REFERENCE COMMITTEE J

SUMMARY REPORT FOR THE NEW ENGLAND DELEGATION

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CONSENT CALENDAR FOR APPROVAL

BOT 9 - Hospital Closures and Physician Credentialing
The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 716-A-18 and that the remainder of the report be filed: This document allows physicians to obtain copies of their credentials and privileges before closure of a hospital. Also develops state legislation requiring preservation of medical staff credentials, notification to state authorities of a closing and a plan for these files by the hospital. Lastly our AMA would develop a data base for physician credentialing and a clearinghouse for verification of credentialing information. Running the clearinghouse will be a significant investment in time and funds. There is some question about the demand for such a service and associated costs.

Joint Council Report CMS and CSAPH: Aligning Clinical and Financial Incentives for High-Value Care
Supports “value based decision making” and cooperation between physicians, patients, insurers and government to create targeted benefit design and tailor patient cost sharing arrangements tied to income and other compliance factors. Physicians should be actively involved in Value Based Insurance Design (VBID). Consideration should be given to the clinical benefit derived and where and who provides the service. Some examples would be helpful. This will need further study. Further our AMA support benefit design reform that integrates patient, provider and payer to promote quality care. Our AMA develops coding guidance for all parties on what is covered and the cost sharing levels. Especially for preventive services, that may include no cost sharing by patients. This is consistent with ACA 2010 legislation. Also for high value care, benefit design aligns patient financial incentives. I think we can support all of the new policy recommendations.

CMS Report 01: Prescription Drug Importation for Personal Use
Our AMA support individual purchase of prescription drugs from Canadian pharmacies when product integrity is assured, in limited amounts and for personal use. In addition, the FDA should administer a program that allows the above and have appropriate funding. This report supports purchase by wholesalers and pharmacies. It opposes Internet purchases for personal use due to safety concerns. I think all of this can be supported. Price transparency will be critical for in person and for wholesalers and pharmacies purchases.

CMS Report 02: Air Ambulance Regulations and Payments
Our AMA supports education to all parties, physicians, the public, first responders on the costs of inappropriate emergency transport use and develop non emergent transportation systems. Also create cost transparency on air ambulances in addition to best practices.

CMS Report 03: Sustain Patient-Centered Medical Home Practices
Our AMA reaffirms the importance of the PCMH to patients and the additional work for physicians and other members of the team. The resolution asks for financial risk limited to costs that are within the control of the physician. In addition, our AMA should ask CMS and other stakeholders to financially support practices in their efforts to become and sustain medical homes. The Medicare incentive payments should come from reductions in other areas such as Part A, D, and C. Specifically reductions in hospital admissions, effective pharmacotherapy and eliminating subsidies for Medicare Advantage Plans.

CMS Report 04 The Site-of-Service Differential
The Council on Medical Service recommends that the following be adopted in lieu of Resolution 817-I-17, and the remainder of the report be filed: Our AMA support equity in payment for the same services irrespective of site (hospital outpatient department) or physician offices. It specifically asks for CMS to implement this policy. It also asks our AMA to develop a data base on physician practice costs and changes over time. The report asks for changes to site neutrality occur without reduction in payment. Of note is that it also asks for compilation of data on true site costs, which may vary by site. This could potentially offset site neutrality. It recommends research on the savings to Medicare from physician services and allocation of funds to support its importance in quality healthcare.
It also asks for periodic surveys by CMS on the practice expense component of the physician fee schedule. Developing a credible and accurate survey tool remains a challenge. Total costs are substantial to our AMA at $100000-200000 dollars.

