutical Manufacturers	1. Our AMA will advocate with interested parties for legislative or regulatory measures that require prescription drug manufacturers to seek Food and Drug Administration and Federal Trade Commission approval before establishing a restricted distribution system. 2. Our AMA supports requiring pharmaceutical companies to allow for reasonable access to and purchase of appropriate quantities of approved out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence assays. 3. Our AMA will advocate with interested parties for legislative or regulatory measures that expedite the FDA approval process for generic drugs, including but not limited to application review deadlines and generic priority review voucher programs.	Retain. Policy is relevant.
H-120.928	Pharmacy Use of Medication Discontinuation Messaging Function	Our AMA strongly encourages: (1) all software providers and those pharmaceutical dispensing organizations that create their own software to include the functionality to accept discontinuation message transmittals in their electronic prescribing software products; and (2) all dispensing pharmacies accepting medication prescriptions electronically to activate the discontinuation message transmittal functionality in their electronic prescribing support software.	Retain. Policy is relevant.
H-120.931	Access to Self-Administered Medications	1. Our AMA supports legislation that prohibits health insurance and pharmacy benefit management (PBM) companies from denying early prescription refills for solutions, ointments, gels, creams, nasal sprays, and other formulations that are difficult and/or imprecise to self-	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		administer. 2. Our AMA supports and encourages interested national medical specialty societies and other stakeholders to continue to advocate on the state level and work with health insurance and PBM companies to re-evaluate their refill policies on medications that are difficult and/or imprecise to self-administer to allow for early refills as needed.	
H-155.970	Cost-Cutting Decisions by Third Party Payers	Our AMA strongly opposes, and will take appropriate action as necessary to restrict, third party payer cost-containment strategies that jeopardize patient health and the quality of care.	Retain. Policy is relevant.
H-160.904	Increasing Collaboration Between Physicians and the Public to Address Problems in Health Care Delivery	Our American Medical Association will continue to consider and implement the most strategic and sustainable approaches to stay engaged with physician and non-physician stakeholders essential to our endeavor to improve the delivery of quality medical care.	Retain. Policy is relevant.
H-160.908	Payment Mechanisms for Physician-Led Team-Based Health Care	1. Our AMA advocates that physicians who lead team-based care in their practices receive the payments for health care services provided by the team and establish payment disbursement mechanisms that foster physician-led team-based care. 2. Our AMA advocates that payment models for physician-led team-based care should be determined by physicians working collaboratively with hospital and payer partners to design models best suited for their particular circumstances. 3. Our AMA advocates that physicians make decisions about payment disbursement in consideration of team member contributions, including but not limited to: a. Volume of services provided; b. Intensity of services provided; c. Profession of the team member; d. Training and experience of the team member; and e. Quality of care provided. 4. Our AMA advocates that an effective payment system for physician-led team-based care should: a. Reflect the value provided by the team and that any savings accrued by this value should be shared by the team; b. Reflect the time, effort and intellectual capital provided by individual team members; c. Be adequate to attract team members with the appropriate skills and training to maximize the success of the team; and	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		d. Be sufficient to sustain the team over the time frame that it is needed.	
H-160.937	The Promotion of Quality Telemedicine	1. The AMA adopts the following principles for the supervision of nonphysician providers and technicians when telemedicine is used: A. The physician is responsible for, and retains the authority for, the safety and quality of services provided to patients by nonphysician providers through telemedicine. B. Physician supervision (e.g. regarding protocols, conferencing, and medical record review) is required when nonphysician providers or technicians deliver services via telemedicine in all settings and circumstances. C. Physicians should visit the sites where patients receive services from nonphysician providers or technicians through telemedicine, and must be knowledgeable regarding the competence and qualifications of the nonphysician providers utilized. D. The supervising physician should have the capability to immediately contact nonphysician providers or technicians delivering, as well as patients receiving, services via telemedicine in any setting. E. Nonphysician providers who deliver services via telemedicine should do so according to the applicable nonphysician practice acts in the state where the patient receives such services. F. The extent of supervision provided by the physician should conform to the applicable medical practice act in the state where the patient receives services. G. Mechanisms for the regular reporting, recording, and supervision of patient care delivered through telemedicine must be arranged and maintained between the supervising physician, nonphysician providers, and technicians. H. The physician is responsible for providing and updating patient care protocols for all levels of telemedicine involving nonphysician providers or technicians. 2. The AMA urges those who design or utilize telemedicine systems to make prudent and reasonable use of those technologies necessary to apply current or future confidentiality and privacy principles and requirements to telemedicine interactions. 3. The AMA emphasizes to physicians their responsibility to ensure that their legal and ethical requirements with respect to patient confidentiality and data integrity are not	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		compromised by the use of any particular telemedicine modality. 4. The AMA advocates that continuing medical education conducted using telemedicine adhere to the standards of the AMA's Physician Recognition Award and the Accreditation Criteria of the Accreditation Council for Continuing Medical Education. 5. Our AMA supports the appropriate use of telemedicine in the education of medical students, residents, fellows and practicing physicians.	
H-160.966	Market Forces on Medical Practice	It is the policy of the AMA that (1) the ratcheting down of physician payment rates will not produce appreciable reductions in the rate of health care cost increase, since payment for physicians' services constitutes only about one-fifth of spending for health care; however, it may well reduce access to care as more physicians leave the area, retire, or in other ways change their practices; (2) at the same time, physician-directed peer review mechanisms must take the lead in fostering appropriate utilization of services and encouraging less hospital-intensive patterns of care where indicated; (3) the capture of a dominant or controlling share of the private health insurance market by any one payer can ultimately result in payer control of physicians' total remuneration; such control should be resisted through all legislative means available; (4) physicians must continue to initiate and publicize voluntary programs to accept assignment and/or other special arrangements for lower-income Medicare beneficiaries as a deterrent to legislation mandating assignment or banning balance billing for all Medicare enrollees regardless of economic status; and (5) it is equally incumbent on those developing state legislative and regulatory proposals to seek the advice of the health care professionals who will be affected by such proposals at the outset; without such input, the state will risk alienating those who provide the care and jeopardizing the health of its residents.	Retain. Policy is relevant.
