REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-A-23

Subject: Council on Medical Service Sunset Review of 2013 House Policies

Presented by: Lynn Jeffers, MD, Chair

Referred to: Reference Committee G

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

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 (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

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to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

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

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

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

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RECOMMENDATION

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

POLICY #	Title	Text	Recommendation
D-130.965	On-Call Coverage Models	Our AMA will compile and make available to the physician community various examples of on-call solutions intended to avoid subjecting physicians to unrealistic and unduly burdensome on-call demands and educate AMA physician members regarding these options.	Retain. Still relevant.
D-160.934	Physician Participation in Multiple Medicare Accountable Care Organizations	Our AMA will continue to work with the Centers for Medicare & Medicaid Services to address accountable care organization (ACO) rules that preclude physician participation in multiple Medicare ACOs.	Retain. Still relevant.
D-165.939	Transitional Reinsurance Fees Under the Affordable Care Act	Our AMA will advocate that any proposed assessment on "issuers of insurance" (scheduled to commence in 2014 for a 3-year period), intended to fund a "risk adjustment program" to cushion insurers against any actual uncertainties surrounding the health status of the uninsured, be taken from administrative and medical management costs.	Retain-in-part. All is still relevant other than "(scheduled to commence in 2014 for a 3-year period)," which should be removed.
D-165.955	Status Report on Expanding Health Care Coverage to all Individuals, with an Emphasis on the Uninsured	1. Our AMA will continue to: (1) place a high priority on expanding health insurance coverage for all; (2) pursue bipartisan support for individually selected and owned health insurance through the use of adequately funded federal tax credits as a preferred long-term solution for covering all; and (3) explore and support alternative means of ensuring health care coverage for all. 2. Our AMA Board of Trustees will consider assisting Louisiana, and other Gulf Coast States if	Rescind. Superseded by Policies H-165.920, H-165.865, D-290.979, H-165.823, and H-165.904. **Individual Health Insurance H-165.920** Our AMA: (1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services; (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary

POLICY #	Title	Text	Recommendation
		they should desire, in developing and evaluating a pilot project(s) utilizing AMA policy as a means of dealing with the impending public health crisis of displaced Medicaid enrollees and uninsured individuals as a result of the recent natural disasters in that region.	interim step toward universal access; (3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, our AMA will: (a) Continue to support equal tax treatment for payment of health insurance coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes; (b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly; (c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and (d) Work toward establishment of safeguards, such as a health

POLICY #	Title	Text	Recommendation
			care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes; (4) will identify any further means through which universal coverage and access can be achieved; (5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it; (6) supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage; (7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons; (8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health

POLICY #	Title	Text	Recommendation
			insurance premium expenditures; (9) supports legislation requiring a "maintenance of effort" period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan; (10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage; (11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one; (12) supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax;

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			(13) advocates that, upon replacement, with tax credits, of the exclusion of employer-sponsored health insurance from employees' federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies; and (14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured. (15) Our AMA reaffirms our policies committed to our patients and their individual responsibility and freedoms consistent with our United States Constitution. **Medicaid Expansion D-290.979** Our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133 percent (138 percent FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded. 2. Our AMA will: (a) continue to advocate strongly for expansion of the Medicaid program to all states and reaffirm existing policies D-290.979, H 290.965 and

POLICY #	Title	Text	Recommendation
			H-165.823; and (b) work with interested state medical associations and national medical specialty societies to provide AMA resources on Medicaid expansion and covering the uninsured to health care professionals to inform the public of the importance of expanded health insurance coverage to all. **Principles for Structuring a Health Insurance Tax Credit H-165.865** (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-

POLICY #	Title	Text	Recommendation
			income persons who could not afford the monthly out-of-pocket premium costs. (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. (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. **Options to Maximize Coverage under the AMA Proposal for Reform H-165.823** That our AMA advocate for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians. 2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards: a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition. b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored

POLICY #	Title	Text	Recommendation
			coverage that meets standards for minimum value of benefits. c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice. d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option. e. The public option is financially self-sustaining and has uniform solvency requirements. f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans. g. The public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost. 3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards: a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.

POLICY #	Title	Text	Recommendation
			b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage. c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled. d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment. e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values. f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees. g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans. h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a

POLICY #	Title	Text	Recommendation
			special enrollment period. 4. Our AMA: (a) will advocate that any federal approach to cover uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status. **Universal Health Coverage H-165.904** Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories; (2) seeks federal legislation that would require the federal government to provide

POLICY #	Title	Text	Recommendation
			financial support to any individuals, organizations, and institutions providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans.
D-185.983	Diabetic Documentation Requirements	1. Our AMA Board of Trustees will consider a legal challenge, if appropriate, to the authority of the Centers for Medicare & Medicaid Services (CMS) and other health care insurers placing onerous barriers on diabetic patients to procure medically necessary durable medical equipment and supplies. 2. Our AMA Board of Trustees will consider a legal challenge, if appropriate, to the authority and policy of CMS and other insurers to practice medicine through their diabetes guidelines, and place excessive time and financial burdens without reimbursement on a physician assisting patients seeking reimbursement for supplies needed to treat their diabetes.	Rescind. Directive accomplished. Research by the AMA Office of General Counsel indicated a reasonable basis did not exist for bringing a lawsuit against CMS related to diabetic documentation requirements.
D-225.986	Blue Cross of California Quality of Care Allegations	Our AMA will reiterate its position stating that medical staffs shall not be impugned and quality of care issues not be imposed between insurance plans and hospitals as a means of addressing economic or contractual issues.	Retain. Still relevant.
D-225.988	Elimination of 48-Hour Signature Rule for Verbal Orders	Our AMA will, through the Organized Medical Staff Section, encourage hospital medical staffs to include policies, which consider	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		applicable state law, on authentication of all medical record entries, including telephone and verbal orders, in their medical staff bylaws.	
D-235.986	Random Drug Screening	Our AMA will develop model medical staff bylaws addressing random drug testing of medical staffs.	Rescind. Directive accomplished. The AMA Physician's Guide to Medical Staff Organization Bylaws includes sample bylaws that address drug screening for medical staff (see Section 5.7, "Drug Testing," pages 90-94).
D-285.998	Creation of Joint AMA Committee with Representatives from the America's Health Insurance Plans	Our AMA will continue to work with America's Health Insurance Plans and other appropriate organizations on issues of mutual interest.	Retain. Still relevant.
D-330.941	Medicare Outpatient Therapy Caps	Our AMA will not support Medicare outpatient rehabilitation therapy caps.	Retain. Still relevant.
D-330.958	Social Security Disability Medical Benefits	Our AMA will take an active role in supporting reduction of the waiting period to receive Social Security Disability medical benefits.	Retain. Still relevant.
D-330.961	Social Security Disability Medical Benefits	Our AMA will continue to monitor future research and related developments on Medicare benefits for Social Security disability recipients and will report and recommend further action to the House of Delegates as appropriate.	Retain. Still relevant.
D-335.983	Review of Self-Administered Drug List Alterations Under Medicare Part B	Our AMA will seek regulatory or legislative changes to require that any alterations to Self-Administered Drug lists made by Medicare Administrative Contractors shall be subject to Carrier Advisory Committee review and advisement.	Retain. Still relevant. SAD List approval does not yet involve Carrier Advisory Committee review and advisement.
D-390.975	Payment for Facilities Expenses in Physicians' Offices	Our AMA will (1) advocate that CMS increase allowed expenditures subject to the SGR target whenever CMS assigns new office expenses to codes that historically have only been performed in the hospital; and (2) incorporate this	Rescind. MACRA repealed the SGR.

POLICY #	Title	Text	Recommendation
		recommended administrative change into the other SGR system changes our AMA has advocated, such as removing drug spending from the SGR system and recognizing new coverage decisions.	
D-390.983	CMS Pharmaceutical Reimbursement Method	Our AMA will work to exclude pharmaceutical costs from the Sustainable Growth Rate formula.	Rescind. MACRA repealed the SGR.
D-400.985	Geographic Practice Cost Index	Our AMA will: (1) use the AMA Physician Practice Information Survey to determine actual differences in rural vs. urban practice expenses; (2) seek Congressional authorization of a detailed study of the way rents are reflected in the Geographic Practice Cost Index (GPCI); (3) advocate that payments under physician quality improvement initiatives not be subject to existing geographic variation adjustments (i.e., GPCIs); and (4) provide annual updates on the Centers for Medicare and Medicaid Services efforts to improve the accuracy of Medicare Economic Index weights and geographic adjustments and their impact on the physician payment schedule, and AMA advocacy efforts on these issues.	Retain-in-part: (4) (1) & (3) Accomplished; (2) Addressed by CMS. Suggest revising policy title to "MEI GPCI Impacts on the Physician Payment Schedule."
D-440.937	Vaccines for Children Program and the New CPT Codes for Immunization Administration	Our AMA will work with the American Academy of Pediatrics and other groups to convince the Centers for Medicare & Medicaid Services to allow state Medicaid agencies to pay physicians for using the new immunization administration codes (90460, 90461) to immunize eligible patients and to be paid fairly for their participation in the Vaccines for Children Program.	Retain. Still relevant.

