REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-A-24

Subject: Council on Medical Service Sunset Review of 2014 House Policies

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee G

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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 ten 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to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.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.

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 |
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| **D-110.993** | Reducing Prescription Drug Prices | Our AMA will (1) continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and (2) encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to contact the National Conference of State Legislatures, which maintains a comprehensive database on all such programs and legislation. | Rescind. Superseded by Policy H-110.987.<br><br>**Pharmaceutical Costs**<br>**H-110.987**<br>1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.<br>2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.<br>3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.<br>4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.<br>5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.<br>6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation. |

| POLICY # | Title | Text | Recommendation |
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| | | | 7. Our AMA supports legislation to shorten the exclusivity period for biologics.<br>8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.<br>9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.<br>10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by ten percent or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of ten percent or more each year or per course of treatment.<br>11. Our AMA advocates for policies that prohibit price gouging on prescription |

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| | | | medications when there are no justifiable factors or data to support the price increase.<br>12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts adhdressing drug price and cost transparency.<br>13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.<br>14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation. |
| **D-120.943** | Review of Straddle Drug Pricing Rules for Medicare Part D Participants | Our AMA: (1) urges the Centers for Medicare and Medicaid Services (CMS) to examine how Medicare Part D plans are applying the straddle drug pricing rules and determine whether costs are being inappropriately shifted to beneficiaries whose drug spending totals span multiple coverage phases; and (2) will prepare a report explaining the straddle drug pricing rules and their potential impact on patients, incorporating information that is available from CMS regarding implementation by Part D plans. | Retain. |
| **D-160.929** | Patient Education Regarding the Medicare Chronic Care Management Fee | Our AMA will create a model letter that its members may use to explain the Medicare chronic care management fee to their patients. | Retain. |
| **D-160.931** | CMS Two Midnight Policy | Our AMA encourages the Centers for Medicare & Medicaid Services to educate the public and develop tools for physicians and patients that outline the financial impact of the two midnight policy. | Retain. |
| **D-160.932** | Medicare's Two-Midnight Rule | Our AMA will petition the Centers for Medicare & Medicaid Services to repeal the August 19 rules | Retain. |

| POLICY # | Title | Text | Recommendation |
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| | | regarding Hospital Inpatient Admission Order and Certification. | |
| **D-160.990** | Identification of Health Care Providers | Our AMA will encourage all medical facilities to provide reliable identification of health care providers. | Retain. |
| **D-165.937** | Health System Reform Resources | Our AMA will continue to develop resources to help physician practices address the ongoing and emerging issues associated with expanding health insurance coverage under the Affordable Care Act. | Retain. |
| **D-165.981** | Transitional Issues in Moving Toward a System of Individually Selected and Owned Health Insurance | (1) Our AMA will inform individual physicians and group practice administrators why self-paying patients (e.g., those who have MSA-type coverage or are uninsured) may be at a significant price disadvantage in purchasing health care services. | Retain. |
| **D-180.994** | Rescinding Provisions Requiring Physicians to Have Hospital Admitting Privileges | Our AMA will work with the American Association of Health Plans, Health Insurance Association of America, and other appropriate organizations to rescind provisions requiring physicians to have hospital medical staff privileges in order to participate in health plans. | Retain. |
| **D-185.995** | Health Plan Coverage of Prescription Drugs | Our AMA will: (1) advocate AMA policies related to health plan coverage of prescription drugs to pharmacy benefit managers, as well at to public and private sector payers; and (2) advocate for the enactment of legislation consistent with AMA policies related to health plan coverage of prescription drugs. | Retain. |
| **D-230.986** | Opposition to Proposed Revision of CMS Conditions of Participation that Limit the Autonomy, Self Governance and Quality Oversight of the Organized Medical Staff | 1. Our AMA through appropriate means, including but not limited to a formal response during the current comment period for the proposed regulation on conditions of participation (CoP) or necessary legal action, including injunctive relief, will actively oppose any Centers for Medicare & Medicaid Services (CMS) policy that would bypass or remove the clinical quality and safety oversight, and credentialing and privileging responsibilities of the physician | Retain. |

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| | | members of the Organized Medical Staff, or that would allow a practitioner to practice at a hospital without being a member of the medical staff.<br>2. Our AMA will actively educate our AMA physician members of the proposed revisions to the CoP by CMS, and the potential adverse effects of such proposals on the quality and safety of patient care, and encourage them to respond individually during the CMS comment period.<br>3. In the name of quality care and patient safety, our AMA will vigorously engage its members, the public, and interested stakeholders to advocate against the proposed revisions to the Medicare CoPs that would bypass or remove the clinical quality and safety oversight, and credentialing and privileging responsibilities of the physician members of the Organized Medical Staff, or that would allow a practitioner to practice at a hospital without being a member of the medical staff.<br>4. (a) Our AMA will update model hospital staff bylaws to address the problem of requiring board recertification to remain on staff; (b) once our AMA develops these model hospital staff bylaw changes with regards to board recertification, they shall be made public in our AMA publications so physicians will recognize this problem of losing staff privileges that may be upon us in the near future; and (c) our AMA representatives to The Joint Commission will convey AMA Policies H-230.986 and H-230.997, which address board certification/recertification and hospital/health plan network privileges, to The Joint Commission. | |
| **D-230.989** | Reappointments to the Medical Staff | Our AMA will work with The Joint Commission to change the requirement for reappointments to medical staffs to every four years. | Retain. |

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| **D-240.993** | Verbal Admission Order Signatures | Our AMA will work with the Centers for Medicare & Medicaid Services to allow authentication of verbal admission orders within 30 days, rather than prior to discharge. | Retain. |
| **D-280.987** | Analysis of Place-of-Service Code for Observation Services | Our AMA will advocate with the Centers for Medicare & Medicaid Services that the status of any observation patient who remains confined at a hospital for more than 24 hours be changed automatically to inpatient, and if they had spent a midnight in observation status, that midnight would be counted toward the three-day prior hospitalization requirement for Medicare coverage of skilled nursing facility care. | Retain. |
| **D-280.989** | Inclusion of Observation Status in Mandatory Three Day Inpatient Stay | 1. Our AMA will continue to monitor problems with patient readmissions to hospitals and skilled nursing facilities and recoding of inpatient admissions as observation care and advocate for appropriate regulatory and legislative action to address these problems.<br>2. Our AMA will continue to advocate that the Centers for Medicare & Medicaid Services explore payment solutions to reduce the inappropriate use of hospital observation status. | Retain. |
| **D-285.977** | Excessive Telephone Wait Times for Physician Appeals of Managed Care Decisions on Patient Care | Our AMA advocates that managed care organizations be required to staff physician contact phone numbers concerning appeals for denied care sufficiently to maintain no more than a five minute average wait time. | Retain. |
| **D-330.911** | Generic Changes in Medicare (Part D) Plans | 1. Our AMA will investigate the incidence and reasoning behind the conversion of one generic drug to another generic drug of the same class in Medicare Advantage drug plans.<br>2. Our AMA will request the Centers for Medicare & Medicaid Services to ensure that pharmaceutical vendors, when they do ask for generic transitions of drugs, list the drugs they believe are more cost effective along with | Retain-in-part. Rescind (1); accomplished with AMA participation in monthly CMS Medicare Part D Workgroup meetings. |

