CMS Report 01  Affordable Care Act Section 1332 Waivers
Section 1332 of the Affordable Care Act (ACA) permits a state to apply for a State Innovation Waiver to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA. These proposals may not increase the federal deficit, but allow for pass through funding so that states may receive funding equal to the amount of forgone financial assistance. This report was created in response to a resolution introduced at I-16. The recommendation in the report allows the savings by innovative programs at the state level to be realized over time and not in each individual year the waiver is provided.

CMS Report 02  Hospital Surveys and Health Care Disparities
Recognizing that hospital quality program assessments like the HCAHPS may place safety net hospitals at a disadvantage in scoring thereby further negatively affecting resources and payments to care for a disadvantaged patient population, this report advocates for risk models that account for social risk factors in hospital quality program assessments.

CMS Report 03  Non-Physician Screening Tests
Written in response to a resolution referred at I-16, this report focuses on wellness program vendors, especially employer-offered wellness programs, which has become a $6 billion industry. Concerns for such programs includes tests not ordered by a physician, tests not always supported by clinical guidelines and false positives leading to further costly unneeded care.

CMS Report 04  Health Insurance Affordability: Essential Health Benefits and Subsidizing the Coverage of High-Risk Patients
In this report, CMS reviewed existing policy as the House and Senate continue to put forth bills related to health care reform. Areas of focus included Essential health benefits (EHB) and insurance for high-cost/high-risk patients. Final recommendations include removal of categories from the EHB package against annual and lifetime limits and out-of-pocket expenses. Furthermore, that the AMA prefer reinsurance (versus high-risk pools) to subsidize costs of high-risk and high-cost patients.

CMS Report 05  Reaffirmation of AMA Policy Opposing Caps on Federal Medicaid Funding
Written in response to referred CMS report at A-17, this report recommends reaffirmation that the AMA opposed caps on federal funding versus state per costs or block grants.

801  Chronic Care Management (CCM) Payment for Patients Also on Home Health
Introduced by multiple states, this resolution asks that the AMA advocate that Rural Health Centers (RHCs) and Federally Qualified Health Centers (FQHCs) be allowed to receive CCM payments for patients also on home health. Patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline are eligible for CCM services. CCM services are usually for non-patient facing time coordinating care. G0181, referenced in the resolution is “physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the
patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more.” Modest financial note of $1000-$5000.

802 Opposition to Medicaid Work Requirements
Introduced by the Medical Student Section, this resolution asks that AMA create policy opposing work requirements for Medicaid eligibility. The resolution highlights that among the adult Medicaid enrollees who were not working, most report major impediments to their ability to work. Medicare enrollees include about 1.75 million students, 3.43 million are too ill for work and 2.74 million who are caring for other family members or home. Work requirements for those eligible is a topic of debate as the ACA increased Medicare eligibility, although States can’t currently implement such a requirement. Modest fiscal note of $1000-$5000.

804 Prior Authorization
This resolution, submitted by Indiana, asks for improvements in the prior authorization (PA) process to address particularly onerous points in the process. Specifically, the resolution asks for reduction in needed PAs for services that only fall outside the standard of care, reduction in need for annual PAs, prompt review by insurers, and reimbursement for time spent obtaining PAs. Furthermore, the resolution asks that the AMA meet with insurers to discuss PAs, and that the AMA, and by administrative and/or legislative means, address the problem this excessive burden places on practicing physicians. The resolved clauses will need some wordsmithering which can be done by the Reference Committee. Modest fiscal note of $1000-$5000.

806 Mandate Transparency by Pharmacy Benefit Managers
Impetus for this resolution, sponsored by the New England Delegation, was a case where a patient had a higher co-pay for a prescription drug after submitting it to through their private insurer/PBM than if they were paying cash. Therefore, one of the resolved clauses asks that AMA create policy requiring that patients be told if this situation exists, so their out of pocket expense may be lower. Along this line, the resolution asks for increased transparency in prescription drugs costs set by PBMs. (ON CONSENT CALENDAR)

810 Pharmacy Benefit Managers and Prescription Drug Affordability
Taken out of order here because same topic as 806. Introduced by multiple specialty societies, this resolution also asks for increased transparency by PBM to regain a hold on prescription drug affordability. Modest fiscal note of $1000-$5000.

807 Structural Barriers to Achieving Better Health Care Efficiency and Outcomes: ACOs and Physician Employment by Hospitals
A study and report back are sought in this resolution put forth by the NED. Areas of concern that were cited by the author included examples where patients were being directed to potentially higher cost sites of care in ACO models, away from independent physician practices. Questions arose whether this was due to ACOs primarily controlled by hospital and hospital systems. (ON CONSENT CALENDAR)

808 Opposition to Reduced Payment for the 25 Modifier
According to CPT, separate, significant physician evaluation and management (E/M) work that goes above and beyond the physician work normally associated with a preventive medicine service or a minor surgical procedure is additionally billable. The code that tells the insurer you should be paid for both services is modifier -25. Introduced by a variety of dermatologic and allergy societies, this resolution asks for an amendment by addition and deletion to existing policy around the 25 Modifier, asking that both services be paid at 100%.