801 Encourage Final Evaluation Reports of Section 1115 Demonstrations at the End of the Demonstration Cycle
The issue this resolution addresses is the lack of timely evaluations of Section 1115 demonstration projects that use Federal Medicaid funds at the state level. At present the evaluations are required at the end of the project. At times there are multiple renewals over years without any interim reports. The GAO has cited the lack of usefulness of these reports for federal decision making and they have recommended to CMS that they establish evaluation reports at the end of each cycle, criteria for limited evaluations and public release of findings. This is new HOD Policy submitted by the Medical Student Section and consistent with previous AMA Policy for transparency, monitoring and evaluation.

802 Due Diligence for Physicians and Practices Joining an ACO with Risk Based Models (Up Side and Down Side Risk)
This Resolution is submitted by the New England Delegation. The resolution asks AMA to support maintaining the up side risk only (MSSP ACO) model in addition to the two sided risk model. The argument is that in those ACO’s to date that have taken on downside risk, there has been minimal savings for most with substantial upfront and ongoing costs that are only feasible for large and well funded organizations. If the only option is two sided risk, it may dissuade small practices and organization from joining the ACO model and lead to further consolidation and takeover by financial firms and large systems. The second resolve is a directive for action to develop resources to help physicians evaluate integrated hospital systems before making a commitment. This Resolution clause could be broadened to include not just hospital systems but physician owned systems. The third resolve is also a directive for action to study successful physician owned MSSP ACOs to help physicians in smaller practices develop their own ACO’s . This seems reasonable but it is unclear how much proprietary information will be released by these organizations.

803 Insurance Coverage for Additional Recommended Screening in States with Laws Requiring Notification of "Dense Breasts" on Mammogram
At present AMA policy only supports insurance coverage for screening mammography. This resolution asks for broader coverage and access to supplemental screening for patients with “dense breasts” after a conversation between the patient and physician. This resolution would be strengthened if supported by position statements from organizations in support of supplemental screening. MSS supports deleting the first resolve and keeping the second resolve.

804 Arbitrary Documentation Requirements for Outpatient Services
This resolution proposed by the Alaska delegation addresses the “72 hour” rule for documentation completion for outpatient services for payment. The resolution asks the AMA to require documentation be completed in “a timely manner” and if more specific definitions are needed, to adopt a 14 day timeframe. This would be new AMA policy. The Directive to Action is for our AMA to educate government and private health plans about the adverse consequences of “unrealistic time frames” and linking payment. It seems reasonable to ask health plans not be prescriptive, but this may need further study on the rate of non-timely documentation and its clinical consequences. For example, the surgical/procedure note should be available prior to a two week time frame.

805 Prompt Pay
AMA policy currently supports a 14 day prompt payment for “clean claims”. Citing technological improvements, this resolution asks our AMA to change the 14 day period to three days. Further, for claims requiring further clarification, the provider should be notified within one business day and not five business days as is present insurance policy. It also asks for heavy penalties to health plans and their employees for non compliance. This is modified AMA policy. I believe the resolution is asking for a three “business day” period. I am not sure if “employees” should be individually responsible (current policy). There is also current AMA policy that supports state society efforts to enforce state level prompt pay statutes that may supersede federal statutes.
**Telemedicine Models and Access to Care in Post-Acute and Long-Term Care**
The Resolutions seeks to eliminate limits on telemedicine visits by practitioners in nursing facilities. It supports evidence based and medical necessity criteria for care and payment. It asks for the Society for Post-Acute and Long-Term Care Medicine to effect change in Medicare policy using the Physician Fee Schedule and Quality Payment Program. This seems like a reasonable resolution with the movement to telemedicine in general and especially in an ACO structure to provide high quality and cost-effective care.

**Emergency Department Copayments for Medicaid Beneficiaries**
RESOLVED, That our American Medical Association oppose imposition of co-pays for Medicaid beneficiaries seeking care in the emergency department. (New HOD Policy). Co-pays in this population deter necessary as well as unnecessary care and hence have unintended consequences. In addition, despite the fact that these co-pays seem relatively small, this patient population is just barely surviving financially and these co-pays, are generally not collected. In essence, it becomes another tax on providers who absorb the cost. In addition, as this draft points out, these co-pays should not be not collected until after the visit due to EMTALA concerns.