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D-450.960	Improve the HCAHPS Rating System	Our AMA will urge the Centers for Medicare & Medicaid Services to modify the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scoring system so that it assigns a unique value for each rating option available to patients.	Rescind. The directive was accomplished by correspondence sent to CMS.
D-450.963	Align the Recognition Periods for the Bridges to Excellence and the National Committee on Quality Assurance Recognition Programs	Our AMA will request the Bridges to Excellence program to align its validation periods for its recognition programs with the validation periods of the National Committee on Quality Assurance recognition programs.	Rescind. Directive accomplished. A letter was sent to the Executive Director of the Health Care Incentives Improvement Institute requesting that the Bridges to Excellence program align its validation periods with those of the NCQA.
D-510.999	Veterans Health Administration Health Care System	Our AMA will: (1) urge state medical associations to encourage their members to advise patients who qualify for Veterans Health Administration (VHA) care of the importance of facilitating the flow of clinical information among all of the patient's health care providers, both within and outside the VHA system; (2) facilitate collaborative processes between state medical associations and VHA regional authorities, aimed at generating regional and institutional contacts to serve as single points of access to clinical information about veterans receiving care from both private physicians and VHA providers; and (3) continue discussions at the national level with the VHA and the Centers for Medicare and Medicaid Services (CMS), to explore the need for and feasibility of legislation to address VHA's payment for prescriptions written by physicians who have no formal affiliation with the VHA.	Retain-in-part. The following subsections are superseded by Policy H-510.983: (1) urge state medical associations to encourage their members to advise patients who qualify for Veterans Health Administration (VHA) care of the importance of facilitating the flow of clinical information among all of the patient's health care providers, both within and outside the VHA system; (2) facilitate collaborative processes between state medical associations and VHA regional authorities, aimed at generating regional and institutional contacts to serve as single points of access to clinical information about veterans receiving care from both private physicians and VHA providers; and **Expansion of U.S. Veterans Health Care Choices H-510.983** 1. Our AMA will continue to work with the Veterans Administration (VA) to provide quality care to veterans.

POLICY #	Title	Text	Recommendation
			2. Our AMA will continue to support efforts to improve the Veterans Choice Program (VCP) and make it a permanent program. 3. Our AMA encourages the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care, and that the VA develop criteria by which individual veterans may request alternative pathways. 4. Our AMA will support consolidation of all the VA community care programs. 5. Our AMA encourages the VA to use external assessments as necessary to identify and address systemic barriers to care. 6. Our AMA will support interventions to mitigate barriers to the VA from being able to achieve its mission. 7. Our AMA will advocate that clean claims submitted electronically to the VA should be paid within 14 days and that clean paper claims should be paid within 30 days. 8. Our AMA encourages the acceleration of interoperability of electronic personal and medical health records in order to ensure seamless, timely, secure and accurate exchange of information between VA and non-VA providers and encourage both the VA and physicians caring for veterans outside of the VA to exchange medical records in a timely manner to ensure efficient care. 9. Our AMA encourages the VA to engage with physicians providing care in the VA system to explore and develop solutions on improving the health care choices of veterans.

POLICY #	Title	Text	Recommendation
			10. Our AMA will advocate for new funding to support expansion of the Veterans Choice Program.
H-120.978	Principles of Drug Utilization Review	Our AMA adopts the following Principles of Drug Utilization Review. Principle 1: The primary emphasis of a DUR program must be to enhance quality of care for patients by assuring appropriate drug therapy. Characteristics: (a) While a desired therapeutic outcome should be cost-effective, the cost of drug therapy should be considered only after clinical and patient considerations are addressed; (b) Sufficient professional prerogatives should exist for individualized patient drug therapy. Principle 2: Criteria and standards for DUR must be clinically relevant. Characteristics: (a) The criteria and standards should be derived through an evaluation of (i) the peer-reviewed clinical and scientific literature and compendia; (ii) relevant guidelines obtained from professional groups through consensus-derived processes; (iii) the experience of practitioners with expertise in drug therapy; (iv) drug therapy information supplied by pharmaceutical manufacturers; and (v) data and experience obtained from DUR program operations. (b) Criteria and standards should identify underutilization as well as overutilization and inappropriate utilization. (c) Criteria and standards should be validated prior to use. Principle 3: Criteria and standards for DUR must be nonproprietary and must be developed and revised	Retain. Still relevant.

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		through an open professional consensus process. Characteristics: (a) The criteria and standards development and revision process should allow for and consider public comment in a timely manner before the criteria and standards are adopted. (b) The criteria and standards development and revision process should include broad-based involvement of physicians and pharmacists from a variety of practice settings. (c) The criteria and standards should be reviewed and revised in a timely manner. (d) If a nationally developed set of criteria and standards are to be used, there should be a provision at the state level for appropriate modification. Principle 4: Interventions must focus on improving therapeutic outcomes. Characteristics: (a) Focused education to change professional or patient behavior should be the primary intervention strategy used to enhance drug therapy. (b) The degree of intervention should match the severity of the problem. (c) All retrospective DUR profiles/reports that are generated via computer screening should be subjected to subsequent review by a committee of peers prior to an intervention. (d) If potential fraud is detected by the DUR system, the primary intervention should be a referral to appropriate bodies (e.g., Surveillance Utilization Review Systems). (e) Online prospective DUR programs should deny services only in cases of patient ineligibility, coverage limitations, or	

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		obvious fraud. In other instances, decisions regarding appropriate drug therapy should remain the prerogative of practitioners. Principle 5: Confidentiality of the relationship between patients and practitioners must be protected. Characteristic: The DUR program must assure the security of its database. Principle 6: Principles of DUR must apply to the full range of DUR activities, including prospective, concurrent and retrospective drug use evaluation. Principle 7: The DUR program operations must be structured to achieve the principles of DUR. Characteristics: (a) DUR programs should maximize physician and pharmacist involvement in their development, operation and evaluation. (b) DUR programs should have an explicit process for system evaluation (e.g., total program costs, validation). (c) DUR programs should have a positive impact on improving therapeutic outcomes and controlling overall health care costs. (d) DUR programs should minimize administrative burdens to patients and practitioners.	
H-120.981	Drug Utilization Review	(1) Our AMA supports DUR programs provided: (a) primary emphasis is placed on high quality patient care through improved prescribing by physicians, dispensing by pharmacists, and medication compliance by patients; (b) physicians are actively involved in the development, implementation, and maintenance of the DUR programs; (c) criteria and	Rescind. Superseded by Policy H-120.978. **Principles of Drug Utilization Review H-120.978** Our AMA adopts the following Principles of Drug Utilization Review. Principle 1: The primary emphasis of a DUR program must be to enhance quality of care for patients by assuring appropriate drug therapy. Characteristics: (a) While a

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		standards for prescribing are developed by physician organizations and they are based on the peer-reviewed medical literature and the experiences of physicians with expertise in drug therapy; (d) focused professional education is emphasized as the primary intervention strategy to improve physician prescribing, pharmacist dispensing, and patient compliance practices; and (e) the confidentiality relationship between physicians and their patients is maintained. (2) Our AMA supports interacting with appropriate pharmacy organizations to develop guidelines for prospective (point-of-sale) DUR that will decrease the incidence of adverse events from drug therapy. (3) Our AMA recognizes the right of government and private third party payers to include in DUR programs a component that addresses fraud and abuse, but reaffirms the right of physicians, who are so accused, to due process. (4) Our AMA opposes DUR programs of government or private third party payers that focus only on cost containment and prevent physicians from prescribing the most appropriate drugs for individual patients.	desired therapeutic outcome should be cost-effective, the cost of drug therapy should be considered only after clinical and patient considerations are addressed; (b) Sufficient professional prerogatives should exist for individualized patient drug therapy. Principle 2: Criteria and standards for DUR must be clinically relevant. Characteristics: (a) The criteria and standards should be derived through an evaluation of (i) the peer-reviewed clinical and scientific literature and compendia; (ii) relevant guidelines obtained from professional groups through consensus-derived processes; (iii) the experience of practitioners with expertise in drug therapy; (iv) drug therapy information supplied by pharmaceutical manufacturers; and (v) data and experience obtained from DUR program operations. (b) Criteria and standards should identify underutilization as well as overutilization and inappropriate utilization. (c) Criteria and standards should be validated prior to use. Principle 3: Criteria and standards for DUR must be nonproprietary and must be developed and revised through an open professional consensus process. Characteristics: (a) The criteria and standards development and revision process should allow for and consider public comment in a timely manner before the criteria and standards are adopted. (b) The criteria and standards development and revision process should include broad-based involvement of physicians and pharmacists from a variety of practice settings. (c) The criteria and standards should be reviewed

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			and revised in a timely manner. (d) If a nationally developed set of criteria and standards are to be used, there should be a provision at the state level for appropriate modification. Principle 4: Interventions must focus on improving therapeutic outcomes. Characteristics: (a) Focused education to change professional or patient behavior should be the primary intervention strategy used to enhance drug therapy. (b) The degree of intervention should match the severity of the problem. (c) All retrospective DUR profiles/reports that are generated via computer screening should be subjected to subsequent review by a committee of peers prior to an intervention. (d) If potential fraud is detected by the DUR system, the primary intervention should be a referral to appropriate bodies (e.g., Surveillance Utilization Review Systems). (e) Online prospective DUR programs should deny services only in cases of patient ineligibility, coverage limitations, or obvious fraud. In other instances, decisions regarding appropriate drug therapy should remain the prerogative of practitioners. Principle 5: Confidentiality of the relationship between patients and practitioners must be protected. Characteristic: The DUR program must assure the security of its database. Principle 6: Principles of DUR must apply to the full range of DUR activities, including prospective, concurrent and retrospective drug use evaluation. Principle 7: The DUR program operations must be structured to achieve the principles of DUR. Characteristics: (a) DUR