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| | | their tier price and alternative drug names. | |
| **D-330.921** | Hospital Systems' Practices of Reclassification of Place of Service, Opting Not to Bill Medicare for Hospital and Aggressive Denial of Hospital Days in Reaction to Recovery Audits | 1. Our American Medical Association will work with the Centers for Medicare & Medicaid Services, the Government Accountability Office, and other stakeholders to ensure that: (a) when hospitals make reclassifications based on screening criteria in proprietary databases, both the admitting physicians and the patient is immediately notified; (b) Recovery Audit Contractors, are precluded from making recoupments associated with "inappropriate admissions" and/or discrepancies between the hospital and physician's site of service; (c) physicians are intimately involved in the development of the data being used by proprietary databases; (d) a process is put in place whereby physicians can substitute their medical judgment for that of the software programs, and carriers and auditors will ensure that that judgment is considered and evaluated by physicians in the same state and specialty; and (e) the evidence underlying data programs and the processes being employed are completely transparent.<br>2. Our AMA will work with CMS to remove the requirement of linkage of Part A and Part B place of service so that admission or consultation documents that were done prior to a determination or reclassification of a place of service be recognized and not result in a rejection in claim for services. | Retain. |
| **D-330.933** | Restoring High Quality Care to the Medicare Part D Prescription Drug Program | Our AMA will:<br>a. work to eliminate prior authorizations under the Medicare Part D Prescription Drug Program which undermine a physician's best medical judgment;<br>b. work with the Centers for Medicare and Medicaid Services (CMS) to enforce the Medicare Part D Prescription Drug Program statutory requirement that all Part | Retain. |

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| | | D plans include at least two drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients;<br>c. work with CMS to place reasonable copays in the Medicare Part D Prescription Drug Program;<br>d. work with other interested parties to simplify the CMS prior authorization process such that a diagnosis or reason written on the prescription should be accepted as documentation for non-formulary request; and<br>e. work with CMS to develop a one-page form for physicians and patients to utilize in appealing a prescription coverage denial. | |
| **D-330.964** | Update to Ambulatory Surgery Procedure List | Our American Medical Association urge the Centers for Medicare and Medicaid Services to immediately update the ambulatory surgery center list of covered procedures. | Rescind. The list of approved ASC procedures is now updated annually. |
| **D-35.988** | The Joint Commission Primary Care Home Initiative | 1. Our AMA Commissioners to The Joint Commission will strongly advocate that the requirements for any primary care home or medical home initiative of The Joint Commission strictly meet the requirements of the *Joint Principles of the Patient-Centered Medical Home* and more specifically that (1) each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care and (2) that a personal physician lead a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.<br>The *Joint Principles of the Patient-Centered Medical Home* were developed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association and approved by the AMA.<br>2. Our AMA will continue to support the concept of physician- | Rescind. Superseded by Policy H-160.919.<br><br>**Principles of the Patient-Centered Medical Home H-160.919**<br>1. Our AMA adopts the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association "Joint Principles of the Patient-Centered Medical Home" as follows:<br><br>Principles<br><br>Personal Physician - Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.<br><br>Physician Directed Medical Practice - The personal physician leads a team of |

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| | | led teams within the patient centered medical home (PCMH) as outlined in the Joint Principles of the Patient-Centered Medical Home.<br>3. Our AMA will respond to The Joint Commission's interpretation of its primary care medical home certification standards addressing non-physician-led PCMHs.<br>4. Our AMA will oppose any interpretation by The Joint Commission, or any other entity, of primary care medical home or patient centered medical home (PCMH) as being anything other than MD/DO physician led. | individuals at the practice level who collectively take responsibility for the ongoing care of patients.<br><br>Whole Person Orientation - The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.<br><br>Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.<br><br>Quality and safety are hallmarks of the medical home:<br><br>Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.<br><br>Evidence-based medicine and clinical decision-support tools guide decision making. |

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| | | | Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.<br><br>Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.<br><br>Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.<br><br>Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.<br><br>Patients and families participate in quality improvement activities at the practice level.<br><br>Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.<br><br>Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:<br><br>It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit. |

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| | | | It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.<br><br>It should support adoption and use of health information technology for quality improvement.<br><br>It should support the provision of enhanced communication access such as secure e-mail and telephone consultation.<br><br>It should recognize the value of physician work associated with remote monitoring of clinical data using technology.<br><br>It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).<br><br>It should recognize case mix differences in the patient population being treated within the practice.<br><br>It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.<br><br>It should allow for additional payments for achieving measurable and continuous quality improvements.<br><br>2. Our AMA supports the patient-centered medical home (as defined in Policy H-160.919) as a way to provide care to |

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| | | | patients without restricting access to specialty care.<br><br>3. It is the policy of our AMA that medical home participation criteria allow any physician practice to qualify as a medical home, provided it can fulfill the principles of a patient-centered medical home.<br><br>4. Our AMA will work with The Joint Commission (TJC) to examine the structures of TJC-accredited medical homes and determine whether differences exist in patient satisfaction, quality, value, and patient safety, as reflected by morbidity and mortality outcomes, between physician-led (MD/DO) and non-physician-led medical homes.<br><br>5. Our AMA supports the physician-led patient-centered medical home and advocate for the public reporting/notification of the professional status (education, training, experience) of the primary care clinician who leads the primary care medical home. |
| **D-390.954** | Hospital-Based Physicians and the Value-Based Payment Modifier | Our AMA will continue to advocate that the Value-Based Payment Modifier program be repealed or significantly modified. | Rescind. The Merit-based Incentive Payment System (MIPS) under the Quality Payment Program replaced the Physician Feedback/Value-Based Payment Modifier program on January 1, 2019. |
| **D-390.981** | Medicare Payment for Services to Skilled Nursing Facility Residents in Physicians' Offices | Our AMA will:<br>(1) inform the Centers for Medicare and Medicaid Services of the problems physicians and their patients experience as a result of the inclusion of the technical component of physicians' office-based services in the consolidated billing protocol for Medicare Skilled Nursing Facility residents;<br>(2) urge the Centers for Medicare and Medicaid Services (CMS) to provide greater oversight of Medicare Skilled Nursing Facilities | Retain. |

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| | | (SNFs) in meeting their obligations to pay physicians for the technical component of services those physicians provide in their offices to Medicare SNF residents;<br>(3) advocate to Congress that it exclude from Medicare's Skilled Nursing Facility (SNF) consolidated billing protocol the technical component of medical services provided in physicians' offices to Medicare SNF residents, because of concern with the negative impact on care that could potentially occur;<br>(4) urge the Centers for Medicare and Medicaid Services to require SNFs to clearly identify those patients who fall under the Medicare SNF consolidated billing program, as opposed to non-skilled extended care facility (ECF) patients, prior to sending patients to physicians' offices for care; and<br>(5) communicate to physicians that in order to assure payment whenever a SNF resident receives a service that is subject to SNF consolidated billing, the SNF and the physician are required to enter into an arrangement prior to providing services and the physician must look to the SNF for payment. | |
| **D-390.984** | Payment by Health Insurance Plans of Medicare Deductibles and Copayments | Our AMA will: (1) seek legislation to compel all insurers paying secondary to Medicare to be required to pay the deductibles and coinsurance owed after the Medicare payment is made; and (2) seek federal legislation to require that a secondary plan not manage the primary Medicare benefit by imposing limits as if it were primary. | Retain. |
| **D-40.991** | Acceptance of TRICARE Health Insurance | Our AMA:<br>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 | Retain. |