**The Improper Use of Beers or Similar Criteria and Third-Party Payer Compliance Activities (H-185.940)**
The Resolution seeks to work with insurers to develop appropriate use criteria, not penalize physicians using these criteria, identify which insurers use these criteria and allow physicians to report on abuses of Beers Criteria. All of this is a Directive to Action. This is an important issue and should be supported. The ACP has a strong position against the use of these criteria and linking them to payment.

**Medicaid Clinical Trials Coverage**
RESOLVED, That our American Medical Association actively lobby for and support federal legislation that guarantees coverage of routine patient care costs for Medicaid enrollees who participate in clinical trials. (Directive to Take Action) This resolution recognizes the large number of patients covered by Federal Medicaid and under representation of minority groups in clinical trials and the barriers to participation. This resolution asks specifically for Medicaid coverage of routine care costs related to clinical trials. This may require further study of current clinical trials reimbursement and cost coverage for clinical services based on insurance coverage.

**Medicare Advantage Step Therapy**
RESOLVED, That our American Medical Association continue strong advocacy for the rejection of step therapy in Medicare Advantage plans and impede the implementation of the practice before it takes effect on January 1, 2019. (Directive to Take Action) Our AMA has policy in place that supports patient access to the most appropriate therapy, utilization management and prior authorization that is not onerous, supported by the literature and practice and timely for the patient. This resolution is specific about “step therapy” and Medicare Advantage Plans. Defining the parameters of step therapy would be helpful.

**Infertility Benefits for Active-Duty Military Personnel**
Our AMA work with the Department of Defense, the American Society for Reproductive Medicine and others to inform beneficiaries regarding low cost infertility care and gamete cryopreservation for active-duty military personnel under Tricare and to fully cover these services. Our AMA already has extensive policy on supporting Veterans access to complete health care. This resolution seems consistent with previous policy. It should also include de-activated military personnel if they qualify for Tricare.

**ICD Code for Patients Harm From Payer Interference**
RESOLVED, That our American Medical Association support the creation and implementation of an ICD code(s) to identify administrator or payer influence that affects treatment and leads to or contributes to, directly or indirectly, patient harm. (New HOD Policy) Unclear on how these codes could be developed. This needs further clarification. Payer influence by cost, choice of therapies, delays in care could be factors for these new ICD codes.

**Direct Primary Care Health Savings Account Clarification**
RESOLVED, That our American Medical Association seek federal changes to the Internal Revenue Code
allowing health savings accounts to be used in direct primary care. (Directive to Take Action) This resolution asks for support of bill H.R. 6317 The Primary Care Enhancement Act. The Act states that Direct Primary Care is not a health plan but a medical service, which should allow individuals to use HSA accounts as means of payment. This is a Directive of Action.

**814 Prior Authorization Relief in Medicare Advantage Plans**
This resolution seeks consistent policy around Medicaid, Medicaid Managed Care and Medicare Advantage plans in regards to: Listing services requiring a PA, notice of changes, standardization of forms, no medication change without prescriber input and minimizing PA in general. I believe most of the resolve clauses are present AMA policy with two exceptions: Define a consistent process for appeals and grievances to Medicaid and Medicaid Managed Care Plans. Develop a communication tool to resolve disagreements between the plan and the ordering provider. Both of these could be supported.

**815 Uncompensated Physician Labor**
RESOLVED, our American Medical Association adopt policy that physicians should be compensated for reviewing and responding to new after-hour patient messages. (New HOD Policy) Current policy of H-390.859 Reimbursement for Telephone and Electronic Communications and H-385.919 Payment for Electronic Communication does support pressing CMS and other payers to separately recognize and pay for non-face to face time., including electronic communication. This seems more of an affirmation of existing AMA policy.