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			programs should maximize physician and pharmacist involvement in their development, operation and evaluation. (b) DUR programs should have an explicit process for system evaluation (e.g., total program costs, validation). (c) DUR programs should have a positive impact on improving therapeutic outcomes and controlling overall health care costs. (d) DUR programs should minimize administrative burdens to patients and practitioners.
H-130.955	Patient Responsibility of On-Call Physicians	The AMA urges hospital medical staffs to have written policies and procedures in place to delineate clearly the patient follow-up responsibilities of staff members who serve in an on-call capacity to the hospital emergency department.	Retain. Still relevant.
H-160.910	Worksite Health Clinics	It AMA policy that any individual, company, or other entity that establishes and/or operates worksite health clinics should adhere to the following principles: a) Worksite health clinics must have a well-defined scope of clinical services, consistent with state scope of practice laws. b) Worksite health clinics must establish a referral system with physician practices or other facilities for appropriate treatment if the patient's conditions or symptoms are beyond the scope of services provided by the clinic. c) Worksite health clinics that use nurse practitioners and other health professionals to deliver care must establish arrangements by which their health care practitioners have direct access to MD/DOs, as	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		consistent with state laws. d) Worksite health clinics must clearly inform patients in advance of the qualifications of the health care practitioners who are providing care, as well as the limitation in the types of illnesses that can be diagnosed and treated. e) Worksite health clinics should develop expertise in specific occupational hazards and medical conditions that are likely to be more common in the particular industry where the company offers products and services. f) Worksite health clinics must use evidence-based practice guidelines to ensure patient safety and quality of care. g) Worksite health clinics must measure clinical quality provided to patients and participate in quality improvement efforts in order to demonstrate improvement in their system of care. h) Worksite health clinics must adopt explicit and public policies to assure the security and confidentiality of patients' medical information. Such policies must bar employers from unconsented access to identifiable medical information so that knowledge of sensitive facts cannot be used against individuals. i) Worksite health clinics must establish protocols for ensuring continuity of care with practicing physicians within the local community. Such protocols must ensure after-hours access of employees and eligible family members, as well as the transmission of reports of all worksite clinic visits and treatments to the physicians	

POLICY #	Title	Text	Recommendation
		of patients with an identified community physician. j) Worksite health clinics administering immunizations must establish processes to ensure communication to the patient's medical home and the state immunization registry documenting what immunizations have been given. k) Patient cost-sharing for treatment received outside of the clinic must be affordable and not prohibit necessary access to care. l) Worksite health clinics should allow the involvement of community physicians in clinic operations. m) Employers implementing worksite health clinics should communicate the eligibility for services of employees' family members. n) Worksite health clinics should be encouraged to use interoperable electronic health records as a means of communicating patient information to and facilitating continuity of care with community physicians, hospitals and other health care facilities.	
H-160.911	Value of Group Medical Appointments	Our AMA promotes education about the potential value of group medical appointments for diagnoses that might benefit from such appointments including chronic diseases, pain, and pregnancy.	Retain. Still relevant.
H-160.952	Access to Specialty Care	The AMA: (1) continues to encourage primary care and other medical specialty organizations to collaborate in developing guidelines to delineate the clinical circumstances under which treatment by primary care physicians, referral for initial or ongoing specialist care, and direct patient self-	Rescind. Accomplished through CMMI TCPi.

POLICY #	Title	Text	Recommendation
		referral to other specialists are appropriate, timely, and cost-effective; (2) encourages the medical specialty organizations that develop referral guidelines to document the impact of the guidelines on the quality, accessibility, timeliness, and cost-effectiveness of care; and (3) urges all health plans that control access to services through a primary care case manager to cover direct access to and services by a specialist other than the case manager without financial penalty when that access is in conformance with such collaboratively developed guidelines.	
H-160.988	Health Care Coalitions	The AMA (1) supports health care coalitions that include strong physician participation so that primary emphasis is given to the quality, availability and access to medical care; and (2) encourages physicians in the clinical practice of medicine to take an active role in the development and activities of health care coalitions in their respective areas.	Retain. Still relevant.
H-165.830	Health Insurance Cancellations	Our AMA supports urgent efforts to maintain coverage while facilitating a smooth transition to alternative coverage options which offer 'meaningful coverage' as defined in Policy H-165.848 for individuals who have received cancellation notices from their health insurance companies as a result of the Affordable Care Act.	Retain. Still relevant for grandfathered plans.
H-185.961	Health Plan Coverage of Prescription Drugs	It is the policy of our AMA that third party payers should not establish a higher cost-sharing requirement exclusively for prescription drugs approved for coverage	Amend Policy H-110.990 to include specification of medical exception process. **Cost Sharing Arrangements for Prescription Drugs H-110.990**

POLICY #	Title	Text	Recommendation
		under a medical exceptions process.	Our AMA: 1. believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients; 2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes; 3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and patient-specific out-of-pocket costs of individual prescription drugs, taking into account insurance status or payer type, prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition; and 4. supports public and private prescription drug plans in offering patient-friendly tools and technology that allow patients to directly and securely access their individualized prescription benefit and prescription drug cost information. 5. payers should not establish a higher cost-sharing requirement exclusively for prescription drugs approved for coverage under a medical exceptions process.

POLICY #	Title	Text	Recommendation
H-185.962	Payment for Advanced Technologies	Our AMA vigorously opposes actions by medical insurers to deny payment for services simply on the basis of the size of medical equipment.	Retain. Still relevant.
H-185.967	Coverage of Children's Deformities, Disfigurement and Congenital Defects	1. The AMA declares: (a) that treatment of a minor child's congenital or developmental deformity or disorder due to trauma or malignant disease should be covered by all insurers; (b) that such coverage shall include treatment which, in the opinion of the treating physician, is medically necessary to return the patient to a more normal appearance (even if the procedure does not materially affect the function of the body part being treated); and (c) that such insurability should be portable, i.e., not denied as a pre-existing condition if the patient's insurance coverage changes before treatment has been either initiated or completed. 2. Our AMA will advocate for appropriate funding for comprehensive dental coverage (including dental implants) for children with orofacial clefting.	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
H-185.981	Third Party Responsibility for Payment	Our AMA (1) will develop, with the assistance of the Blue Cross and Blue Shield Association, the Group Health Association of America, the Health Insurance Association of America, and other relevant health care organizations, guidelines for a standardized system of verifying eligibility for health benefits; (2) will assume a leadership role with these organizations in the development of guidelines for a standardized system of verifying eligibility for health benefits; and (3) following the development of such guidelines, will work with major insurers and managed care plans to promote the development of a standardized, national health benefits verification system based on the guidelines, which would include an obligation on the part of the insurer or managed care plan to pay physicians for any services rendered to patients whose eligibility for benefits have been verified erroneously.	Rescind. ACA established EHBs and HHS Administrative Simplification Eligibility and Benefits Transaction covers inquiries and responses about a patient's eligibility for insurance benefits.
H-185.983	Patient's Out-of-Pocket Contributions to Private Health Insurance	(1) The AMA takes the position that the practice of basing copayments on a different basis than the third party reimbursement should be condemned. (2) If physicians learn that their patients' copayments are being computed on a different basis than the third party's reimbursement, they should inform their patients and, when appropriate, help them make fully informed, cost-conscious alternative choices about their insurance coverage. (3) If physicians suspect that copayments are being set unfairly, they should bring these matters to	Retain. Still relevant. Suggest revising every iteration of "copayments" to "copayments and coinsurance."