H-165.851	Options for Implementing and Financing Tax Credits for Individually Selected and Owned Health Insurance	Our AMA supports incremental steps toward financing individual tax credits for the purchase of health insurance, including but not limited to capping the tax exclusion for employment-based health insurance.	Reconcile with Policies H-165.828 and H-165.865.

POLICY #	Title	Text	Recommendation
H-165.887	Development of Health Care Priorities	Our AMA supports efforts to move patients in public programs into the private sector, through the implementation of vouchers or other mechanisms, thereby enabling individual patients to participate in the prioritization of their health care services; and encourages state governments that are investigating the prioritization of health care services provided under Medicaid programs to consider other potential allocation methodologies including variable levels of funding tied to relative health benefit, beneficiary income, or other factors, for such services.	Retain. Policy is relevant.
H-180.968	Third Party Payer Credentialing	It is the policy of the AMA that third party payers should not exclude non-board-certified physicians as a class from participation in their programs, without regard to individual training, experience, and current competence.	Retain. Policy is relevant.
H-185.925	Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act	1. Our AMA supports improvements to the essential health benefits benchmark plan se lection process to ensure limits and exclusions do not impede access to health care and coverage. 2. Our AMA encourages federal regulators to develop policy to prohibit essential health benefits substitutions that do not exist in a state's benchmark plan and the selective use of exclusions or arbitrary limits that prevent high-cost claims or that encourage high-cost enrollees to drop coverage. 3. Our AMA encourages federal regulators to review current plans for discriminatory exclusions and submit any specific incidents of discrimination through an administrative complaint to Office for Civil Rights.	Retain. Policy is relevant.
H-185.926	Reproductive Health Insurance Coverage	Our AMA supports: (1) insurance coverage for fertility treatments regardless of marital status or sexual orientation when insurance provides coverage for fertility treatments; and (2) local and state efforts to promote reproductive health insurance coverage r egardless of marital status or sexual orientation when insurance provides coverage for fertility treatments.	Retain. Policy is relevant.
H-200.998	Tax Credit to Disadvantaged Area Medical Practices	Our AMA actively supports national and state legislation which would grant income tax credits to medical practices establishe d in disadvantaged communities and in areas of critical physician need.	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
H-215.966	Evaluating Advertising	1. AMA policy is that organizations conferring titles/awards/rankings on hospitals should adopt the following criteria: a. Significant physician involvement in selection of criteria and methodology. b. Significant physician involvement in screening potential award winners. c. Significant physician involvement in on-site hospital review (if part of the ranking/title/award process). d. Significant physician involvement in the judging process and final selection of award winners. e. Evidenced based performance measures for selection. f. Public transparency and substantive information regarding all aspects including the leadership involved in the criteria, methodology, selection process. g. Disclosure of any conflicts of interest	Retain. Policy is relevant.
H-215.975	Uniform Standards for Not-For-Profit and For-Profit Hospitals	The AMA supports the concept that all hospitals be held to the same standards of care, community service, professional education and commitment to their respective communities.	Retain. Policy is relevant.
H-220.938	The Joint Commission Adherence to its Own Standards	The AMA Board of Trustees directs its Commissioners to The Joint Commissi on (TJC) to strongly advocate that TJC: (1) consistently enforce its standards regarding unilateral amendment of medical staff bylaws; (2) continue to cite hospitals for unilateral amendment of medical staff bylaws, rules and regulations, which may lead to loss of accreditation if the violation is not rectified within a specified time frame; and (3) cite hospitals for including provisions in their corporate bylaws that allow for the unilateral amendment of medical staff bylaws, rules and regulations, when state statutes do not require the governing body of the hospital to have such authority.	Retain. Policy is relevant.
H-220.975	Medical Staff Comment on The Joint Commission "Field Review of Proposed Standards"	Our AMA believes that all “Field Review of Proposed Standards” that are sent to hospitals should be sent simultaneously to the medical staff of said hospital, with their comments to be returned directly to The Joint Commission for its consideration.	Retain. Policy is relevant.
H-220.976	Bylaws Approval Time Limit	The AMA supports including a standard in The Joint Commission Accreditation Manual for Hospitals requiring that initial medical staff bylaws and subsequent amendments be approved or disapproved by the hospital	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		governing body within a reasonable period of time specified in the medical staff bylaws and, if the governing body fails to act within the time specified, the proposed changes should be deemed adopted.	
H-220.978	Hospital Medical Staff Representation on the Hospital Governing Body	The AMA supports amending The Joint Commission Leadership Standard LD.01.03.01 to provide for representation at all meetings of the governing body, with vote by one or more medical staff members nominated and elected by the medical staff, consistent with applicable state law.	Retain. Policy is relevant.
H-225.943	Mixed Medical Staffs	Our AMA affirms its unyielding support for the principle that the members of the organized medical staff must work collectively to improve patient care and outcomes, regardless of the employment status or practice setting of each individual member, and through its Organized Medical Staff Section and other appropriate channels, will provide guidance to medical staffs, including but not limited to effective medical staff leadership strategies and relevant updates to the *AMA Physician's Guide to Medical Staff Organization Bylaws*, that facilitate representation of and encourage participation in medical staff activities by community-based and independent physicians.	Retain. Policy is relevant.