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| | | resolution.<br>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.<br>3. Encourages the TRICARE Management Activity and its contractors to continue and strengthen their efforts to recruit and retain mental health and addiction service providers in TRICARE networks, which should include providing adequate reimbursement for mental health and addiction services.<br>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.<br>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.<br>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.<br>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 | |

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| | | as part of a physician-led health care team, consistent with state law; and (b) paying for transitional care management services, including payment of copays for services provided to TRICARE for Life beneficiaries receiving primary coverage through Medicare.<br>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. | |
| **D-400.988** | PLI-RVU Component of RBRVS Medicare Fee Schedule | Our AMA will: (1) continue its current activities to seek correction of the inadequate professional liability insurance component in the Resource-Based Relative Value Scale Formula; (2) continue its current activities to seek action from the Centers for Medicare & Medicaid Services to update the Professional Liability Insurance Relative Value Units (PLI-RVU) component of the RBRVS to correctly account for the current relative cost of professional liability insurance and its funding; and (3) support federal legislation to provide additional funds for this correction and update of the PLI-RVU component of the RBRVS, rather than simply making adjustments in a budget-neutral fashion. | Retain. |
| **D-450.961** | Hospital-Based Physicians and the Value-Based | Our AMA encourages national medical specialty societies to pursue the development of relevant performance measures that | Rescind. The Merit-based Incentive Payment System (MIPS) under the Quality Payment Program replaced the |

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| | Payment Modifier | demonstrate improved quality and lower costs, and work with the Centers for Medicare & Medicaid Services to have those measures incorporated into the Value-Based Payment Modifier program and other quality measurement and improvement programs. | Physician Feedback/Value-Based Payment Modifier program on January 1, 2019. |
| **D-465.999** | Critical Access Hospital Necessary Provider Designation | Our AMA: (1) will call on the Centers for Medicare & Medicaid Services to support individual states in their development of rural health networks; (2) opposes the elimination of the state-designated Critical Access Hospital (CAH) "necessary provider" designation; and (3) will pursue steps to require the federal government to fully fund its obligations under the Medicare Rural Hospital Flexibility Program. | Retain. |
| **D-480.991** | Access to Medical Care | Our AMA shall work with the Centers for Medicare and Medicaid Services to maximize access to the devices and procedures available to Medicare patients by ensuring reimbursement at least covers the cost of said device or procedure. | Retain. |
| **D-70.965** | Membership on RVS Update Committee (RUC) and CPT Coding Committee | Our AMA will request that representative societies send delegates or alternate delegates to the American Medical Association/Specialty Society Relative Value Scale Update Committee and the AMA Current Procedural Terminology Editorial Panel and Physician Advisory Committee who are currently engaged for a substantial portion of their professional activities with the practice of medicine either in active patient care or closely related activities. | Retain. |
| **H-130.990** | Freestanding Emergency Medical Care | (1) The AMA is concerned that the use of the term "emergency" in the title or description of a medical practice or a hospital center without maintaining specific emergency capabilities is not in the public interest since needed critical emergency service may be delayed. (2) The AMA firmly believes that the optimal provision of emergency | Retain. |

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| | | care requires prompt physical access to the immediate resources of the hospital and that a freestanding emergency center without such access may delay definitive care of critical emergencies. (3) The AMA endorses the following criteria to aid in determining if a full range of emergency services is being offered: hours of operation, staffing and medical direction, relationship to the local emergency medical services system, ancillary service and equipment, protocols, private physician referrals, medical records, and payment for services. | |
| **H-160.944** | Defining "Observation Care" | 1. The AMA will work with third party payers to establish a uniform definition of “observation care,” including the following: (a) The patient should be designated as under “observation care” if the physician's intent for hospital stay is less than 24 hours. If the physician's intent and expectation is for a hospital stay of greater than 24 hours, then the stay should be considered inpatient. The use of 24 hours as a threshold for observation is a guideline. It is not unusual for observation to extend to a few hours beyond 24 hours or for patients to be admitted to inpatient status before 24 hours. (b) Patients classified as under “observation care” require hospital level-of-care. (c) The patient should be registered as under “observation care” after initial physician evaluation of the patient’s signs and symptoms and appropriate testing. Post day surgical patients should be registered as under “observation care” if, after a normal recovery period, they continue to require hospital level-of-care as determined by a physician.<br>2. The AMA will establish policy on “observation care” and develop model legislation to ensure that: (a) After initial approval of inpatient admission by insurers, there should be no retrospective reassignment to | Retain. |

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| | | "observation care" status by insurers unless the original information given to insurers is incorrect. (b) Insurers should provide 60 days prior notice to providers of changes to "observation care" criteria or the application of those criteria with opportunity for comment. There should be no implementation of criteria or changes without first following these protocols. (c) Insurers' "observation care" policies should include an administrative appeal process to deal with all utilization and technical denials within a 60-day time frame for final resolution. An expedited appeal process should be available for patients in the admission process, allowing for a decision within 24 hours. (d) Insurers and HMOs should provide clearly written educational materials on "observation care" to subscribers highlighting differences between inpatient and "observation care" benefits and patient appeal procedures.<br>3. Our AMA will work with all appropriate governmental and non-governmental organizations to assure that both patients and physicians are treated fairly in the process of delineating the hospital admission status of patients, and to ensure that the process is transparent and administratively simple. | |
| **H-160.983** | Satellite and Commercial Medical Clinics | The AMA believes that (1) in principle, self-regulatory measures are preferable to mandatory state regulation as a mechanism to ensure quality of care in freestanding emergency and urgent care facilities; and (2) recently initiated self-regulatory programs applicable to freestanding facilities should be given ample opportunity to demonstrate their effectiveness in practice. | Retain. |
| **H-165.829** | The Future of Employer- | Our AMA: (1) supports requiring state and federally facilitated Small Business Health Options Program | Retain. |

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| | Sponsored Insurance | (SHOP) exchanges to maximize employee choice of health plan and allow employees to enroll in any plan offered through the SHOP; and (2) encourages the development of state waivers to develop and test different models for transforming employer-provided health insurance coverage, including giving employees a choice between employer-sponsored coverage and individual coverage offered through health insurance exchanges, and allowing employers to purchase or subsidize coverage for their employees on the individual exchanges. | |
| **H-165.865** | Principles for Structuring a Health Insurance Tax Credit | (1) AMA support for replacement of the present exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits will be guided by the following principles: (a) Tax credits should be contingent on the purchase of health insurance, so that if insurance is not purchased the credit is not provided. (b) Tax credits should be refundable. (c) The size of tax credits should be inversely related to income. (d) The size of tax credits should be large enough to ensure that health insurance is affordable for most people. (e) The size of tax credits should be capped in any given year. (f) Tax credits should be fixed dollar amounts for a given income and family structure. (g) The size of tax credits should vary with family size to mirror the pricing structure of insurance premiums. (h) Tax credits for families should be contingent on each member of the family having health insurance. (i)Tax credits should be applicable only for the purchase of health insurance, including all components of a qualified Health Savings Account, and not for out-of-pocket health expenditures. (j) Tax credits should be advanceable for low-income persons who could | Retain. |