POLICY #	Title	Text	Recommendation
		the attention of the state insurance commissioner or other state regulator and ask for assistance from their state medical society.	
H-190.956	Errors in Electronic Claims	Our AMA will publicize and encourage physicians to make use of AMA resources created to help physicians submit accurate electronic claims, and advocates that at the time of claim confirmation or no later than two business days after receiving an electronic claim, a third-party payer should provide the physician with an exception report notifying the physician of all information that is missing from the claim, any errors in the claim, any attachment that is missing or in error, and any other circumstances which preclude the claim from being a clean claim.	Retain. Still relevant.
H-190.983	Submission of Electronic Claims Through Electronic Data Interchange	The AMA: (1) will take a leadership role in representing the interests of the medical profession in all major efforts to develop and implement EDI technologies related to electronic claims submission, claims payment, and the development of EDI standards that will affect the clinical, business, scientific, and educational components of medicine; (2) supports aggressive time tables for implementation of EDI as long as the implementation is voluntary, and as long as all payers are required to receive standard electronic claims and provide electronic reconciliation prior to physicians being required to transmit electronic claims; (3) supports the acceptance of the ANSI 837 standard as a uniform, but not exclusive, standard for those physicians who wish to bill	Rescind. Superseded by Policy H-190.978. **Promoting Electronic Data Interchange H-190.978** Our AMA: (1) adopts the following policy principles to encourage greater use of electronic data interchange (EDI) by physicians and improve the efficiency of electronic claims processing: (a) public and private payers who do not currently do so should cover the processing costs of physician electronic claims and remittance advice; (b) vendors, claims clearinghouses, and payers should offer physicians a full complement of EDI transactions (e.g., claims submission; remittance advice; and eligibility, coverage and benefit inquiry); (c) vendors, clearinghouses, and payers should adopt American National Standards Institute (ANSI) Accredited Standard's

POLICY #	Title	Text	Recommendation
		electronically; and (4) will continue to monitor the cost effectiveness of EDI participation with respect to rural physicians.	Committee (ASC) Insurance Subcommittee (X12N) standards for electronic health care transactions and recommendations of the National Uniform Claim Committee (NUCC) on a uniform data set for a physician claim; (d) all clearinghouses should act as all-payer clearinghouses (i.e., accept claims intended for all public and private payers); (e) practice management systems developers should incorporate EDI capabilities, including electronic claims submission; remittance advice; and eligibility, coverage and benefit inquiry into all of their physician office-based products; (f) states should be encouraged to adopt AMA model legislation concerning turnaround time for "clean" paper and electronic claims; and (g) federal legislation should call for the acceptance of the Medicare National Standard Format (NSF) and ANSI ASC X12N standards for electronic transactions and NUCC recommendations on a uniform data set for a physician claim. This legislation should also require that (i) any resulting conversions, including maintenance and technical updates, be fully clarified to physicians and their office staffs by vendors, billing agencies or health insurers through educational demonstrations and (ii) that all costs for such services based on the NSF and ANSI formats, including educational efforts be fully explained to physicians and/or their office staffs during negotiations for such contracted services; (2) continues to encourage physicians to develop electronic data interchange

POLICY #	Title	Text	Recommendation
			(EDI) capabilities and to contract with vendors and payers who accept American National Standards Institute (ANSI) standards and who provide electronic remittance advice as well as claims processing; (3) continues to explore EDI-related business opportunities; (4) continues to facilitate the rapid development of uniform, industry-wide, easy-to-use, low cost means for physicians to exchange electronically claims and eligibility information and remittance advice with payers and others in a manner that protects confidentiality of medical information and to assist physicians in the transition to electronic data interchange; (5) continues its leadership roles in the NUCC and WEDI; and. (6) through its participation in the National Uniform Claim Committee, will work with third party payers to determine the reasons for claims rejection and advocate methods to improve the efficiency of electronic claims approval.
H-20.906	Health and Disability Coverage for Health Care Workers at Risk for HIV and Other Serious Infectious Diseases	(1) Health Insurance A currently held health insurance policy of a health care worker should not be terminated, coverage reduced or restricted, or premiums increased solely because of HIV infection. (2) Disability Coverage a) Each health care worker should consider the risks of exposure to infectious agents posed by his/her type of practice and the likely consequences of infection in terms of changes needed in that practice mode and select disability insurance coverage	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		accordingly. The policy selected should contain a reasonable definition of "sickness" or "disability," an own-occupation clause, and guaranteed renewability, future insurability, and partial disability provisions; b) In making determinations of disability, carriers should take into consideration the recommendations of the professional and institutional staff with whom an infected health care worker is associated, including the worker's own personal physician; c) Since there are a variety of disability insurance coverages available and a diversity of practice modes, each health care professional should individually assess his/her risk of infection and that of his/her employees and select disability coverage accordingly.	
H-190.991	Excessive Requests for Information from Insurance Carriers and Delays in Processing Insurance Claims	1. It is the policy of our AMA (A) to continue to oppose excessive and unnecessary requests for additional information and unexplained delays in processing and payment by third party insurance carriers where a completed standard claim form for reimbursement has been submitted, and (B) that state medical societies should pursue existing AMA model legislation to require the payment of claims with interest where clean claims are not paid on a timely basis. 2. Our AMA will: (A) work with all payers to ensure that they stop the practice of delaying payments by asking for documentation to review,	Rescind. Superseded by Policy H-190.981. **Required Timely Reimbursements by all Health Insurers H-190.981** 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.

POLICY #	Title	Text	Recommendation
		prior to payment; and (B) work with payers to establish rules to continue to allow the payer to conduct prepayment documentation review if the payer has performed a post payment documentation review and proven that the provider has been submitting incorrect claims. 3. If efforts to work with payers to end the practice of delaying payments without reasonable justification fail, our AMA will seek legislation that would accomplish this.	

H-190.992	Electronic Claims Submission	It is the policy of the AMA to: (1) support, assist and encourage the use of electronic data interchange (EDI) and electronic media claims (EMC) by physicians; (2) support and continue its involvement in the development of uniform EMC format and technical requirements; (3) continue to support the elimination of the Medicare 14-day payment delay regulation following Medicare carrier receipt of a claim; and (4) oppose the establishment, at this time, of any time tables or plans for mandatory EMC or EDI use by physicians.	Rescind. Superseded by Policy H-190.978. **Promoting Electronic Data Interchange H-190.978** Our AMA: (1) adopts the following policy principles to encourage greater use of electronic data interchange (EDI) by physicians and improve the efficiency of electronic claims processing: (a) public and private payers who do not currently do so should cover the processing costs of physician electronic claims and remittance advice; (b) vendors, claims clearinghouses, and payers should offer physicians a full complement of EDI transactions (e.g., claims submission; remittance advice; and eligibility, coverage and benefit inquiry); (c) vendors, clearinghouses, and payers should adopt American National Standards Institute (ANSI) Accredited Standard's Committee (ASC) Insurance Subcommittee (X12N) standards for electronic health care transactions and recommendations of the National Uniform Claim Committee (NUCC) on a uniform data set for a physician claim; (d) all clearinghouses should act as all-payer clearinghouses (i.e., accept claims intended for all public and private payers); (e) practice management systems developers should incorporate EDI capabilities, including electronic claims submission; remittance advice; and eligibility, coverage and benefit inquiry into all of their physician office-based products; (f) states should be encouraged to adopt AMA model legislation concerning turnaround time for “clean” paper and electronic claims; and (g) federal legislation should call for the acceptance of the Medicare National Standard Format (NSF) and ANSI ASC X12N standards for electronic transactions and

POLICY #	Title	Text	Recommendation
			NUCC recommendations on a uniform data set for a physician claim. This legislation should also require that (i) any resulting conversions, including maintenance and technical updates, be fully clarified to physicians and their office staffs by vendors, billing agencies or health insurers through educational demonstrations and (ii) that all costs for such services based on the NSF and ANSI formats, including educational efforts be fully explained to physicians and/or their office staffs during negotiations for such contracted services; (2) continues to encourage physicians to develop electronic data interchange (EDI) capabilities and to contract with vendors and payers who accept American National Standards Institute (ANSI) standards and who provide electronic remittance advice as well as claims processing; (3) continues to explore EDI-related business opportunities; (4) continues to facilitate the rapid development of uniform, industry-wide, easy-to-use, low cost means for physicians to exchange electronically claims and eligibility information and remittance advice with payers and others in a manner that protects confidentiality of medical information and to assist physicians in the transition to electronic data interchange; (5) continues its leadership roles in the NUCC and WEDI; and (6) through its participation in the National Uniform Claim Committee, will work with third party payers to determine the reasons for claims rejection and advocate methods to

POLICY #	Title	Text	Recommendation
			improve the efficiency of electronic claims approval.
H-220.931	Evidence-Based Value of Joint Commission Standards and Measures	Our AMA asks The Joint Commission that all present and future standards and performance measures set forth by The Joint Commission be supported by the best available evidence.	Retain. Still relevant.
H-220.991	AMA Policy on Hospital Accreditation	The AMA (1) believes that the objective of hospital accreditation should be primarily to evaluate the quality of patient care, to provide recommendations for remedying deficiencies and improving the quality of patient care, and to withhold accreditation from those institutions which do not meet an acceptable standard of patient care; (2) opposes accreditation requirements which impose rigid, uniform, mandatory administrative procedures, methods of operation, nomenclature, or forms of organization for the hospital, its governing board, attending staff and committees; and (3) recognizes that excellence in patient care is more easily attainable when the accreditation process is flexible and is concerned with evaluating the quality of hospital service and not the administrative procedures or form of organization used to provide patient care.	Retain. Still relevant.
H-225.958	Insurance Plan Inquiries Regarding Quality of Care and Peer Review Issues	Our AMA insists that all insurance plan inquiries regarding quality of care and peer review issues be evaluated through objective due process and peer review; and supports a position stating that all future peer review and quality of care issues between insurance companies and medical staffs be brought to an objective	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		and neutral peer review body.	
H-225.962	Medical Staff Membership Category for Physicians Providing Telemedicine	The AMA recommends that organized medical staffs, as part of their responsibility for the quality of professional services provided by individuals with clinical privileges, identify to the governing body of the hospital/medical care organization those clinical services that can be provided by telemedicine; and recommends that organized medical staffs (a) amend the medical staff bylaws to allow physicians providing telemedicine to be granted and maintain medical staff membership if they meet other obligations of such membership and (b) incorporate Policy 160.937, regarding their responsibility for supervision of non-physician providers and technicians delivering services via telemedicine, in the medical staff bylaws or rules and regulations.	Retain. Still relevant.
H-225.968	Standard Admitting Orders	It is the policy of the AMA that any standard admitting orders are the responsibility of and should be developed and approved by the medical staff.	Retain. Still relevant.
H-225.970	Full Participation for All Members of Hospital Medical Staff	The AMA opposes efforts by hospital administrations or governing boards to abrogate the voting rights of the physicians who serve on the medical executive committee. The AMA will communicate to its members its strong concern about hospital administrations' or governing boards' efforts to limit the participation of any physician who serves on the medical executive committee in the self-governing medical staff.	Retain. Still relevant. Will be discussed by OMSS Policy Committee.