H-225.944	Medical Staff Engagement at Critical Access Hospitals	Our AMA encourages all MD/DO(s) on staff at Critical Access Hospitals to contribute to the quality and safety of care provided in those organizations by participating in medical staff activities, including but not limited to credentialing and privileging activities.	Retain. Policy is relevant.
H-225.949	Medical Staff and Hospital Engagement of Community Physicians	1. Our AMA encourages medical staffs to develop medical staff membership categories for physicians who provide a low volume or no volume of clinical services in the hospital ("community physicians"). 2. Our AMA encourages medical staffs and hospitals to engage community physicians, as appropriate, in medical staff and hospital activities, which may include but need not be limited to: (a) medical staff duties and leadership; (b) hospital governance; (c) population health management initiatives; (d) transitions of care initiatives; and (e) educational and other professional and collegial events.	Retain. Policy is relevant.
H-225.984	Hospital Corporate Bylaws	The AMA encourages hospital medical executive committees to: (1) regularly examine the hospital/corporate bylaws, rules and regulations for any conflicts with the medical staff bylaws, rules and regulations or practices; (2) request that their hospital board of trustees/directors notify them of any proposed or	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		impending changes in the hospital/corporate bylaws; and (3) advise members/applicants of the medical staff of the effect of these hospital/corporate bylaws, rules and regulations.	
H-225.986	Physician Economic Incentive Program	The AMA: (1) opposes physician economic incentives that conflict with patients' welfare; and (2) believe the physician must remain the patient's advocate in the patient's relationship with the hospital.	Retain. Policy is relevant.
H-230.963	Limitations of Membership on Multiple Hospital Medical Staffs	Our AMA: (1) supports the principle that a hospital may not limit a physician's participation or medical staff privileges at the hospital based in whole or in part on the physician's membership or participation at a different hospital or hospital system or on the medical staff membership or participation of a partner, associate or employee of the physician at a different hospital or hospital system; (2) opposes hospitals placing limitations on medical staff privileges or participation at a hospital based in whole or in part on the physician's membership or participation at a different hospital or hospital system or on the medical staff membership or participation of a partner, associate or employee of the physician at a different hospital or hospital system; and (3) opposes hospitals placing limitations on medical staff privileges or participation at a hospital based in whole or in part on the physician (or a partner, associate or employee of the physician) having a financial relationship with another hospital/health system.	Retain. Policy is relevant.
H-230.984	Peer Review of the Performance of Hospital Medical Staff Physicians	The AMA (1) encourages state and local medical associations to establish procedures and committees for monitoring, upon the request of the medical staff, the effectiveness of hospital medical staff peer review; and (2) supports working with the AHA and other appropriate organizations to devise methods to encourage the development of such programs.	Retain. Policy is relevant.
H-230.997	Recertification and Hospital or Health Plan Network Privileges	(1) The fact that a board-certified practitioner fails to undergo the recertification examination shall not be adequate reason to modify or withhold hospital privileges or health plan network status from a physician. (2) Modification or withholding of hospital privileges or health plan network status shall be purely on the basis of assessment of performance.	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
H-235.968	Physician Review of Medical Staff Activities	The AMA recommends that hospital medical staffs have a policy that would allow minutes of medical staff committees, except minutes concerning peer review or corrective action information, be made available for review by medical staff members in the medical staff office; and recommends that the medical executive committee approve all reports, policies and recommendations from medical staff clinical departments and committees and have a process to distribute significant changes to the members of the medical staff.	Retain. Policy is relevant.
H-235.970	Conflict of Interest Issues and Medical Staff Leaders	Our AMA encourages medical staffs to adopt and incorporate into their bylaws medical staff conflict of interest policies that reflect the following principles: 1. Disclosure of potential conflicts. Candidates for election or appointment to medical staff leadership positions should disclose in writing to the medical staff, prior to the date of election or appointment, any personal, professional or financial affiliations or relationships of which they are reasonably aware, including employment or contractual relationships, which could foreseeably result in a conflict of interest with their acting on behalf of the medical staff. Elected or appointed medical staff leaders should disclose potential conflicts in writing to the medical staff whenever they arise. 2. Management of conflicts. When conflicts of interest exist, elected or appointed medical staff leaders should, as appropriate, recuse themselves from the deliberative process and/or abstain from voting on the matter to which the conflict relates. The medical staff should establish a process for disqualification from the deliberative process and/or from voting on the matter at hand for any elected or appointed medical staff leader with an identified conflict who fails to disclose the interest or who fails to recuse himself or herself from the deliberative process and/or from voting on the matter to which the conflict relates, as appropriate.	Retain. Policy is relevant.
H-235.985	Medical Executive Committee Composition	The AMA's policy states that the medical staff shall govern itself by the bylaws, rules and regulations which define the Medical Staff Executive Committee, whose members are selected in accordance with criteria and standards established by the medical staff, consistent with applicable state law.	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
H-260.964	Reimbursement for Clinical Lab Work	Our AMA supports the concept that a professional fee should be paid directly to the appropriate physician for clinical laboratory work, regardless of payer source.	Retain. Policy is relevant.
H-260.998	Laboratory Services Contracted by a Physician	Our AMA believes that: (1) laboratories should bill and collect from patients or third-party payers for laboratory services; (2) attending physicians are entitled to fair compensation for professional services rendered; and (3) bills for laboratory services performed by attending physicians should show the location where services were rendered and a description of such services.	Retain. Policy is relevant.
H-280.951	Quality of Care and Staffing in Nursing Homes	Our AMA will support the policy that staffing levels in nursing homes should appropriately address: (1) the acuity of the patient population; (2) the functional level of the patient and the services provided; (3) the existence of shortages for certain types of staff in some geographic locations and temporary shortages due to events such as employee illness or termination; and (4) the quality, education, and training of staff.	Retain. Policy is relevant.