809 Expansion of Network Adequacy Policy
Builds on existing policy surrounding network adequacy, the resolution asks that insurers terminating in network providers distribute a copy of the communication sent to patients be shared with the provider at least two weeks prior and that insurers notify providers at least 30 days prior to removal from a network

811 Update OBRA Nursing Facility Preadmission Screening Requirements
Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that 1) all
applicants to a Medicaid-certified nursing facility be evaluated for serious mental illness (SMI) and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and 3) receive the services they need in those settings. Asks that PASSR process reviewed and made more cost effective to reduce delays in appropriate placement. Modest fiscal note.

812 Medicare Coverage of Services Provided by Proctored Medical Students
Submitted by Michigan, asks that CMS through the Medicare Physician Fee Schedule, allow for payment of medical services provided by medical students while under the physician’s personal observation, direction or supervision.

813 Sustain Patient-Centered Medical Home Practices
Asks for recognition of efforts and costs associated with promulgation of the Patient Centered Medical Home.

814 Appropriate Reimbursement for Evaluation and Management Services for Patients with Severe Mobility-related Impairments
Recognizing that caring for patients with mobility issues may require specialized equipment, staff and resources, this resolution, submitted by Academy of PM&R asks for an increase in E/M services for patients with the same, without passing the increased reimbursements onto patients. Further education is also requested.

815 Pediatric Representation for E/M Documentation Guideline Revision
Asks for AAP participation in future Evaluation and Management documentation guidelines to address needs of pediatricians and children

816 Social Determinants of Health in Payment Models
Citing Massachusetts programs that highlight significant annual savings from programs in the homeless and those with behavioral health issues, this resolution asks for payment reform to increase screening for social determinants of health. From CMS.gov - Healthy People 2020 Approach to Social Determinants of Health - A “place-based” organizing framework, reflecting five (5) key areas of social determinants of health (SDOH), was developed by Healthy People 2020. These five key areas (determinants) include: Economic Stability, Education, Social and Community Context, Health and Health Care, Neighborhood and Built Environment.

817 Addressing the Site of Service Differential
Not to be confused with the differential service provided by your local Jiffy Lube, this resolution, submitted by New Mexico asks for a report back at I-2018 to study elements of the Site of Service differential to qualify actual cost by hospitals and physicians. A second resolved asks that the AMA support a revised payment system making payment site-neutral. A modest fiscal note is associated, but I would expect a larger expense based on the ask.

818 On-Call and Emergency Services Pay
Asks for an amendment by addition to existing policy that physicians be compensated when on-call. A second resolved asks for policy guidance to enable physicians to receive compensation for the same.

819 Consultation Codes and Private Payers
Given that CMS and some private insurers have stopped payment for consult codes, citing abuses of their use, this resolution asks that the AMA “engage and advocate” for payment with commercial insurers that propose eliminating payment for consultation codes in the future. It also asks for payers to release data as evidence of purported abuse. Modest fiscal note.

820 Elimination of the Laboratory 14 Day Rules Under Medicare
Implemented in 2007, the Medicare 14-day rule bundles pathology specimen payment under DRGs or OPPS (outpatient) payments. Asks for active lobbying to separate out payments for clinical and laboratory pathology specimens. Modest fiscal note.
821 **Hormonal Contraception as a Preventive Service**
On October 6, 2017, the Departments of Health and Human Services, Treasury, and Labor (the Departments) announced two companion interim final rules that provide conscience protections to Americans who have a religious or moral objection to paying for health insurance that covers contraceptive methods, including certain contraceptives that many may view as abortifacients, as well as sterilization procedures. Asks that AMA advocate to rescind the rule, increasing access to contraception. Modest fiscal note.

822 **Elimination of All Cost Sharing for Screening Colonoscopies**
Citing cost sharing my Medicare and private insurers for screening colonoscopy in certain clinical situations which may deter patients from proceeding with this evidenced based screening tool, the resolution asks the AMA develop national policy to removal all cost sharing schemes.

823 **Unconscionable Generic Drug Pricing**
Citing examples of commonly used medications with have been subject to astronomical price increases, the resolution asks that the AMA advocate for national legislation to prevent price gouging. Also asks for report back about AMA Truth in Rx Campaign. The campaign’s focuses are price transparency, restoring affordability and putting patients first over middlemen.

824 **Payment for Dementia Treatment in Hospitals and Other Psychiatric Facilities**
Introduced by Georgia, this resolution aims to promote payment by CMS and other payers for admissions for dementia where that is the primary diagnosis.

825 **Support for VA Health Services for Woman Veterans**
Put forth by Pennsylvania, aims to increase awareness about gender based health care disparities and access to care in the VA for women.

**CONSENT CALENDAR FOR DENIAL**

803 **Air Ambulance Regulations and Reimbursements**
Submitted by the Medical Student Section, this resolution asks that the AMA study the role, clinical efficacy and cost-effectiveness of air ambulance services. The resolutions highlights escalating costs of such transports, decreased competition in the industry (more than half controlled by 4 for-profit operators) and large balance billing amounts to patients for transports involving relatively minor injuries a large part of the time. Modest fiscal note of $1000-$5000. In reviewing the resolution, it appears that the Medical Student Section has identified the key issues in this area, which is why I am recommending denial as written.

**RESOLUTIONS FOR DISCUSSION**

805 **A Dual System for Universal Health Care in the United States**
Introduced by Montana, this resolution advocates for a “single universal government system” that provides healthcare to all citizens while at the same time deregulating the private health care system.