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| | | not afford the monthly out-of-pocket premium costs.<br>(2) It is the policy of our AMA that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the United States Code.<br>(3) Our AMA will support the use of tax credits, vouchers, premium subsidies or direct dollar subsidies, when designed in a manner consistent with AMA principles for structuring tax credits and when designed to enable individuals to purchase individually owned health insurance. | |
| **H-180.951** | Tax Treatment of Health Insurance: Comparing Tax Credits and Tax Deductions | Our AMA supports the use of appropriately structured and adequately funded tax credits as the most effective mechanism for enabling uninsured individuals to obtain health insurance coverage. | Retain. |
| **H-180.953** | Decreased Insurance Premiums for Nonsmokers | Our AMA:<br>(1) encourages insurance companies to review and make public their current actuarial experience with respect to smokers and nonsmokers and to consider ways of making available to nonsmokers, at reduced rates, policies for accident, auto, life, homeowners, fire, and health insurance; and<br>(2) supports the concept of health insurance contracts with lower premiums for nonsmokers, reflecting their decreased need for medical services and serving as a financial incentive for smokers (tobacco users) to discontinue this destructive habit. | Retain. |
| **H-185.933** | Patient Access to Penile Prosthesis as Legitimate Treatment for Erectile Dysfunction | Our AMA will work in concert with national specialty and state medical societies to advocate for patient access to the full continuum of care of evidence-based erectile dysfunction treatment modalities including oral pharmacotherapy, penile vasoactive injection therapy, | Retain. |

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| | | vacuum erection device therapy and penile prosthetics. | |
| **H-185.935** | Reference Pricing | Our AMA supports the appropriate use of reference pricing as a possible method of providing health insurance coverage of specific procedures, products or services, consistent with the following principles:<br>1. Practicing physicians must be actively involved in the identification of services that are appropriate for a reference pricing system.<br>2. Appropriate reference pricing strategies may be considered for elective services or procedures for which there is evidence of a significant variation in cost that does not correspond to a variation in quality of care. Additional considerations include the relative complexity of the service, the potential for variation either across patients or during the course of a treatment, and the sufficient availability of providers in a geographic region.<br>3. Reference prices should be set at a level that reflects current market conditions and ensures that patients have access to a choice of providers. Prices should be reviewed annually and adjusted as necessary based on changes in market conditions.<br>4. Hospitals or facilities delivering services subject to reference pricing should avoid cost-shifting from one set of services to another.<br>5. Information about the services subject to reference pricing and the potential patient cost-sharing obligations must be fully transparent and easily accessible to patients and providers, both prior to and at the point of care. Educational materials should be made available to help patients and physicians understand the incentives and disincentives inherent in the reference pricing arrangement.<br>6. Insurance companies must notify | Retain. |

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| | | patients of all services subject to reference pricing at the time of health plan enrollment. Patients must be indemnified against any additional charges associated with changes to reference pricing policies for the balance of the contract period.<br>7. Insurers that use reference pricing must develop and maintain systems that allow patients to effectively and appropriately compare prices among providers, including systems that help patients calculate their estimated costs for each provider prior to seeking care.<br>8. Plan sponsors should continually monitor and evaluate the effect of reference pricing policies on access to high quality patient care and ensure that procedures are in place to make plan modifications as necessary. | |
| **H-185.941** | Patient Cost-Sharing Requirements for Hospital Inpatient and Observation Services | Our AMA will advocate that patients be subject to the same cost-sharing requirements whether they are admitted to a hospital as an inpatient, or for observation services. | Retain. |
| **H-185.975** | Requiring Third Party Reimbursement Methodology be Published for Physicians | Our AMA:<br>(1) urges all third party payers and self-insured plans to publish their payment policies, rules, and fee schedules;<br>(2) pursues all appropriate means to make publication of payment policies and fee schedules a requirement for third party payers and self-insured plans;<br>(3) will develop model state and federal legislation that would require that all third party payers and self-insured plans publish all payment schedule updates, and changes at least 60 days before such changes in payment schedules are enacted, and that all participating physicians be notified of such changes at least 60 days before changes in payment schedules are enacted.<br>(4) seeks legislation that would mandate that insurers make | Retain. |

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| | | available their complete payment schedules, coding policies and utilization review protocols to physicians prior to signing a contract and at least 60 days prior to any changes being made in these policies;<br>(5) works with the National Association of Insurance Commissioners, develop model state legislation, as well developing national legislation affecting those entities that are subject to ERISA rules; and explore the possibility of adding payer publication of payment policies and fee schedules to the Patient Protection Act; and<br>(6) supports the following requirements: (a) that all payers make available a copy of the executed contract to physicians within three business days of the request; (b) that all health plan EOBs contain documentation regarding the precise contract used for determining the reimbursement rate; (c) that once a year, all contracts must be made available for physician review at no cost; (d) that no contract may be changed without the physician's prior written authorization; and (e) that when a contract is terminated pursuant to the terms of the contract, the contract may not be used by any other payer. | |
| **H-185.997** | Insurance Coverage for Complete Maternity Care | Our AMA (1) reaffirms its policy of encouraging health insurance coverage for care of the newborn from the moment of birth;<br>(2) urges the health insurance industry and government to include in their plans, which provide maternity benefits, coverage for normal obstetrical care, and all obstetrical complications including necessary intrauterine evaluation and care of the unborn infant;<br>(3) urges the health insurance industry to offer such plans on the broadest possible basis;<br>(4) urges the health insurance industry to make available, on an optional basis, coverage for | Retain. |

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| | | treatment associated with voluntary control of reproduction;<br>(5) will advocate for expanding coverage of maternity care to dependent women under the age of 26 on their parents' large group plans; and<br>(6) will advocate that individual, small and large group health plans provide 60 days of newborn coverage for all newborns born to participants in the plan. | |
| **H-190.965** | Claims Denial and Payment Delays | Our AMA policy is that insurers should not deny payment on lost claims discovered beyond the required filing date when the physician has proof that the electronic or paper claim was filed in a timely manner. | Retain. |
| **H-190.970** | Status Report on the National Uniform Claim Committee and Electronic Data Interchange | The AMA advocates the following principles to improve the accuracy of claims and encounter-based measurement systems:<br>(1) the development and implementation of uniform core data content standards (e.g., National Uniform Claim Committee (NUCC) data set);<br>(2) the use of standards that are continually modified and uniformly implemented;<br>(3) the development of measures and techniques that are universal and applied to the entire health care system;<br>(4) the use of standardized terminology and code sets (e.g., CPT) for the collection of data for administrative, clinical, and research purposes; and<br>(5) the development and integration of strategies for collecting and blending claims data with other data sources (e.g., measuring the performance of physicians on a variety of parameters in a way that permits comparison with a peer group). | Retain. |
| **H-190.972** | Strategy for Eliminating Delayed Payments to Physicians by | It is the policy of our AMA that delayed payments to physicians and hospitals without justification by third party payers should be prohibited by law. | Retain. |