H-280.953	Physicians Visits Under Medicare Skilled Nursing Facility Prospective Payment System	Our AMA will: (1) work with the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC) to ensure that physician visits to nursing homes and skilled nursing facilities be based on the physician's determination of appropriate care for each patient; (2) work with CMS to ensure that its Medicare carriers implement these policies in a uniform way; and (3) advocate that physician assessments necessary to comply with both the prospective payment system (PPS) as well as TJC requirements be recognized and reimbursed.	Retain. Policy is relevant.
H-285.941	Managed Care Consensus Bill	The AMA continues to support the enactment of comprehensive legislation that addresses the wide range of patient protection and physician fairness issues, such as disclosure of health plan information to enrollees and prospective enrollees, utilization review and grievance procedures, due process in physician selective contracting decisions, and physician involvement in health plan medical policies.	Retain. Policy is relevant.
H-285.950	Managed Care Organizations' Use of Physicians to Provide Second Opinions to Physicians Providing Emergency Services	The AMA adopts the following principles to guide the use by managed care plans of physicians employed or contracted with to specifically provide second opinions to physicians providing emergency services. The AMA encourages managed care plans to follow these guidelines when employing or contracting with physicians to provide second opinions to physicians providing emergency services. (1) All managed care plans shall disclose to their	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		enrollees and prospective enrollees any plan requirements or the existence of contractual arrangements whereby physicians are required to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities. (2) The required use of physicians to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities shall not impede the immediate diagnosis and therapy of acute cardiac, trauma, and other critical patient situations for which delay may result in death or an increase in severity of illness. (3) Any physician with a contractual arrangement to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities shall be licensed to practice medicine and actively practicing emergency medicine in the same state in which the second opinion is provided. (4) Any physician with a contractual arrangement to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities shall have active staff privileges in any facility in which the second opinion is provided. (5) To the degree possible, patients presenting at an emergency department or facility should be involved in the decisions regarding the treatment, referral, and follow-up care for their condition. (6) In the event of disagreements over second opinions, final decisions regarding the treatment, referral, and follow-up care provided to patients presenting at emergency departments or facilities shall be made by the attending emergency physician or other appropriate physicians on staff at the facility.	
H-285.967	Distribution of Premiums Collected by Managed Care Companies	The AMA develop and support appropriate legislation to require managed care plans to publish, on an annual basis, relevant operating and financial information.	Retain. Policy is relevant.
H-285.971	Population Based Practices in Managed Care Systems	The AMA recommends to all managed care plans that they: (1) develop population based programs for prevention, health risk assessments, and health's status improvement; (2) adopt a process to measure clinical quality provided to patients and demonstrate how quality in their system	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		of care is improving; (3) develop programs which assure that communicable and environmentally induced health problems are followed up by physicians within the plan in cooperation with competent health department personnel; and (4) manage these programs in concert with established standards of preventive medicine and public health.	
H-285.983	Organized Medical Staffs in Medical Delivery Systems	The AMA supports expanding the concept of physician governance of medical delivery systems by recommending that: (1) Medical delivery systems establish self-governing medical staffs similar, if not identical, to those in hospitals; (2) The principles of self-governance should include, but not be limited to: (a) the development of medical staff bylaws which cannot be unilaterally changed by the governing board of a medical delivery system; (b) physician election of representatives to the governing board and other appropriate committees of medical delivery systems including credentialing, privileging, quality assurance and utilization review committees; (c) due process protections for physicians credentialed by a medical delivery system; and (d) full indemnification by medical delivery systems of physicians who, in good faith, serve as members of credentialing, quality assurance and utilization review committees of medical delivery systems; and (3) Policy of the AMA is that the establishment of guidelines, review of decisions, and the adjudication of patient care quality issues in managed care plans must be performed by participating practicing physicians.	Retain. Policy is relevant.
H-290.973	Medicaid Citizenship Documentation	Our AMA strongly advocates that a state Medicaid agency's record of payment for the birth of an individual in a US hospital is satisfactory documentary evidence of both identity and citizenship.	Retain. Policy is relevant.
H-315.972	HIPAA Business Associate Contracting, Domestic and Foreign, and Foreign Outsourcing	1. Our AMA encourages physicians who have entered or who are considering entering a business associate agreement (BAA) to undertake careful due diligence regarding the business associate and to consider with legal counsel the inclusion of contractual provisions such as: a. strong confidentiality clauses; b. required steps to mitigate any harmful effects of wrongful use or disclosure of protected health information (PHI); c. assurance that, upon the contract's termination, all PHI is returned to the covered entity, and no copies are retained by the business associate, except as required for legal or audit purposes; d. indemnification of the covered entity against	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		any losses caused by a business associate; e. the business associate's procurement of specified types of liability insurance which may either protect the covered entity or enable the business associate to meet its indemnity; f. posting a surety bond (a.k.a. performance bond) to ensure faithful performance of the BAA by the business associate; or g. physicians should take care that the original contract should contain provisions addressing the costs involved with the return and maintenance of the PHI at or after the end of the contract term. 2. Our AMA supports legislation and/or regulation requiring all third parties who receive and maintain clinical information from a clinician to make those data available to the clinician in usable form at the end of the business relationship.	
H-320.941	Eliminate Fail First Policy in Addiction Treatment	Our AMA will advocate for the elimination of the "fail first" policy implemented at times by some insurance companies and managed care organizations for addiction treatment.	Retain. Policy is relevant.
H-320.943	Medicare and Insurance Takeback Procedures	Our AMA: (1) will advocate to ensure that when a patient hospitalization is retrospectively found not to meet criteria for inpatient admission, then the take back amount be only the difference between the cost of the admission and the cost of necessary observation for that patient stay; and (2) will advocate to ensure that, for any care provided to hospital patients who have Medicare, managed Medicare, or commercial insurance, hospitals have the option to rebill denied inpatient claims as outpatient claims, when a physician using clinical judgment makes a prospective decision to admit a patient who is later not found to meet admission criteria.	Retain. Policy is relevant.