**816 Medicare Advantage Plan Inadequacies**
Our AMA investigate deficiencies in Medicare Advantage Plans. The resolution has multiple issues in the Resolve clauses: One resolve would be to investigate all deficiencies in Medicare Advantage plans. The second is specific to nursing home, rehab and physical therapy services and the third is the transparency issue. The second resolve also has two requests, one for coverage for healthy seniors only and a cap on administrative costs. These may be separate resolutions dealing with different issues.

**817 Increase Reimbursement for Psychiatric Services**
RESOLVED, That our American Medical Association support increasing reimbursement for psychiatric services through direct funding adjustments or the CPT Editorial Panel process. We will need clarification on “direct funding” and CPT Editorial Panel Process” and how this can improve reimbursement.

**818 Drug Pricing Transparency**
RESOLVED, our American Medical Association advocate to the U.S. Surgeon General for federal legislation that investigates all drug pricing. There is currently detailed AMA policy on transparency, review of generic drug applications, price gouging, increase in costs of over 10% per year and working with stakeholders such as the FDA, FTC and Generic Pharmaceutical Association to address the high and rising costs of prescription drugs. It appears that this resolution introduces another specific stakeholder, surgeon general to develop and support legislation on drug pricing. I don’t know if this is within the purview of the Surgeon General’s office.

**819 Medicare Reimbursement Formula for Oncologists Administering Drugs**
The Resolution asks for appropriate reimbursement for cognitive oncologic outpatient services. It also asks for fair reimbursement for the costs of therapeutic agents and their administration. I presume reimbursement would be a flat fee basis, to avoid “ perverse” incentives to use costlier drugs.

**820 Ensuring Quality Health Care for our Veterans**
RESOLVED, That our American Medical Association amend policy H-510.986, “Ensuring Access to Care for our Veterans,” by addition to read as follows: Ensuring Access to Safe and Quality Care for our Veterans H-510.986. This resolution calls for all physicians to participate in the care of veterans. Veterans should receive full benefits in a timely manner within or outside the VA system. Create a state based registry of physicians who are accepting veterans as patients. The highest quality of physicians be employed with the highest quality of care and the Veterans system seek accreditation similar to other health care facilities. This seems like a reasonable clarification and further prescription for delivering high quality care. The AMA already has extensive policy on Veterans care.
Direct Primary Care and Concierge Medicine Based Practices
RESOLVED, That our American Medical Association actively lobby for revision to the U.S. tax code to allow funds from health savings accounts to be used for concierge medicine and direct primary care without incurring a tax penalty. Current policy H 385.912 does support Direct Primary Care as a qualified medical expense by the Internal Revenue Service. The resolution clarifies this policy to include health savings accounts as a legal method to pay for health services provided by DPC. Fiscally this will require legal interpretation of current IRS code and a method to change these regulations.

Bone Density Reimbursement
RESOLVED, That our American Medical Association advocate for the correction of the underpayment by Medicare, Medicaid, and third party payers to medical practices for office-based DXA tests. (New HOD Policy). The Resolution documents the decrease in reimbursement for DXA scans to a low of 30-37 dollars per scan while the cost per scan is around 150 dollars per scan. There has been some increase but not enough to cover the costs. The resolution would be new HOD policy but supported by H-425.981. This can be supported.

Medicare Cuts to Radiology Imaging
RESOLVED, That our American Medical Association advocate for elimination of the Medicare differential imaging payments for small practices versus facility payments (New HOD Policy); and be it further; RESOLVED, That our AMA advocate for elimination of the Medicare computed radiography (CR) payment reductions. (New HOD Policy). This resolution states that computed radiography and digital radiography have comparable image quality. Larger systems can afford the upgrade to digital but there are areas of the country with small practices that cannot and offer a service of value with CR to their community. The two resolves ask for equity irrespective of facility or non facility and equity for CR versus Digital Radiography(DR). We should hear more testimony on this before supporting.