POLICY #	Title	Text	Recommendation
H-225.985	Medical Staff Review of Quality of Care Issues Prior to Exclusive Contract	The AMA believes that the medical staff should review and make recommendations to the governing body related to exclusive contract arrangements, prior to any decision being made, in the following situations: (1) the decision to execute an exclusive contract in a previously open department or service; (2) the decision to renew or otherwise modify an exclusive contract in a particular department or service; (3) the decision to terminate an exclusive contract in a particular department or service; and (4) prior to termination of the contract the medical staff should hold a hearing, as defined by the medical staff and hospital to permit interested parties to express their views on the hospital's proposed action.	Retain. Still relevant.
H-225.996	Computer-Based Hospital and Order System	The AMA supports the concept of early involvement and participation by the hospital medical staff in decisions as to installation of a hospital information system and in the development of policies governing the use of such a system in the institution.	Retain. Still relevant.
H-235.961	Employment Status and Eligibility for Election or Appointment to Medical Staff Leadership Positions	1. Our AMA adopted as policy the principle that a medical staff member’s personal or financial affiliations or relationships, including employment or contractual relationships with any hospital or health care delivery system, should not affect his or her eligibility for election or appointment to medical staff leadership positions, provided that such interests are disclosed prior to the member's election or appointment and in a manner consistent with the	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		requirements of the medical staff bylaws. 2. Our AMA will draft model medical staff bylaws provisions supporting the principle that a medical staff member's personal or financial affiliations or relationships, including employment or contractual relationships with any hospital or health care delivery system, should not affect his or her eligibility for election or appointment to medical staff leadership positions, provided that such interests are disclosed prior to the member's election or appointment and in a manner consistent with the requirements of the medical staff bylaws. 3. Our AMA encourages medical staffs and their advisors to consult the AMA Physician's Guide to Medical Staff Organization Bylaws and the AMA Conflict of Interest Guidelines for Organized Medical Staffs when developing policies for the disclosure of medical staff leaders' personal or financial affiliations or relationships and the management of resulting conflicts of interest.	
H-235.962	Medical Staff-Hospital Compacts	1. Given the limited utility of medical staff-hospital compacts relative to their significant potential unintended consequences, our AMA recommends that organized medical staffs and physicians not enter into compacts or similar agreements with their hospitals' governing bodies or administrations. Instead, the AMA encourages organized medical staffs and hospital governing bodies to: A. Clearly define within the medical staff bylaws the	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		obligations of each party; B. Outline within the medical staff bylaws the processes by which conflicts between the organized medical staff and the hospital governing body are to be resolved; and C. Regard the medical staff bylaws as a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. 2. Our AMA will publicize to medical staffs the pitfalls of medical staff-hospital compacts and modify as needed the Physician's Guide to Medical Staff Organization Bylaws.	
H-235.964	Preservation of Medical Staff Self-Governance	Our AMA strongly supports any hospital medical staff whose rights of self-governance are being threatened by the hospital administration or the governing body.	Retain. Still relevant.
H-235.972	Proxy Voting at Medical Staff Meetings	It is the policy of the AMA that proxy voting prior to or at medical staff meetings should not be permitted in medical staff bylaws.	Retain. Still relevant.
H-280.948	Long-Term Care Residents With Criminal Backgrounds	1. Our AMA encourages the long-term care provider and correctional care communities, including the American Medical Directors Association, the Society of Correctional Physicians, the National Commission on Correctional Health Care, the American Psychiatric Association, long-term care advocacy groups and offender advocacy groups, to work together to develop national best practices on how best to provide care to, and develop appropriate care plans for, individuals with violent criminal backgrounds or violent tendencies in long-term care facilities while	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		ensuring the safety of all residents of the facilities. 2. Our AMA encourages more research on how to best care for residents of long-term care facilities with criminal backgrounds, which should include how to vary approaches to care planning and risk management based on age of offense, length of incarceration, violent tendencies, and medical and psychiatric history. 3. Our AMA encourages research to identify and appropriately address possible liabilities for medical directors, attending physicians, and other providers in long-term care facilities caring for residents with criminal backgrounds. 4. Our AMA will urge the Society of Correctional Physicians and the National Commission on Correctional Health Care to work to develop policies and guidelines on how to transition to long-term care facilities for individuals recently released from incarceration, with consideration to length of incarceration, violent tendencies, and medical and psychiatric history.	
H-285.928	Health Plan and Fiscal Intermediary Insolvency Protection Measures	(1) It is the policy of the AMA that health plans should be legally responsible to pay directly for physician services in the event of an insolvency of fiscal intermediaries like groups, independent practice associations, and physician practice management companies. (2) Our AMA continues to advocate at the state level for protective measures for patients and physicians who are adversely affected by health insurers and their fiscal	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		intermediaries that declare insolvency, to include: (a) actuarially sound capitation rates and administrative costs; (b) submission of timely financial information by health plans to independent practice associations and medical groups; and (c) the establishment of financial and monetary standards for health plans, as well as for independent practice associations, and groups that assume financial risk unrelated to direct provision of patient care.	
H-285.929	Patient Notification of Physician Contract Termination	Our AMA encourages medical groups and other corporate entities, such as physician practice management corporations and limited liability corporations, to include in the contract language governing notification of patients regarding termination of a physician's contract, wording which is in compliance with Council on Ethical and Judicial Affairs Opinion 7.03 and/or model language developed by state medical societies.	Rescind. Superseded by Policy H-225.950. **AMA Principles for Physician Employment H-225.950** 1. Addressing Conflicts of Interest a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address. b) Employed physicians should be free to exercise their personal and professional judgment in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these

POLICY #	Title	Text	Recommendation
			interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization. c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority. d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients. (i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and (ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions. e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the

POLICY #	Title	Text	Recommendation
			practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience. 2. Advocacy for Patients and the Profession a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated. b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees. 3. Contracting a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession. b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.

POLICY #	Title	Text	Recommendation
			c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based. d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations,

POLICY #	Title	Text	Recommendation
			or other proceedings against the physician. (e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures. (f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff. (g) Physicians are discouraged from entering into agreements that restrict the physician’s right to practice medicine for a specified period of time or in a

POLICY #	Title	Text	Recommendation
			specified area upon termination of employment. (h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved. 4. Hospital Medical Staff Relations a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs. b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes. c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

POLICY #	Title	Text	Recommendation
			5. Peer Review and Performance Evaluations a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings. b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status. c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians. d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment. e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed

POLICY #	Title	Text	Recommendation
			physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc. (f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met: i. The agreement is for the provision of services on an exclusive basis; and ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned

POLICY #	Title	Text	Recommendation
			upon termination of the agreement. 6. Payment Agreements a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement. b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.
H-285.931	The Critical Role of Physicians in Health Plans and Integrated Delivery Systems	Our AMA adopts the following organizational principles for physician involvement in health plans and integrated delivery systems (IDS): (1) Practicing physicians participating in a health plan/IDS must: (a) be involved in the selection and removal of their leaders who are involved in governance or who serve on a council of advisors to the governing	Retain. Still relevant.

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

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

POLICY #	Title	Text	Recommendation
		and procedures to the practicing physicians who participate in the health plan/IDS. Participating physicians must have an identified process to access their physician representative. (10) Consideration should be given to compensating physician leaders/representatives involved in governance and management for their time away from practice. Our AMA aggressively advocates to private health care accreditation organizations the incorporation of the organizational principles for physician involvement into their standards for health plans, networks and integrated delivery systems.	
H-285.940	Denials of Payment for Necessary Services Because of Lack of Authorization	1. Our AMA seeks the elimination of clauses in managed care contracts that allow plans to refuse to pay for provision of covered services for the sole reason that required notification of these services was not reported in a timely manner. 2. Our AMA supports a requirement that payers provide a retro-authorization process, with reasonable timeframes for submission and consideration and with reasonable procedural standards for all tests, procedures, treatments, medications and evaluations requiring authorization.	Rescind. Superseded by Policy H-320.939. **Prior Authorization and Utilization Management Reform H-320.939** 1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care. 2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same

POLICY #	Title	Text	Recommendation
			medical specialty/subspecialty as the prescribing/ordering physician. 3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm. 4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.
H-315.973	Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data	1. It is AMA policy that any payer, clearinghouse, vendor, or other entity that collects and uses electronic medical records and claims data adhere to the following principles: a. Electronic medical records and claims data transmitted for any given purpose to a third party must be the minimum necessary needed to accomplish the intended purpose. b. All covered entities involved in the collection and use of electronic medical records and claims data must comply with the HIPAA Privacy and Security Rules. c. The physician must be informed and provide permission for any analysis undertaken with his/her electronic medical records and claims data, including the data being studied and how the results will be used. d. Any additional work required by the physician practice to collect data beyond the average data collection for the submission of transactions (e.g., claims,	Rescind. Superseded by Policy D-478.995. **National Health Information Technology D-478.995** 1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care. 2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C)