H-320.987	Second Opinions When Required by Carrier	The AMA believes that second opinions for medical or surgical services and procedures are best provided by physicians who have the training, experience or skills which provide the necessary information base to assess the need for or advisability of a specific medical or surgical intervention.	Retain. Policy is relevant.
H-320.989	Third Party Utilization Review Programs	Our American Medical Association recommends that hospital medical staffs, prior to approving the written plan for utilization review, ensure the inclusion of provisions that require the hospital to seek formal review and recommendations from the medical staff concerning "any qualified outside organization" that is going to contract with the hospital to perform review activities specified in the plan, prior to entering into the contract.	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
H-320.990	Standardization of Mandatory Second Surgical Opinion Programs	The AMA urges third party payers who require second opinions to inform their subscribers so that they understand the requirements of such programs.	Retain. Policy is relevant.
H-320.991	Hospital Preadmission Review/Certification	The AMA believes that the following principle should be applied in evaluating any preadmission review program, so as to minimize any detrimental impacts on quality or accessibility of care: There should be direct and continuing communications to physicians and insured~~s~~ **patients** regarding prior authorization requirements.	Retain-in-part; amend by deletion and addition to make the policy consistent with language used in other AMA policies.
H-330.879	Providers and the Annual Wellness Visit	1. Our AMA supports that the Medicare Annual Wellness Visit (AWV) is a benefit most appropriately provided by a physician or a member of a physician-led health care team that establishes or continues to provide ongoing continuity of care. 2. Our AMA supports that, at a minimum, any clinician performing the AWV must enumerate all relevant findings from the visit and make provisions for all appropriate follow-up care. 3. Our AMA supports that the Centers for Medicare & Medicaid Services (CMS) provide a means for physicians to determine whether or not Medicare has already paid for an AWV for a patient in the past 12 months. 4. Our AMA encourages CMS to educate Medicare enrollees, that, in choosing their primary care physician, they are encouraged to make their AWVs with their primary care physician in order to facilitate continuity and coordination of their care.	Retain. Policy is relevant.
H-330.880	Virtual Supervision of "Incident to" Services	1. Our AMA supports pilot programs in the Medicare program to enable virtual supervision of "incident to" services that require direct supervision if they are developed with specialty society input and abide by the following principles: A. The physician billing "incident to" must fulfill other requirements of direct supervision of "incident to" services, including first seeing the patient and initiating the course of treatment, and providing subsequent services at a rate that shows active participation in and management of the course of treatment. B. The extent of supervision provided by the physician should conform to the applicable medical practice act in the state where the patient receives services. C. Non-physician practitioners and employees providing "incident to" services must follow existing requirements for the provision of	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		"incident to" services, including abiding by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services. D. The delivery of "incident to" services must be consistent with state scope of practice laws. E. Virtual supervision of "incident to" services must require the supervising physician to be connected through real-time audio and video technology with the room in which the "incident to" service is provided, to ensure that the physician is immediately able to provide assistance and direction during the provision of the service. F. Virtual supervision of "incident to" services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes. G. Physicians providing virtual supervision of "incident to" services should visit the sites in person where patients receive procedures from non-physician practitioners or employees. H. Physicians providing virtual supervision of "incident to" services must establish protocols for arranging for emergency services, including having an agreement with a physician at the site at which "incident to" services are provided, to ensure the provision of immediate assistance. I. Patients receiving "incident to" services that are virtually supervised must have access to the certification, licensure and/or board certification qualifications of the health care practitioners who are providing and supervising the care in advance of their visit. J. Patients receiving "incident to" services that are virtually supervised must have a choice of provider, as is required for all medical services. 2. Our AMA encourages national medical specialty societies to develop best practices and protocols for virtual supervision of "incident to" services, including specifying which services and procedures would not qualify for this practice.	
H-330.899	Medicare Pharmaceutical Benefit	Our AMA utilizes the following principles in evaluating legislative proposals for the addition of a Medicare pharmaceutical benefit: (1) Any pharmaceutical benefit should be fully funded by additional budgetary allocations, separate from existing budget provisions. The benefit should provide for adequate accounting so that drug program expenditures can be tracked separately from all other expenditures. (2) The pharmaceutical benefit should be targeted to reduce hardship for those with low-incomes	Retain. Policy is relevant.

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		and those with catastrophic costs. (3) Any legislation should provide a pharmaceutical benefit that is equal across geographic regions. (4) A pharmaceutical benefit should be designed in a way that allows for benefits options under both the traditional Medicare fee-for-service program and any version of the Medicare program that relies on the private marketplace. Different levels of drug benefits for different products would be permissible. (5) A pharmaceutical benefit should include a tiered deductible and co-payment structure that encourages economically responsible behavior. (6) Any pharmaceutical benefit should be designed to prevent adverse selection. (7) Any pharmaceutical benefit should be designed in a manner that prevents interference with clinical decision-making and physician prescribing decisions. (8) Any pharmaceutical benefit should be designed in a manner that minimizes the administrative burden placed on physicians. (9) Any pharmaceutical benefit should be designed in a manner that ensures beneficiary access to local pharmacies, and not be limited to mail order pharmacies. (10) In the implementation of any Medicare drug benefit, employers are highly encouraged to preserve existing coverage, and for Medicare beneficiaries with existing drug coverage, any Medicare benefit should be supplemental to and coordinated with that existing coverage.	