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| | Third Party Payers | | |
| **H-190.975** | Universality of CMS 1500 Form | The AMA will undertake the task of asking individual carriers and/or their representative organizations to maintain the universal contents and acceptance of specific data in the CMS 1500 Form so that it will remain as a truly universal form for the patient-doctor claim form. | Retain. |
| **H-190.979** | Insurance Company Filing Deadlines | Our AMA will work with the insurance industry so that where there is a specified filing deadline for services, this deadline is reset when insurance companies contend that they have either not received a filed claim or require additional supporting documentation. | Retain. |
| **H-190.981** | Required Timely Reimbursements by all Health Insurers | Our AMA will prepare and/or seek sponsorship of legislation calling for all health insurance entities and third-party payers--inclusive of not-for-profit organizations and health maintenance organizations--to pay for "clean" claims when filed electronically within 14 days and paper claims within 30 days, with interest accruing thereafter. These time periods should be considered ceilings, not floors or fixed differentials between paper and electronic claims. | Retain. |
| **H-220.939** | Activities of The Joint Commission | 1. Our AMA supports continued active AMA participation as a corporate member of The Joint Commission. 2. Pursuant to Policy 220.949 (AMA Policy Database), our AMA: (a) Advocates accountability through voluntary, professionally directed quality assurance mechanisms as part of every system of health care delivery; (b) Monitors the effects of The Joint Commission standards, surveys, and other activities on the quality, cost, and outcomes of care; (c) Retains its current role in The Joint Commission and continue to evaluate that role on a regular basis; and (d) Continues to investigate additional methods to facilitate participation in voluntary accreditation mechanisms. 3. Our | Retain. |

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| | | AMA establishes the following goals for AMA participation in The Joint Commission: (a) To assist The Joint Commission to define its mission, long-term goals, and role in the accreditation arena; (b) To assure continued physician involvement in medical decision-making by advocating a requirement for integrated medical delivery systems to have organized medical staffs; (c) To advocate the improvement of the quality and consistency of The Joint Commission accreditation process, surveyors, and survey reports; (d) To urge consideration of cost implications when revising The Joint Commission standards, developing and implementing other activities, and increasing the costs of surveys; (e) To work toward minimal revision of The Joint Commission standards, unless there is a clear need to change them to improve patient care or outcome, once the proposed medical staff standards for the 1996 AMH are finalized; (f) To urge The Joint Commission to focus on its accreditation activities and to provide accountability to the public for health services through private sector accreditation activities; and (g) To work toward The Joint Commission recognition as an accreditation body for integrated health care networks. | |
| **H-220.946** | Unreasonable Burden of The Joint Commission Standards and Surveys | The AMA requests The Joint Commission to study and consider the ability of small hospitals, particularly in rural areas, to bear the burden of the increasing demands on staff and financial resources in the implementation of the current and proposed standards; and urges The Joint Commission to eliminate standards that increase health care costs without demonstrably improving the quality of care. | Retain. |
| **H-220.959** | Compliance with The Joint Commission | The AMA Commissioners to The Joint Commission oppose the accreditation of hospitals that do | Retain. |

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| | Accreditation Standards | not adhere to The Joint Commission standards prohibiting unilateral amendment of medical staff bylaws by either the governing body or the medical staff. | |
| **H-220.983** | The Joint Commission Standard IV Should Not Tie Clinical Privilege Termination to Contract | The AMA does not believe The Joint Commission standards should dictate specific provisions of individual contracts between physicians and hospitals that are mutually agreeable to the parties. | Retain. |
| **H-225.989** | AMA Opposes Forcing Medical Staffs to Repay Hill-Burton Obligations of Free Medical Care | The AMA (1) opposes attempts to create new and arbitrary requirements for hospital compliance with the Hill-Burton Act by shifting responsibility for these requirements to hospital medical staffs; (2) believes that a hospital's Hill-Burton Act obligations should be satisfied in a manner that does not interfere with the professional rights of its medical staff; and (3) endorses exploration of means to assure equal access to medical care for the people of the U.S. | Retain. |
| **H-225.991** | Communication and Cooperation Between Hospital Management and Medical Staff | The AMA encourages hospitals to make known to physicians the diagnostic codes which are recorded by medical records and business departments so the accuracy of these diagnoses can be confirmed. | Retain. |
| **H-230.970** | Proper Notification of a Physician Regarding Possible Loss of Medical Staff Membership or Privileges | Except in the instance of summary suspension, hospital notification of possible loss of medical staff membership and/or privileges must be sent by certified mail, return receipt requested, or its equivalent. | Retain. |
| **H-235.971** | Amending Medical Staff Bylaws | The AMA provides the assistance of its legal staff to hospital medical staffs and county and state medical associations when a hospital board of directors unilaterally changes, amends, or substitutes medical staff bylaws, or denies seats to duly elected medical staff officers. | Retain. |
| **H-235.976** | Medical Staff Bylaws and | Our AMA reaffirms that (1) medical staff bylaws are a contract | Retain. |

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| | Medical Staff Autonomy | between the organized medical staff and the hospital; and (2) application for medical staff appointment and clinical privileges should provide that each member of the medical staff, as well as the hospital, is bound by the terms of the medical staff bylaws, and the terms of the medical staff bylaws should be incorporated by reference into the application. | |
| **H-235.987** | Right of Committees of Medical Staffs to Meet in Executive Sessions | The AMA (1) supports the right of any hospital medical staff committee to meet in executive session, with only voting members of the medical staff present, in order to permit open and free discussion of issues such as peer review and to maintain confidentiality; and (2) encourages individual medical staffs to incorporate provisions in their bylaws to affirm this right. | Retain. |
| **H-235.988** | Non-Physicians Voting on the Medical Staff | The AMA opposes any regulation that would mandate voting privileges for non-physician members of medical staffs. | Retain. |
| **H-240.961** | Definition of a Hospital Day | Our AMA defines a Hospital Day as a 24-hour period that begins at the hour of admission. | Retain. |
| **H-240.998** | Preferential Hospital Rates | Our AMA (1) opposes hospital charge/cost arrangements granting unwarranted advantage to any group of patients; and (2) urges all health care payers, government and private, to pay their equitable share of costs incurred by hospitals and other facilities consistent with a reasonable definition of full financial requirements. | Retain. |
| **H-260.980** | Clinical Laboratory Improvement Act of 1988 | 1. It is the policy of the AMA to (a) continue and intensify its efforts to seek appropriate and reasonable modifications in the proposed rules for implementation of the Clinical Laboratory Improvement Amendments (CLIA) 88; (b) communicate to Congress and to the Centers for Medicare & Medicaid Services (CMS) the positive contribution of physician office laboratory testing to high quality, cost effective care so that through administrative revision of | Retain-in-part. Rescind (2); accomplished by October 2015 sign-on letter to Congress. |