POLICY #	Title	Text	Recommendation
		eligibility) must be compensated by the entity requesting the data. e. Criteria developed for the analysis of physician claims or medical record data must be open for review and input by relevant outside entities. f. Methods and criteria for analyzing the electronic medical records and claims data must be provided to the physician or an independent third party so re-analysis of the data can be performed. g. An appeals process must be in place for a physician to appeal, prior to public release, any adverse decision derived from an analysis of his/her electronic medical records and claims data. h. Clinical data collected by a data exchange network and searchable by a record locator service must be accessible only for payment and health care operations. 2. It is AMA policy that any physician, payer, clearinghouse, vendor, or other entity that warehouses electronic medical records and claims data adhere to the following principles: a. The warehouse vendor must take the necessary steps to ensure the confidentiality, integrity, and availability of electronic medical records and claims data while protecting against threats to the security or integrity and unauthorized uses or disclosure of the information. b. Electronic medical records data must remain accessible to authorized users for purposes of treatment, public health, patient safety, quality improvement, medical liability defense, and research. c. Physician and patient	advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems. 3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs. 4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

POLICY #	Title	Text	Recommendation
		permission must be obtained for any person or entity other than the physician or patient to access and use individually identifiable clinical data, when the physician is specifically identified. d. Following the request from a physician to transfer his/her data to another data warehouse, the current vendor must transfer the electronic medical records and claims data and must delete/destroy the data from its data warehouse once the transfer has been completed and confirmed.	5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process. 6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability. 7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability. 8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records. 9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.
H-320.963	Disclosure of Medical Review Criteria and Eligibility Guidelines	The AMA will continue to press for the release of all Medicare carrier screens nationwide, including local screens, frequency parameters, and computer edits to identify claims for medical review.	Rescind. Superseded by Policies H-320.948 and H-340.898. **Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans H-320.948** It is the policy of our AMA, when a health plan or utilization review organization makes a determination to retrospectively deny payment for a medical service, or down-code such a service, the physician rendering the service, as well as the patient

POLICY #	Title	Text	Recommendation
			who received the service, shall receive written notification in a timely manner that includes: (1) the principal reason(s) for the determination; (2) the clinical rationale used in making the determination; and (3) a statement describing the process for appeal. **Medicare Review Activities H-340.898** Our AMA: (1) strongly urges CMS to provide physician organizations with the opportunity for significant comment and input on the Medicare Integrity Program; (2) continues to oppose any type of "bounty" system for compensation to any Medicare contractor, including those in the Medicare Integrity Program, and instead urge CMS to base compensation on the proper repayment of claims, rather than on the numbers of resulting referrals to law enforcement agencies; (3) continues to advocate for the ongoing involvement of physician organizations and hospital and organized medical staffs in refining and implementing any Medicare review contractor's activities and the need to emphasize physician education and clinical improvements; (4) urges CMS to delete all "incentives" or other "award fees" for any Medicare review contractor; and (5) urges CMS to clarify that in any Statement of Work or contract with a Medicare review contractor that: (a) extrapolation should not occur unless it is to develop educational or compliance program interventions; and (b) referrals to the Office of Inspector General should not occur unless a hospital does not respond to intervention or

POLICY #	Title	Text	Recommendation
			when significant evidence of fraud exists.
H-330.886	Strengthening Medicare Through Competitive Bidding	1. Our AMA supports the following principles to guide the use of competitive bidding among health insurers in the Medicare program: a. Eligible bidders should be subject to specific quality and financial requirements to ensure sufficient skill and capacity to provide services to beneficiaries. b. Bidding entities must be able to demonstrate the adequacy of their physician and provider networks. c. Bids must be based on a clearly defined set of standardized benefits that should include, at a minimum, all services provided under the traditional Medicare program and a cap on out-of-pocket expenses. d. Bids should be developed based on the cost of providing the minimum set of benefits to a standardized Medicare beneficiary within a given geographic region. e. Geographic regions should be defined to ensure adequate coverage and maximize competition for beneficiaries in a service area. f. All contracting entities should be required to offer beneficiaries a plan that includes only the standardized benefit package. Expanded benefit options could also be offered for beneficiaries willing to pay higher premiums. g. Processes and resources must be in place to provide beneficiary education and support for choosing among alternative plans. 2. Our AMA supports using a competitive bidding	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		process to determine federal payments to Medicare Advantage plans.	
H-330.902	Subsidizing Prescription Drugs for Elderly Patients	Our AMA strongly supports subsidization of prescription drugs for Medicare patients based on means testing.	Retain. Policy remains relevant through implementation of the IRA.
H-330.952	Medicare Carrier Advisory Committee	The AMA will advocate to all relevant parties (e.g., CMS and Medicare carriers) that the role of the state medical associations and state specialty societies in representing the interests and views of physicians in their respective states should not in any way be diminished by the operations of the Medicare Carrier Advisory Committee.	Retain. Still relevant.
H-330.958	Regionalization of Medicare Carriers	The AMA will continue to: (1) encourage state medical associations and national medical specialty societies to participate proactively in the Medicare Carrier "Notice and Comment" program with their respective carriers; and (2) monitor the impact of present and future Medicare carrier regionalization on the consistency of carrier interpretations and efficiency of operations.	Retain. Still relevant.
H-335.978	Medicare Fair Hearing	The AMA urges CMS to encourage Medicare carriers to utilize as Hearing Officers licensed physicians of the same specialty and in the same geographical area as that of the physician who requests the Fair Hearing and to make known to the requesting physician, prior to the Fair Hearing, the educational and medical credentials of the Hearing Officer.	Retain. Still relevant.
H-340.907	Notification When Physician Specific Information is Exchanged	The AMA will petition CMS to require notification of a physician under focused review that his or her name is being exchanged between any carrier and the QIOs and	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		to identify the reason for this exchange of information.	
H-365.997	Corporation or Employer-Sponsored Examinations	The AMA encourages employers who provide or arrange for special or comprehensive medical examinations of employees to be responsible for assuring that these examinations are done by physicians competent to perform the type of examination required. Whenever practical, the employee should be referred to his or her personal physician for such professional services. In the many instances in which an employee does not have a personal physician, efforts should be made to assist him or her in obtaining one, with emphasis on continuity of care. This effort should be aided by the local medical society wherever possible.	Retain. Still relevant.
H-373.999	Patient Advocacy/Protection Activities	The AMA will continue to aggressively pursue legislative, regulatory, communications and advocacy opportunities to identify and correct patient care and access problems created by new health care delivery mechanisms.	Retain. Still relevant.
H-375.977	Peer Review - Caused Litigation	The AMA urges medical staffs to review their hospital's policies for directors and officers liability and general liability coverage to determine if the policy provides defense, indemnity, or loss of income coverage for those members of the medical staff who are involved in a lawsuit as a result of the activities they have performed in good faith, conducting official peer review responsibilities or other official administrative duties of the medical staff.	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
H-375.978	Medical Peer Review Outside Hospital Settings	The AMA requests state medical associations to study the need for, and if appropriate, to pursue the enactment of, legislation designed to protect the records of peer review activities in ambulatory health care facilities against discoverability in judicial or administrative proceedings.	Rescind. Accomplished.
H-385.923	Definition of "Usual, Customary and Reasonable" (UCR)	1. Our AMA adopts as policy the following definitions: (a) “usual; fee means that fee usually charged, for a given service, by an individual physician to his private patient (i.e., his own usual fee); (b) a fee is ‘customary’ when it is within the range of usual fees currently charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area; and (c) a fee is ‘reasonable’ when it meets the above two criteria and is justifiable, considering the special circumstances of the particular case in question, without regard to payments that have been discounted under governmental or private plans. 2. Our AMA takes the position that there is no relationship between the Medicare fee schedule and Usual, Customary and Reasonable Fees.	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
H-385.962	Physician Bargaining	The AMA acknowledges that some state medical associations are in favor of a budgeting process that incorporates the ability for physician groups to bargain collectively on state-level budgets and will continue to support such state medical associations in their negotiations and development of budgeting process.	Rescind. Superseded by Policies H-165.888 and H-155.960. **Evaluating Health System Reform Proposals H-165.888** 1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles: A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs. B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed. C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be. D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and

POLICY #	Title	Text	Recommendation
			procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan. E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care. F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system. G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President. H. True health reform is impossible without true tort reform. 2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be

POLICY #	Title	Text	Recommendation
			specifically included in national health care reform legislation. 3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation. 4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients. **Strategies to Address Rising Health Care Costs H-155.960** Our AMA: (1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government; (2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease; (b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and (d) promote "value-based decision-making" at all levels; (3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and

POLICY #	Title	Text	Recommendation
			medical education and training; (4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers; (5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors; (6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings; (7) encourages third-party payers to use targeted benefit design, whereby patient cost-