H-330.934	Sharing Demographic Medicare Data with Other Public Entities by CMS	The AMA supports continued provision of aggregate anonymous demographic information to state and local health agencies where its use will promote community health and improve utilization of health care dollars, as long as adequate safeguards to protect individual privacy are preserved.	Retain. Policy is relevant.
H-330.937	Local Medical Policy of Medical Payers	AMA policy states that when payers apply local medical policies to physicians in remote areas from where the local medical policy was originally developed, this local medical policy must be widely disseminated to the physicians in those areas along with ~~**printed**~~ explanations to the practitioners involved.	Retain-in-part; amend by deletion as printing is no longer the standard and if maintained, it becomes the expectation.
H-340.913	Peer Review by Actively Practicing Physicians	The AMA continues to urge CMS to assure that under the Medicare review process only actively practicing physicians in the same specialty and similar practice settings be allowed to perform Medicare reviews.	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
H-345.980	Advocating for Reform in Payment of Mental Health and Substance Use Disorder Services	Our American Medical Association advocates that funding levels for public sector mental health and substance use disorder services not be decreased in the face of governmental budgetary pressures, especially because private sector payment systems are not in place to provide accessibility and affordability for mental health a nd substance use disorder services to our citizens.	Retain. Policy is relevant.
H-375.964	IOM Report on QIO Program	Our AMA opposes the removal of medical review responsibilities from the QIO scope of work and further opposes conversion of contracts to national or regional contractors.	Retain. Policy is relevant.
H-385.909	The Rights of Patients, Providers and Facilities to Contract for Non-Covered Services	Our AMA will: (1) engage in efforts to convince the Centers for Medicare & Medicaid Services to abstain from inappropriate bundling in situations in which functional and aesthetic considerations should be considered separately; and (2) actively oppose further regulations that would interfere with the rights of patients, providers, and facilitie s to privately contract for non-covered services.	Retain. Policy is relevant.
H-385.910	Physician Communications and Care Coordination During Patient Hospitalization	Our AMA will continue to advocate that third party payers establish separate physician payments for interprofessional consultative services related to the care of hospitalized patients.	Retain. Policy is relevant.
H-385.924	Support for State Medical Association Economic Research, Development and Planning	The AMA urges state medical associations to establish bureaus or departments of economic research, development and planning to study, develop and disseminate data concerning the economic aspects of medical practice. The AMA continues to assist state associations in collecting such data and to act as a clearinghouse for data so gathered. The AMA encourages state medical associations to designate representatives to deal energetically with third party agencies and programs, utilizing the concept of usual, customary or reasonable charges.	Retain. Policy is relevant.
H-385.991	Balance Billing	Our AMA supports the right of the physician to balance bill a patient for any care given, regardless of method of payment, where permissible by law or contractual agreement.	Retain. Policy is relevant.
H-390.836	Support for Seamless Physician Continuity of Care	Our AMA encourages physicians who encounter contractual difficulties with Medicare Advantage (MA) plans to contact their Centers for Medicare & Medicaid Services (CMS) Regional office.	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
H-390.839	Requiring Secondary and Supplemental Insurers to Medicare to Follow Medicare Payments	Our AMA will support payment by secondary insurers of the balance of the approved Medicare payment in an amount bringing Medicare and secondary payments up to the full allowance of the secondary insurer for services covered by the secondary insurer.	Retain. Policy is relevant.
H-390.854	Freedom of Choice	(1) The AMA will seek appropriate cases to challenge the legality and constitutionality of Medicare restrictions on non-participating physicians' medical practice and on patient freedom of choice by such mechanisms as limitations on balance billing and prohibitions on private "opt out" arrangements between physicians and patients. (2) The AMA will strongly resist such restrictions being extended to other payers in national health care reform legislation.	Retain. Policy is relevant.
H-390.977	Reimbursement for Diagnostic Studies Identified as Surgical Procedures	(1) The AMA supports the concept of separate payment by private and public payers for the services of physicians who perform diagnostic procedures separately and apart from surgical therapy. (2) The AMA supports the concept of one inclusive fee or payment to a physician by private and public payers for diagnostic surgical procedures performed in conjunction with and as a part of surgical therapy and encourages payers to utilize for payment purposes a coding system which can recognize the greater complexity or extent of the service which may be rendered. (3) The AMA urges physicians billing third parties to ensure that all services provided are completely described or coded on the appropriate claim form(s).	Retain. Policy is relevant.
H-405.993	Median Physician Income	The AMA encourages all who prepare reports on physician income to include not simply "mean" (average) data, but also "median" data and quartile distributions, which are far more representative of actual physician income profiles and are better reflections of medical care costs.	Retain. Policy is relevant.
H-406.999	Goal of Health Care Data Collection	The AMA (1) continues to advocate that health care data collected by government and third-party payers be used for education of both consumers and providers; and (2) believes that government, third party payers and self-insured companies should make physician-specific utilization information **from carefully selected studies** available to medical societies.	Retain-in-part; amend by addition to fulfill the intent of Board Report W-A-92, the origin of this policy.
H-410.970	Use of Practice Parameters	Our AMA: (1) urges organizations that have developed practice parameters to recognize that practice parameters are educational tools, not mechanisms to determine reimbursement or credentialing, to assist physicians in clinical decision making and are not replacements for	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		clinical decision making. Physicians must retain autonomy to vary from practice parameters without retribution in order to provide the quality of care that meets the individual needs of their patients; (2) encourages physicians to be cost conscious and to exercise discretion, consistent with good medical care, when implementing practice parameters; and (3) encourages physician organizations developing practice parameters to include appropriate explanatory disclaimers to ensure that practice parameters are used in a manner that is consistent with AMA policy.	