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| | | the regulations, clarification of Congressional intent and, if necessary, additional legislation, the negative impact of these proposed regulations on patient care and access can be eliminated; (c) continue to work with Congress, CMS, the Commission on Laboratory Assessment, and other medical and laboratory groups for the purposes of making the regulations for physicians' office laboratories reasonable, based on scientific data, and responsive to the goal of improving access to quality services to patients; (d) protest the reported high costs being considered for certification of laboratories and the limited number of laboratory categories proposed; (e) encourage all components of the federation to express to CMS and members of Congress their concerns about the effect of the proposed rules on access and cost of laboratory services; and (f) protest the very limited list of waivered tests.<br>2. Our AMA will send a letter to CMS stating that CLIA requirements regarding provider-performed microscopy procedures and annual competency assessments are overly burdensome for physicians and their practices. | |
| **H-280.964** | Medicare Certified Beds in Nursing Facilities | The AMA will work with CMS to eliminate any unnecessary requirements for designating by location Medicare Certified beds within a nursing facility, thus allowing each facility to flexibly apply the certified status to any appropriate bed within the facility. | Retain. |
| **H-285.917** | Stop Trial by Health Insurers | 1. Our AMA opposes (a) any health insurer’s efforts to make determinations regarding whether or not a physician has made a medical mistake; and (b) the practice of health plans using adverse event reporting data for purposes other than quality improvement and learning, as it could shift the focus of such reporting from improving patient | Retain. |

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| | | safety to fostering a punitive environment.<br>2. Our AMA will (a) inform all health insurance companies that they are not the appropriate entity for determining medical mistakes; and (b) encourage physicians to be aware of contractual provisions that would allow insurers to deny payment in the event of a medical mistake. | |
| **H-285.918** | Mandatory Subspecialty Consultation | Our AMA: (1) opposes the unilateral actions of hospitals and health care organizations to mandate specialty consultation for a patient with a specific disease state, when the mandate specifically denies the physician providing care the ability to determine medical necessity of the consultation and/or the consultation is not requested by the patient, and (2) discourages physicians from requesting hospital medical staff oversight committees, health plans and managed care organizations to mandate specialty consultations when the physician or physician group would gain financially from the mandatory consultation due to increased revenues from consultation billing, unless the consultation is required by law or regulation. | Retain. |
| **H-285.943** | Payment for Managed Care Administrative Services | Our 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 | Retain. |

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| | | phone precertification, utilization review activities, formulary review, etc.), to be assessed to the various insurers. | |
| **H-285.974** | Residents Working with Managed Care Programs | The AMA encourages managed care plans to allow residents to care for patients under faculty supervision in the inpatient and outpatient setting. | Retain. |
| **H-285.975** | Consensus Opinions | Policy of the AMA is that all managed care programs must provide, or offer reimbursement for acquisition of, sufficient opinions necessary to reach a conclusion regarding the management of a given medical condition. | Rescind. Superseded by Policy H-390.917.<br><br>**Consultation Follow-Up and Concurrent Care of Referral for Principal Care H-390.917** (1) It is the policy of the AMA that: (a) the completion of a consultation may require multiple encounters after the initial consultative evaluation; and (b) after completion of the consultation, the consultant may be excused from responsibility of the care of the patient or may share with the primary care physician in concurrent care; he/she may also have the patient referred for care and thus become the principal care physician. (2) The AMA communicate the appropriate use of consultation, evaluation and management, and office medical services codes to third party payers and advocate the appropriate reimbursement for these services in order to encourage high quality, comprehensive and appropriate consultations for patients. |
| **H-290.969** | Medicaid Waivers and Maintenance of Effort Requirements | Our AMA opposes any efforts to repeal the Medicaid maintenance of effort requirements in the ACA and American Recovery and Reinvestment Act (ARRA), which mandate that states maintain eligibility levels for all existing adult Medicaid beneficiaries until 2014 and for all children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019. | Rescind. No longer relevant. |
| **H-290.984** | Mandatory Enrollment of | The AMA, in keeping with its support for free market competition | Retain. |

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| | Medicare-Medicaid Patients in Managed Care Plans | among all modes of health care delivery and financing, strongly opposes mandatory enrollment of Medicare and/or Medicaid patients in managed care plans. | |
| **H-290.987** | Medicaid Waivers for Managed Care Demonstration Projects | (1) Our AMA adopts the position that the Secretary of Health and Human Services should determine as a condition for granting waivers for demonstration projects under Section 1115(a) of the Medicaid Act that the proposed project: (i) assist in promoting the Medicaid Act's objective of improving access to quality medical care, (ii) has been preceded by a fair and open process for receiving public comment on the program, (iii) is properly funded, (iv) has sufficient provider reimbursement levels to secure adequate access to providers, (v) does not include provisions designed to coerce physicians and other providers into participation, such as those that link participation in private health plans with participation in Medicaid, and (vi) maintains adequate funding for graduate medical education. (2) Our AMA advocates that CMS establish a procedure which state Medicaid agencies can implement to monitor managed care plans to ensure that (a) they are aware of their responsibilities under EPSDT, (b) they inform patients of entitlement to these services, and (c) they institute internal review mechanisms to ensure that children have access to medically necessary services not specified in the plan's benefit package. | Retain. |
| **H-315.968** | Privacy Issues Regarding Insurance Company Explanation of Benefits | 1. Our AMA advocates that electronic medical record (EMR) vendors be required to create user-triggered mechanisms that alert health care professionals of confidential medical information that should be safeguarded.<br>2. Our AMA encourages physicians to clearly identify health care information on both paper and electronic records that the patient has requested to be kept private. | Retain. |

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| | | 3. Our AMA encourages physicians to develop individualized treatment plans for minors aged 12-17, in collaboration with parents or guardians, that outline expectations for the services provided and transitions toward increased privacy as the minor ages into adulthood.<br>4. Our AMA encourages physicians to inform their patients that they can request confidential communications from their office and health insurer by alternate means or locations than the policy holder's contact information, and to provide their patients with a Health Insurance Portability and Accountability Act (HIPAA) Privacy Rights Request Form.<br>5. Our AMA advocates that health insurers be required to develop a method of listing health care services on Explanation of Benefits statements that would preserve confidentiality for all insured individuals.<br>6. Our AMA advocates that health insurers be required to communicate clear procedures to all insured dependents on how to request confidential communications.<br>7. Our AMA advocates that health insurers be required to create privacy protections for all insured individuals on information that is contained on their Internet websites. | |
| **H-315.992** | Copying Records for Audits | Our AMA supports taking appropriate action to ensure that the financial responsibility for producing or copying patient records at the request of any regulatory agency having the authority to do so shall be borne entirely by the requesting agency and the request for said records shall be made at least 30 days in advance of any deadline. | Retain |
| **H-320.956** | Advance Directives and Utilization Review | The policy of the AMA is that: (1) the prior existence of advance directives (expressions of intent to forgo resuscitative, extraordinary, | Retain. |