POLICY #	Title	Text	Recommendation
			sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and (8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care. (9) Our AMA will, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system.
H-385.963	Physician Review of Accounts Sent for Collection	(1) The AMA encourages all physicians and employers of physicians who treat patients to review their accounting/collection policies to ensure that no patient's account is sent to collection without the physician's knowledge. (2) The AMA urges physicians to use compassion and discretion in sending accounts of their patients to collection, especially accounts of patients who are terminally ill, homeless, disabled, impoverished, or have marginal access to medical care.	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
H-390.884	Medicare Policy Change	Primary Care Consultation Policy: The AMA opposes Medicare's policy regarding denial of payment for consultation provided by primary care physicians for patients who are being cleared for surgery, as this policy is contrary to the best interests of Medicare patients and the fundamental goals of RBRVS, and will take any measures possible to have this policy changed.	Rescind. Superseded by Policy D-70.953. **Medicare's Proposal to Eliminate Payments for Consultation Service Codes D-70.953** Our American Medical Association opposes all public and private payer efforts to eliminate payments for inpatient and outpatient consultation service codes, and supports legislation to overturn recent Center for Medicare & Medicaid Services' (CMS) action to eliminate consultation codes. 2. Our AMA will work with CMS and interested physician groups through the CPT Editorial Panel to address all concerns with billing consultation services either through revision or replacement of the current code sets or by some other means. 3. Our AMA will, at the conclusion of the CPT Editorial Panel's work to address concerns with billing consultation services, work with CMS and interested physician groups to engage in an extensive education campaign regarding appropriate billing for consultation services. 4. Our AMA will: (a) work with the Centers for Medicare & Medicaid Services to consider a two-year moratorium on RAC audit claims based on three-year rule violations for E/M services previously paid for as consultations; and (b) pursue Congressional action through legislation to reinstate payment for consultation codes within the Medicare Program and all other governmental programs. 5. Our AMA will petition the CMS to limit RAC reviews to less than one year from payment of claims.

POLICY #	Title	Text	Recommendation
H-390.891	Hospital Services Provided Within Three Days of Hospital Admission	The AMA will resist strongly efforts to incorporate payment for Medicare Part B physician services into hospital payments.	Rescind. Superseded by Policy H-280.947. **Three Day Stay Rule H-280.947** 1. Our American Medical Association will continue to advocate that Congress eliminate the three-day hospital inpatient requirement for Medicare coverage of post-hospital skilled nursing facility services, and educate Congress on the impact of this requirement on patients. 2. Our AMA will continue to advocate, as long as the three-day stay requirement remains in effect, that patient time spent in the hospital, observation care or in the emergency department count toward the three-day hospital inpatient requirement for Medicare coverage of post-hospital skilled nursing facility services. 3. Our AMA will actively work with the Centers for Medicare and Medicaid Services (CMS) to eliminate any regulations requiring inpatient hospitalization as a prerequisite before a Medicare beneficiary is eligible for skilled (SNF) or long-term care (LTC) placement.
H-390.962	Notification to Patients of Charge Amounts Prior to Service as Per Omnibus Reconciliation Act of 1986	(1) The AMA opposes efforts by commercial carriers or the federal government which would require physicians to predict reimbursement for services rendered. (2) The AMA supports the repeal of the provision of OBRA 1986 regarding notification of patients receiving elective surgery of the physician charge, the expected amount of Medicare reimbursement, and the balance that the patient would be responsible for paying when the charge for the service is $500 or	Rescind. Superseded by Policy H-335.992. **Modifying the Medicare Unnecessary Services Program H-335.992** (1) The AMA continues to support the repeal of the "medically unnecessary" provisions of Section 9332(c) of OBRA 1986. (2) Until such time as repeal is achieved, the AMA urges CMS to require that there be stated on the medically unnecessary notices mailed by carriers (a) the basis for the denial; (b) the name, position, and title of the person

POLICY #	Title	Text	Recommendation
		more and the claim is not accepted on an assigned basis. (3) The AMA supports repeal of those provisions of OBRA that require physicians to refund payments associated with Medicare services that are deemed medically unnecessary by CMS after the fact. (4) The AMA believes that increases in Medicare reimbursement need to be universal, that current reimbursement should be adjusted and that there should be no discrimination in schedules between participating and nonparticipating physicians	to be contacted regarding questions about the review; and (c) the screening criteria or parameter used in denying payment for the service. Additionally, Policy H-330.892 supports physician choice of Medicare participation. **Medicare Participation Status H-330.982** It is AMA policy to eliminate any restrictions, including timing, on physicians' ability to determine their Medicare participation status.
H-390.992	Prospective Payment System and DRGs for Physicians	The AMA (1) endorses the concept that any system of reimbursement for physicians' services should be independent of reimbursement systems for other providers of health care; and (2) opposes expansion of prospective pricing systems until their impact on the quality, cost and access to medical care have been adequately evaluated.	Rescind. Superseded by Policy H-385.989. **Payment for Physicians Services H-385.989** Our AMA: (1) supports a pluralistic approach to third party payment methodology under fee-for-service, and does not support a preference for "usual and customary or reasonable" (UCR) or any other specific payment methodology; (2) affirms the following four principles: (a) Physicians have the right to establish their fees at a level which they believe fairly reflects the costs of providing a service and the value of their professional judgment. (b) Physicians should continue to volunteer fee information to patients, to discuss fees in advance of service where feasible, to expand the practice of accepting any third party allowances as payment in full in cases of financial hardship, and to communicate voluntarily to their patients their willingness to make appropriate arrangements in cases of financial need. (c) Physicians should have the

POLICY #	Title	Text	Recommendation
			right to choose the basic mechanism of payment for their services, and specifically to choose whether or not to participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service. (d) All methods of physician payment should incorporate mechanisms to foster increased cost-awareness by both providers and recipients of service; and (3) supports modification of current legal restrictions, so as to allow meaningful involvement by physician groups in: (a) negotiations on behalf of those physicians who do not choose to accept third party allowances as full payment, so that the amount of such allowances can be more equitably determined; (b) establishing additional limits on the amount or the rate of increase in charge-related payment levels when appropriate; and (c) professional fee review for the protection of the public. Additionally, Policy H-385.922 supports using the term "payment" instead of "reimbursement" as the term for compensating physicians. **Payment Terminology H-385.922** It is AMA policy to change the terminology used in compensating physicians from "reimbursement" to "payment."
H-400.984	Geographic Practice Costs	1. Our AMA will work to ensure that the most current, valid and reliable data are collected and applied in calculating accurate geographic practice cost indices (GPCIs) and in determining geographic	Rescind. (1) Addressed by PPI; (2) Addressed by CMS.

POLICY #	Title	Text	Recommendation
		payment areas for use in the new Medicare physician payment system. 2. Our AMA supports the use of physician office rent data, along with other practice expense data, to measure geographic variation in rent costs and to determine the proportion of overall costs that relate to rental expense. These data should be obtained through new or existing data sources that are accurate, standardized, verifiable and include per unit costs in physician offices.	
H-400.988	Medicare Reimbursement, Geographical Differences	The AMA reaffirms its policy that geographic variations under a Medicare payment schedule should reflect only valid and demonstrable differences in physician practice costs, especially liability premiums, with other non-geographic practice cost index (GPCI) -based adjustments as needed to remedy demonstrable access problems in specific geographic areas.	Rescind. Superseded by Policy H-155.957. **Geographic Variation in Health Care Cost and Utilization H-155.957** Our American Medical Association: (1) encourages further study into the possible causes of geographic variation in health care delivery and spending, with particular attention to risk adjustment methodologies and the effects of demographic factors, differences in access to care, medical liability concerns, and insurance coverage options on demand for and delivery of health care services; (2) encourages the development of interoperable national claims databases in order to facilitate research into health care utilization patterns across all segments of the health care delivery system; and (3) supports efforts to reduce variation in health care utilization that are based on ensuring appropriate levels of care are provided within the context of specific clinical parameters, rather than solely on aggregated benchmarks.

POLICY #	Title	Text	Recommendation
H-410.980	Principles for the Implementation of Clinical Practice Guidelines at the Local/State/Regional Level	Our AMA has adopted the following principles regarding the implementation of clinical practice guidelines at the local/state/regional level: (1) Relevant physician organizations and interested physicians shall have an opportunity for input/comment on all issues related to the local/state/regional implementation of clinical practice guidelines, including: issue identification; issue refinement, identification of relevant clinical practice guidelines, evaluation of clinical practice guidelines, selection and modification of clinical practice guidelines, implementation of clinical practice guidelines, evaluation of impact of implementation of clinical practice guidelines, periodic review of clinical practice guideline recommendations, and justifications for departure from clinical practice guidelines.. (2) Effective mechanisms shall be established to ensure opportunity for appropriate input by relevant physician organizations and interested physicians on all issues related to the local/state/regional implementation of clinical practice guidelines, including: effective physician notice prior to implementation, with adequate opportunity for comment; and an adequate phase-in period prior to implementation for educational purposes. (3) clinical practice guidelines that are selected for implementation at the local/state/regional level	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		shall be limited to practice parameters that conform to established principles, including relevant AMA policy on practice parameters. (4) Prioritization of issues for local/state/regional implementation of clinical practice guidelines shall be based on various factors, including: availability of relevant and high quality practice parameter(s), significant variation in practice and/or outcomes, prevalence of disease/illness, quality considerations, resource consumption/cost issues, and professional liability considerations. (5) clinical practice guidelines shall be used in a manner that is consistent with AMA policy and with their sponsors' explanations of the appropriate uses of their clinical practice guidelines, including their disclaimers to prevent inappropriate use. (6) clinical practice guidelines shall be adapted at the local/state/regional level, as appropriate, to account for local/state/regional factors, including demographic variations, patient case mix, availability of resources, and relevant scientific and clinical information. (7) clinical practice guidelines implemented at the local/state/regional level shall acknowledge the ability of physicians to depart from the recommendations in clinical practice guidelines, when appropriate, in the care of individual patients. (8) The AMA and other relevant physician organizations should develop principles to assist physicians in appropriate	