H-410.997	Practice Parameters and Review Criteria	Our AMA believes that variations from medical practice guidelines and parameters are not, except in very limited circumstances, per se indicators of quality or medical necessity problems. Only where a variation involves provision of a service or procedure deemed by the preponderance of medical opinion to be inappropriate in any clinical situation should it be used as a per se indicator for judgments regarding quality or payment denials. Otherwise, variations from the guidelines and parameters should constitute only a signal for further peer-to-peer considerations relative to quality or payment issues.	Retain. Policy is relevant.
H-450.929	CMS Emergency Department Patient Experience of Care Survey (EDPEC)	Our AMA will monitor the development of ~~**the**~~ Centers for Medicare and Medicaid Services' ~~**E**~~**e**mergency ~~**D**~~**d**epartment ~~**P**~~**p**atient ~~**E**~~**e**xperience of ~~**C**~~**c**are ~~**(EDPEC)**~~ ~~**S**~~**s**urvey**s** and advocate for fair and reliable reporting that accurately reflects the quality of care provided by physicians and/or hospitals.	Retain-in-part; amend by deletion and addition to reflect the fact that while the initial CMS EDPEC survey has been completed, subsequent surveys are ongoing.
H-450.930	Developing Measures for Good Access to Care	1. Our AMA will collaborate with the appropriate organizations to support specialty-designed measures of access to care that ensure physicians have the measures they need to be successful under the Medicare Access and Chip Reauthorization Act (MACRA). 2. Our AMA encourages the Centers for Medicare and Medicaid Services (CMS) to use specialty society-developed access to care measures for the Clinical Practice Improvement incentives rather than CMS-generated measures of access.	Retain. Policy is relevant.
H-450.937	Medical Care Outside the United States	1. Our AMA advocates that employers, insurance companies, and other entities that facilitate or incentivize medical care outside the US adhere to the following principles:	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		A. Medical care outside of the US must be voluntary. B. Financial incentives to travel outside the US for medical care should not inappropriately limit the diagnostic and therapeutic alternatives that are offered to patients, or restrict treatment or referral options. C. Patients should only be referred for medical care to institutions that have been accredited by recognized international accrediting bodies (e.g., the Joint Commission International or the International Society for Quality in Health Care). D. Prior to travel, local follow-up care should be coordinated and financing should be arranged to ensure continuity of care when patients return from medical care outside the US. E. Coverage for travel outside the US for medical care must include the costs of necessary follow-up care upon return to the US. F. Patients should be informed of their rights and legal recourse prior to agreeing to travel outside the US for medical care. G. Access to physician licensing and outcome data, as well as facility accreditation and outcomes data, should be arranged for patients seeking medical care outside the US. H. The transfer of patient medical records to and from facilities outside the US should be consistent with HIPAA guidelines. I. Patients choosing to travel outside the US for medical care should be provided with information about the potential risks of combining surgical procedures with long flights and vacation activities. 2. Our AMA supports efforts that allow for the reporting and tracking of quality and safety issues associated with medical procedures performed abroad.	
H-450.941	Pay-For-Performance, Physician Economic Profiling, and Tiered and Narrow Networks	1. Our AMA will collaborate with interested parties to develop quality initiatives that exclusively benefit patients, protect patient access, do not contain requirements that permit third party interference in the patient-physician relationship, and are consistent with AMA policy and Code of Medical Ethics, including Policy H-450.947, which establishes the AMA's Principles and Guidelines for Pay-for-Performance and Policy H-406.994, which establishes principles for organizations to follow when developing physician profiles, and that our AMA actively oppose any pay-for-performance program that does not meet all the principles set forth in Policy H-450.947.	Retain-in-part; **rescind clause (4)**, as time frame for reporting directive has passed. Additionally, in 2018 the AMA published a thorough guide, including model contract language, titled: Evaluating Pay-for-Performance Contracts.

POLICY #	Title	Text	Recommendation
		2. Our AMA strongly opposes the use of tiered and narrow physician networks that deny patient access to, or attempt to steer patients towards, certain physicians primarily based on cost of care factors. 3. Our AMA pledges an unshakable and uncompromising commitment to the welfare of our patients, the health of our nation and the primacy of the patient-physician relationship free from intrusion from third parties. ~~**4. Because there are reports that pay-for-performance programs may pose more risks to patients than benefits, our AMA will prepare an annual report on the risks and benefits of pay-for-performance programs, in general and specifically the largest programs in the country including Medicare, for the House of Delegates over the next three years, beginning at the 2007 Interim Meeting. This report should shall clearly delineate between private pay-for-performance programs and voluntary public pay-for-reporting and other related quality initiatives.**~~ 5. Our AMA will continue to work with other medical and specialty associations to develop effective means of maintaining high quality medical care which may include physician accountability to robust, effective, fair peer review programs, and use of specialty-based clinical data registries. 6. As a step toward providing the Centers for Medicare and Medicaid Services (CMS) with data on special populations with higher health risk levels and developing variable incentives in achieving quality, our AMA will continue to work with CMS to encourage and support pilot projects, such as the Physician Quality Reporting Initiative (PQRI), by state and specialty medical societies that are developed collaboratively to demonstrate effective incentives for improving quality, cost-effectiveness, and appropriateness of care. 7. Our AMA will advocate that physicians be allowed to review and correct inaccuracies in their patient specific data well in advance of any public release, decreased payments, or forfeiture of opportunity for additional compensation.	
H-450.943	Effects of Pay-for-Performance on Minority Health Disparities	Our American Medical Association urges that physicians with expertise in eliminating racial and ethnic health disparities be involved in the design, implementation and evaluation of pay-for-performance programs.	Retain. Policy is relevant.
H-450.999	Practice Evaluation	(1) Our AMA urges state and local medical societies to consider developing public	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		information programs to inform consumers about existing quality assurance activities. (2) Our AMA encourages increased use of office or hospital outpatient facilities, and use of these facilities for diagnostic testing prior to hospitalization whenever medically feasible, and where quality of service can be assured.	