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| | | unwanted or other care highly unlikely to improve or stabilize health status) should not jeopardize the provision of medically appropriate care, if the care is consistent with agreed upon limits; (2) individual physicians should not be reprimanded by reviewing bodies for abiding by the wishes of patients when providing appropriate care to individuals who have exercised advance directives. | |
| **H-320.965** | Responsibility for Hospital Admissions | It is the policy of the AMA that the determination of the medical necessity for hospital admission should be made only by a Doctor of Medicine, or a doctor of osteopathy licensed in the same jurisdiction as the treating physician. | Retain. |
| **H-330.944** | New Durable Medical Equipment Requirements | The AMA will work with CMS to develop and implement an exemption policy for low-cost DME supplies that are dispensed by physicians through their offices, based on such factors as current Medicare payment amounts, whether the item is usually disposable, linkage to a particular physician treatment, and specialty society recommendations. Claim for such supplies under these circumstances would not be subject to CMS's DME regulatory requirements and would be submitted to the local Medicare carrier. | Retain. |
| **H-335.973** | Reimbursement Violations | Our AMA will urge physicians who experience problems with their Medicare carrier's application of Medicare review criteria to report those problems, issues or concerns to their state medical association and state "Medicare Carrier Advisory Committee" for discussion and resolution. | Retain |
| **H-385.927** | Additional Prompt Payment Advocacy | Our AMA continues to support state medical association and national medical specialty society efforts and work independently with federal and state legislators and agencies to provide for a percentage of the financial penalty and/or accrued interest to be paid directly to the physician in the | Retain. |

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| | | cases where payers do not make payment within the specified time frame. | |
| **H-385.948** | Reasonable Charge for Preauthorization | The AMA strongly supports and advocates fair compensation for a physician's administrative costs when providing service to managed care patients. | Retain. |
| **H-385.956** | Payment for Ethics Consultations | The policy of the AMA is that physician provision of clinical ethics consultations for the guidance of individual patients or physicians, apart from and beyond their duties as members of hospital ethics committees, is an appropriately compensable medical service. Payment for these services should be made when they are reported with the appropriate existing CPT consultation codes (and prolonged physician service codes, if appropriate). The AMA recognizes that this does not address any aspect of payment for ethics consultations by non-physicians. | Retain. |
| **H-385.959** | Primary and Consultative Care | The AMA will promulgate policies to recognize the services of internists, pediatricians, family physicians and obstetrician/gynecologists as capable of providing both primary care and consultative care. | Retain. |
| **H-390.867** | Medical Rehabilitation Services | The AMA believes: (1) Rehabilitation criteria for reimbursement should be defined by medical needs of patients for rehabilitative care that includes functional, cognitive, social considerations, and cognitive status, specifically the so called “three-hour rule” is not a valid exclusion criterion for entry into a rehabilitation unit nor can it be the basis for denial of ongoing coverage in such a unit. (2) The severity of medical conditions, regardless of settings, must be accounted for, including a case-mix approach adjusted for regional variances to meet individual patient needs for high quality, cost effective medical, rehabilitation services. | Retain. |

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| **H-390.976** | Delayed Payment of Medical Insurance Claims | Our AMA (1) expresses its concern and displeasure about CMS's practice of slowing payment of Medicare claims, which places an unwarranted financial burden upon the elderly and the practitioners and facilities which serve senior citizens; (2) supports model state legislation to establish incentives and/or penalties among private and public third party payers to rectify the problem of delayed insurance reimbursements; and (3) believes that reasonable interest should begin on uncontroverted claims not later than 30 days following receipt of a claim by the payer. | Rescind. Superseded by Policies H-190.959 and H-190.981 and AMA Model State Legislation.<br><br>**Physician Reimbursement by Health Insurance and Managed Care Companies H-190.959**<br>1. Our AMA shall make it a top priority to seek regulatory and legislative relief to ensure that all health insurance and managed care companies pay for clean claims submitted electronically within fourteen days.<br>2. When electronic claims are deemed to be lacking information to make the claim complete, the health insurance and managed care companies will be required to notify the health care provider within five business days to allow prompt resubmission of a clean claim.<br>3. Our AMA shall advocate for heavy penalties to be imposed on health insurance and managed care companies, including their employees, that do not comply with laws and regulations establishing guidelines for claims payment.<br>4. Our AMA will continue to encourage regulators to enforce existing prompt pay requirements.<br><br>**Required Timely Reimbursements by all Health Insurers H-190.981**<br>Our AMA will prepare and/or seek sponsorship of legislation calling for all health insurance entities and third-party payers--inclusive of not-for-profit organizations and health maintenance organizations--to pay for "clean" claims when filed electronically within 14 days and paper claims within 30 days, with interest accruing thereafter. These time periods should be considered ceilings, |

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| | | | not floors or fixed differentials between paper and electronic claims. |
| **H-390.985** | CMS Consultation with Physicians | The AMA encourages CMS to consult with clinically experienced practicing physicians on all determinations affecting medical practice and patient care. | Retain. |
| **H-390.987** | Medicare Assignments and Laboratory Reimbursements | The AMA supports educational efforts to assist physicians in differentiating between procedural billing and professional billing, particularly as they relate to billing for the drawing of a specimen and billing for interpreting the laboratory test results. | Retain. |
| **H-450.932** | Public Reporting of Quality and Outcomes for Physician-Led Team-Based Care | 1. Our AMA will advocate that internal reporting of quality and outcomes of team-based care should be done at both the team and individual physician level.<br>2. Our AMA will advocate that public reporting of quality and outcomes data for team-based care should be done at the group/system/facility level, and not at the level of the individual physician.<br>3. Our AMA reaffirms the intent of the codified mandate in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA 2008) that public reporting of quality and outcomes data for team-based care should be done at the group/system level, and not at the level of the individual physician.<br>4. Our AMA will advocate that the current regulatory framework of public reporting for Meaningful Use also provide "group-level reporting" for medical groups/organized systems of care as an option in lieu of requiring MU reporting only on an individual physician basis. | Retain. |
| **H-450.946** | Ensuring Quality in Health System Reform | Our AMA: (1) will discuss quality of care in each of its presentations on health system reform; (2) will advocate for effective quality management programs in health system reform that: (a) incorporate substantial input by actively | Rescind. Superseded by Policies H-450.966, H-450.970, H-450.994, and H-450.944. |

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| | | practicing physicians and physician organizations at the national, regional and local levels; (b) recognize and include key quality management initiatives that have been developed in the private sector, especially those established by the medical profession; and (c) are streamlined, less intrusive, and result in real reduced administrative burdens to physicians and patients; and (3) will take a leadership role in coordinating private and public sector efforts to evaluate and enhance quality of care by maintaining a working group of representatives of private and public sector entities that will: (a) provide for an exchange of information among public and private sector quality entities; (b) oversee the establishment of a clearinghouse of performance measurement systems and outcomes studies; (c) develop principles for the development, testing, and use of performance/outcomes measures; and (d) analyze and evaluate performance/outcomes measures for their conformance to agreed upon principles. | **Quality Management, H-450.966**<br>(1) continues to advocate for quality management provisions that are consistent with AMA policy;<br>(2) seeks an active role in any public or private sector efforts to develop national medical quality and performance standards and measures;<br>(3) continues to facilitate meetings of public and private sector organizations as a means of coordinating public and private sector efforts to develop and evaluate quality and performance standards and measures;<br>(4) emphasizes the importance of all organizations developing, or planning to develop, quality and performance standards and measures to include actively practicing physicians and physician organizations in the development, implementation, and evaluation of such efforts;<br>(5) urges national medical specialty societies and state medical associations to participate in relevant public and private sector efforts to develop, implement, and evaluate quality and performance standards and measures; and<br>(6) advocates that the following principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts: (a) Standards and measures shall have demonstrated validity and reliability. (b) Standards and measures shall reflect current professional knowledge and available medical technologies. (c) Standards and measures shall be linked to health outcomes and/or access to care. (d) Standards and measures shall be representative of the range of |