POLICY #	Title	Text	Recommendation
		documentation of their adherence to, or appropriate departure from, clinical practice guidelines implemented at the local/state/regional level. (9) clinical practice guidelines, with adequate explanation of their intended purpose(s) and uses other than patient care, shall be widely disseminated to physicians who will be impacted by the clinical practice guidelines. (10) Information on the impact of clinical practice guidelines at the local/state/regional level shall be collected and reported by appropriate medical organizations.	
H-415.999	Preferred Provider Organizations	The AMA believes that state and local medical societies should (1) monitor PPOs which develop in their areas and should apprise their members of the status, structure and extent of physician and provider enrollment in any such plans; and (2) consider investigating the pros and cons of the society itself serving as an organizational focus for local physicians' effective and informed responses to PPOs, without compromising support for the existing policy of pluralism in health care delivery systems.	Retain. Still relevant.
H-440.840	Patient Access to Anti-Tuberculosis Medications	Our AMA supports state and federal policy to cover TB testing for individuals deemed to have a high risk for contracting TB infection and to provide anti-tuberculosis medications to patients with both active and latent TB free of charge or insurance co-pays or deductibles in order to prevent the transmission of	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		this airborne infectious disease.	
H-465.982	Rural Health	The AMA: (1) encourages state medical associations to study the relevance of managed competition proposals to meeting health care needs of their rural populations; (2) encourages state associations to work with their respective state governments to implement rural health demonstration projects; and (3) will provide all adequate resources to assist state associations in dealing with managed competition in rural areas.	Retain. Still relevant.
H-480.948	Medicare/Medicaid Coverage of Multi-Use Technology Platforms	AMA policy is that third party payers, including the Medicare and Medicaid programs, should investigate the possibility of allowing patients to use common consumer electronic devices as assistive devices and reimburse patient expenses related to the acquisition of such devices when used for bona fide health care needs.	Rescind. Superseded by Policies H-480.943 and H-385.919. **Integration of Mobile Health Applications and Devices into Practice H-480.943** 1. Our AMA supports the establishment of coverage, payment and financial incentive mechanisms to support the use of mobile health applications (mHealth apps) and associated devices, trackers and sensors by patients, physicians and other providers that: (a) support the establishment or continuation of a valid patient-physician relationship; (b) have a high-quality clinical evidence base to support their use in order to ensure mHealth app safety and effectiveness; (c) follow evidence-based practice guidelines, especially those developed and produced by national medical specialty societies and based on systematic reviews, to ensure patient safety, quality of care and positive health outcomes; (d) support care delivery that is patient-centered, promotes care coordination and facilitates team-based communication; (e) support data portability and

POLICY #	Title	Text	Recommendation
			interoperability in order to promote care coordination through medical home and accountable care models; (f) abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services facilitated by the app; (g) require that physicians and other health practitioners delivering services through the app be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and (h) ensure that the delivery of any services via the app be consistent with state scope of practice laws. 2. Our AMA supports that mHealth apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and security of patients' medical information. 3. Our AMA encourages the mobile app industry and other relevant stakeholders to conduct industry-wide outreach and provide necessary educational materials to patients to promote increased awareness of the varying levels of privacy and security of their information and data afforded by mHealth apps, and how their information and data can potentially be collected and used. 4. Our AMA encourages the mHealth app community to work with the AMA, national medical specialty societies, and other interested physician groups to develop app transparency principles, including the provision of a standard privacy notice to patients if apps collect, store and/or transmit protected health information.

POLICY #	Title	Text	Recommendation
			5. Our AMA encourages physicians to consult with qualified legal counsel if unsure of whether an mHealth app meets Health Insurance Portability and Accountability Act standards and also inquire about any applicable state privacy and security laws. 6. Our AMA encourages physicians to alert patients to the potential privacy and security risks of any mHealth apps that he or she prescribes or recommends, and document the patient's understanding of such risks 7. Our AMA supports further development of research and evidence regarding the impact that mHealth apps have on quality, costs, patient safety and patient privacy. 8. Our AMA encourages national medical specialty societies to develop guidelines for the integration of mHealth apps and associated devices into care delivery. **Payment for Electronic Communication H-385.919** Our AMA will: (1) advocate that pilot projects of innovative payment models be structured to include incentive payments for the use of electronic communications such as Web portals, remote patient monitoring, real-time virtual office visits, and email and telephone communications; (2) continue to update its guidance on communication and information technology to help physicians meet the needs of their patients and practices; and (3) educate physicians on how to effectively and fairly bill for electronic communications between patients and their physicians.
H-510.990	Health Care Policy for Veterans	Our AMA encourages the Department of Veterans Affairs to continue to	Rescind. Superseded by Policies H-510.983 and H-510.985.

POLICY #	Title	Text	Recommendation
		explore alternative mechanisms for providing quality health care coverage for United States Veterans, including an option similar to the Federal Employees Health Benefit Program (FEHBP).	**Expansion of US Veterans' Health Care Choices H-510.983** 1. Our AMA will continue to work with the Veterans Administration (VA) to provide quality care to veterans. 2. Our AMA will continue to support efforts to improve the Veterans Choice Program (VCP) and make it a permanent program. 3. Our AMA encourages the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care, and that the VA develop criteria by which individual veterans may request alternative pathways. 4. Our AMA will support consolidation of all the VA community care programs. 5. Our AMA encourages the VA to use external assessments as necessary to identify and address systemic barriers to care. 6. Our AMA will support interventions to mitigate barriers to the VA from being able to achieve its mission. 7. Our AMA will advocate that clean claims submitted electronically to the VA should be paid within 14 days and that clean paper claims should be paid within 30 days. 8. Our AMA encourages the acceleration of interoperability of electronic personal and medical health records in order to ensure seamless, timely, secure and accurate exchange of information between VA and non-VA providers and encourage both the VA and physicians caring for veterans outside of the VA to exchange medical records in a timely

POLICY #	Title	Text	Recommendation
			manner to ensure efficient care. 9. Our AMA encourages the VA to engage with physicians providing care in the VA system to explore and develop solutions on improving the health care choices of veterans. 10. Our AMA will advocate for new funding to support expansion of the Veterans Choice Program. **Access to Health Care for Veterans H-510.985** Our American Medical Association: (1) will continue to advocate for improvements to legislation regarding veterans' health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the Veterans Administration health care system; (2) will monitor implementation of and support necessary changes to the Veterans Choice Program's "Choice Card" to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the Veterans Administration health care system; (3) will call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans; (4) will advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician; (5) will advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans; and

POLICY #	Title	Text	Recommendation
			(6) will support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation's veterans.
H-55.994	Coverage of Chemotherapy in Physicians' Offices	The AMA advocates that physicians who bill any third party payer for administering chemotherapy should ensure that the services billed for are described adequately and fully on the appropriate claim form and that the chemotherapy descriptors and code numbers provided by CPT are utilized.	Retain. Still relevant.
H-55.995	Medicare Coverage of Outpatient Chemotherapy Drugs	Carriers should recognize and encourage the administration of chemotherapy in physicians' offices, wherever practical and medically acceptable, as being more cost-effective than administration in many other settings.	Retain. Still relevant.
H-70.980	Bundling CPT Codes	1. Our AMA, through its CPT Editorial Panel and Advisory Committee, will continue to work with CMS to provide physician expertise commenting on the medical appropriateness of code bundling initiatives for Medicare payment policies. 2. Our AMA strongly urges the Centers for Medicare & Medicaid Services (CMS) to not treat bundling of existing services into a common code as a new procedure and new code. 3. Our AMA will advocate for a phase-in of new values for codes where the cuts resulting from the identification of misvalued services cause a significant reduction from the value of	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		the existing codes and work with CMS to achieve a smooth transition for such codes. 4. The RUC will take into consideration CMS's willingness or reluctance to transition large payment reductions as it schedules the review of relative values for bundled services or other codes that come before the RUC as a result of the identification of potentially misvalued services. 5. Our AMA strongly supports RUC recommendations and any cuts by CMS beyond the RUC recommendations will be strongly opposed by our AMA.	
H-75.988	Extension of Medicaid Coverage for Family Planning Services	The AMA supports legislation that will allow states to extend Medicaid coverage for contraceptive education and services for at least two years postpartum for all eligible women.	Retain. Still relevant.
H-90.971	Enhancing Accommodations for People with Disabilities	Our AMA encourages physicians to make their offices accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.	Retain. Still relevant.
H-90.986	SSI Benefits for Children with Disabilities	The AMA will use all appropriate means to inform members about national outreach efforts to find and refer children who may qualify for Supplemental Security Income benefits to the Social Security Administration and promote and publicize the new rules for determining disability.	Retain. Still relevant.