H-460.896	Stem Cell Tourism	Our AMA (a) encourages the study of appropriate guidance for physicians to use when advising patients who seek to engage in stem cell tourism and how to guide them in risk assessment, (b) encourages further research on stem cell tourism, and (c) urges physicians to educate themselves on these issues.	Retain. Policy is relevant.
H-475.991	Postoperative Care - Responsibility and Reimbursement	Our AMA: (1) continues to support repeal of the federal law which allows reimbursement to optometrists for the unsupervised/independent provision of postoperative care; and (2) reaffirms its position that physicians performing surgery have an ethical and professional responsibility to continue the care of their individual patients through the post-surgical recovery and healing period, or to arrange coordination of such care, especially in those situations where there is a reasonable expectation that another physician will provide postoperative surgical care.	Retain. Policy is relevant.
H-475.996	Revision of AMA Surgical Screening Criteria	The AMA (1) urges national medical specialty societies to review all criteria sets in use within the QIO program to determine whether sections applicable to the practice of their members are in need of revision and, if they are, to develop recommendations for change; (2) encourages state medical societies to organize specialty specific liaison activities between specialty groups and their respective QIOs in order to address particular issues that may arise concerning the development or application of criteria; and (3) supports continued efforts to collect information on screening criteria sets and to evaluate the process by which they are being applied.	Retain. Policy is relevant.
H-480.953	Interoperability of Medical Devices	Our AMA believes that intercommunication and interoperability of electronic medical devices could lead to important advances in patient safety and patient care, and that the standards and protocols to allow such seamless intercommunication should be developed fully with these advances in mind. Our AMA also recognizes that, as in all technological advances, interoperability poses safety and medico-legal challenges as well. The development of standards and production of interoperable equipment protocols should strike the proper balance to achieve	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		optimum patient safety, efficiency, and outcome benefit while preserving incentives to ensure continuing innovation.	
H-480.968	Telemedicine	The AMA: (1) encourages all national specialty societies to work with their state societies to develop comprehensive practice standards and guidelines to address both the clinical and technological aspects of telemedicine; (2) will assist the national specialty societies in their efforts to develop these guidelines and standards; and urges national private accreditation organizations (e.g., URAC and JCAHO) to require that medical care organizations which establish ongoing arrangements for medical care delivery from remote sites require practitioners at those sites to meet no less stringent credentialing standards and participate in quality review procedures that are at least equivalent to those at the site of care delivery.	Retain. Policy is relevant.
H-70.914	Opposing Coverage Decisions Based Solely on ICD-10 Code Specificity	Our AMA opposes limitations in coverage for medical services based solely on diagnostic code specificity.	Retain. Policy is relevant.
H-70.918	Medicare Evaluation and Management Medical Decision Making Guidelines	It is AMA policy that: (1) all Medicare contractors disclose any Medical Decision Making tool or **~~score sheet~~** **algorithm** used in audits; (2) all Medicare contractors have a **clearly defined** process to resolve conflicts of interpretation on Medical Decision Making ~~tools and/or score sheets~~ between practicing physicians and contractor clinical auditors; and (3) any Medical Decision Making tool or **~~score sheet~~** **algorithm** must be based on the **~~factors for arriving at complexity, as defined in~~** **instructions for Medical Decision Making as** outlined in CPT Guidelines that accompany the CPT **~~Book~~** **Code Set**.	Retain-in-part; amend by deletion and addition to update this policy to align with current CPT guidelines.
H-70.958	Medicare ICD-10 Coding Requirements	Our AMA will: (1) request that the Centers for Medicare & Medicaid Services ensure that its Medicare carriers fully understand and implement the distinction between coding to the "highest level of specificity" within a code category, and that coding for the condition(s) to the "highest degree of certainty" for that visit. For this purpose, symptoms, signs, abnormal test results or other reason for the visit are appropriate and acceptable diagnoses; and (2) will use all appropriate vehicles to communicate to physicians the correct method to report ICD-10-CM codes to describe diagnoses and other reasons for the physician-patient encounter.	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
H-70.960	Documentation Requirements for Physician Care Plan Oversight	The AMA will (1) continue to work with CMS so that CPT codes 99375 and 99376, for Care Plan Oversight, are recognized for payment to all physicians; (2) the AMA CPT Editorial Panel will consider revising the Care Plan Oversight codes to more accurately reflect medical practice; (3) will work with CMS to develop documentation requirements that are more consistent with standard medical practice and are not time based; and (4) the CPT Editorial Panel will continue to monitor CMS's implementation of documentation requirements.	Sunset; policy obsolete with advent of the Chronic Care Management (99490, 99491; 99437, 99439) and Complex Chronic Care Management (99487, 99489) CPT codes.
H-75.984	Increasing Availability and Coverage for Immediate Postpartum Long-Acting Reversible Contraceptive Placement	1. Our AMA: (a) recognizes the practice of immediate postpartum and post pregnancy long-acting reversible contraception placement to be a safe and cost effective way of reducing future unintended pregnancies; and (b) supports the coverage by Medicaid, Medicare, and private insurers for immediate postpartum long-acting reversible contraception devices and placement, and that these be billed separately from the obstetrical global fee. 2. Our AMA encourages relevant specialty organizations to provide training for physicians regarding (a) patients who are eligible for immediate postpartum long-acting reversible contraception, and (b) immediate postpartum long-acting reversible contraception placement protocols and procedures.	Retain. Policy is relevant.
H-85.957	Encouraging Standardized Advance Directives Forms Within States	Our AMA encourages each state society to develop a standardized form of advance directives for use by physicians and other health care providers as a template to discuss end-of-life care with their patients.	Retain. Policy is relevant.