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| | | | health care services commonly provided by those being measured. (e) Standards and measures shall be representative of episodes of care, as well as team-based care. (f) Standards and measures shall account for the range of settings and practitioners involved in health care delivery. (g) Standards and measures shall recognize the informational needs of patients and physicians. (h) Standards and measures shall recognize variations in the local and regional health care needs of different patient populations. (i) Standards and measures shall recognize the importance and implications of patient choice and preference. (j) Standards and measures shall recognize and adjust for factors that are not within the direct control of those being measured. (k) Data collection needs related to standards and measures shall not result in undue administrative burden for those being measured.<br>(BOT Rep. 35, A-94; Reaffirmed: CMS Rep. 10, I-95; Reaffirmed: CMS Rep. 7, A-05; Modified: CMS Rep. 6, A-13; Reaffirmed in lieu of Res. 714, A-14; Reaffirmed in lieu of Res. 814, I-14; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmed in lieu of Res. 203, I-15; Reaffirmed in lieu of. Res. 216, I-15; Reaffirmed: BOT Rep. 20, A-16; Reaffirmed: CMS Rep. 02, I-17; Reaffirmation: A-22)<br><br>**Quality Management Principles, H-450.970**<br>Our AMA (1) continues to support the concept that physicians and healthcare organizations should strive |

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| | | | continuously to improve the quality of health care;<br>(2) encourages the ongoing evaluation of continuous quality improvement models;<br>(3) promotes implementation of effective quality improvement models; and<br>(4) identifies the useful approaches for assisting physicians in implementing quality improvement procedures in their medical practices and office management.<br>(BOT Rep. AA, A-92; Reaffirmed: CMS Rep. 9, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20)<br><br>**Quality of Care – Essentials and Guidelines for Quality Assessment H-450.995**<br>(1) Including favorable outcome as one characteristic, the AMA believes that medical care of high quality should: (a) produce the optimal possible improvement in the patient's physiologic status, physical function, emotional and intellectual performance and comfort at the earliest time possible consistent with the best interests of the patient;<br>(b) emphasize the promotion of health, the prevention of disease or disability, and the early detection and treatment of such conditions;<br>(c) be provided in a timely manner, without either undue delay in initiation of care, inappropriate curtailment or discontinuity, or unnecessary prolongation of such care;<br>(d) seek to achieve the informed cooperation and participation of the patient in the care process and in decisions concerning that process;<br>(e) be based on accepted principles of medical science and the proficient use of |

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| | | | appropriate technological and professional resources;<br>(f) be provided with sensitivity to the stress and anxiety that illness can generate, and with concern for the patient's overall welfare;<br>(g) make efficient use of the technology and other health system resources needed to achieve the desired treatment goal; and<br>(h) be sufficiently documented in the patient's medical record to enable continuity of care and peer evaluation.<br>(2) The AMA believes that the following guidelines for quality assessment should be incorporated into any peer review system. (a) The criteria utilized to assess the degree to which medical care exhibits the essential elements of quality should be developed and concurred in by the professionals whose performance will be reviewed.<br>(b) Such criteria can be derived from any one of the three basic variables of care: structure, process, or outcome. However, emphasis in the review process should be on statistically verifying linkages between specific elements of structure and process, and favorable outcomes, rather than on isolated examination of each variable.<br>(c) To better isolate the effects of structure and process on outcome, outcome studies should be conducted on a prospective as well as a retrospective basis to the degree possible.<br>(d) The evaluation of "intermediate" rather than "final" outcomes is an acceptable technique in quality assessment.<br>(e) Blanket review of all medical care provided is neither |

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| | | | practical nor needed to assure high quality of care. Review can be conducted on a targeted basis, a sampling basis, or a combination of both, depending on the goals of the review process. However, judgment as to performance of specific practitioners should be based on assessment of overall practice patterns, rather than solely on examination of single or isolated cases. By contrast, when general assessment of the quality of care provided by a given health care system or across systems is desired, random sampling of all care episodes may be the more appropriate approach.<br>(f) Both explicit and implicit criteria are useful in assessing the quality of care.<br>(g) Prior consultation as appropriate, concurrent and retrospective peer review are all valid aspects of quality assessment.<br>(h) Any quality assessment program should be linked with a quality assurance system whereby assessment results are used to improve performance.<br>(i) The quality assessment process itself should be subject to continued evaluation and modification as needed.<br>(CMS Rep. A, A-86; Reaffirmed: CMS Rep. E, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: BOT Action in response to referred for decision: Res. 718, A-17)<br><br>**Quality Assurance in Health Care H-450.994**<br>(1) Accountability through voluntary, professionally directed quality assurance mechanisms should be part of every system of health care delivery. The cost of quality assurance programs and activities should be considered a |

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| | | | legitimate element in the cost of care. (Reaffirmed: Res. 711, A-94)<br>(2) To fulfill their fundamental responsibility to maximize the quality of services, health care institutions should establish, through their governing bodies, a formal structure and process to evaluate and enhance the quality of their health care services. This should be accomplished by participation of the professional staff, management, patients and the general public. When appropriate, health care institutions should be urged by licensing and accrediting bodies to establish a formal committee to coordinate all quality assurance activities that occur among the various health care professions within the facility.<br>(3) Voluntary accreditation programs with standards that exceed those of state licensure and that focus on quality-of-care issues should be offered to all health care facilities. Various agencies that accredit health care facilities should develop a formal interagency structure to coordinate their activities and to resolve any inter-organizational problems that may arise.<br>(4) Public and private payment programs should limit their coverage for services provided in health care facilities to those that meet professionally acceptable standards of acceptable quality, should structure their reimbursement to support the improvement of quality, and should provide information on quality for the benefit of their subscribers.<br>(5) Educational programs on quality assurance issues for health care professionals should be expanded through the inclusion of such material in health professions education programs, in preceptorships, in |

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| | | | clinical graduate training and in continuing education programs. (6) Educational programs should be developed to inform the public about the various aspects of quality assurance. Health care facilities and national and local health care organizations should make information available to the public about the factors that determine the quality of care provided by health care facilities, and about the extent to which individual health care facilities meet professionally acceptable standards of quality. (7) Research should be undertaken to assess the effects of peer review programs and payment mechanisms on the overall quality of health care. (BOT Rep. NN, A-87; Modified: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: BOT Rep. 20, A-16; Reaffirmed: BOT Action in response to referred for decision: Res. 718, A-17) |
| **H-450.965** | Medical Staff Leadership in Continuous Quality Improvement | The AMA will work with the AHA to assure that hospitals, in their continuous quality improvement/total quality management (CQI/TQM) programs, include practicing physicians in the development and implementation of such programs, especially the development of criteria sets and clinical indicators; provide feedback on CQI/TQM findings to physicians on a confidential basis; and inform all members of the medical staff on the CQI/TQM programs developed. | Retain. |
| **H-450.997** | Quality Assurance and Peer Review for Hospital Sponsored Programs | The AMA urges hospital medical staffs to make certain that all hospital sponsored, initiated, or affiliated medical services have appropriate peer review and quality assurance programs. | Retain. |