REFERENCE COMMITTEE A *(Medical Service)*
SUMMARY REPORT FOR THE NEW ENGLAND DELEGATION
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Please list two questions for the Candidate Interviews based on the topics represented within your reference committee.

1. Polls now show that a majority of the U.S. population/and physicians support a single payer health care system. Should the AMA consider rescinding its current policy on single payer and be open and engaged with legislators to develop a single payer model for universal consideration?

2. CMS reports 02 and 03 discuss many issues related to product affordability, marketplace competition, and choice on the health insurance exchanges. Yet true affordability and access to care remain problematic for the ~20% of the U.S. population using the health insurance exchanges, an issue that was not addressed in the reports. How would you recommend the AMA address the problem with patient access and affordability (specifically first dollar costs) on the health insurance exchanges.

CONSENT CALENDAR FOR APPROVAL

BOT 40 Medicare Coverage of Services Provided by Proctored Medical Students
Original resolution from MSS I-17 sought to expand billing for patient services to include services rendered by medical students. This BOT report reviewed CMS policy and then presented rationale for the recommendation to not adopt this resolution (due to liability concerns, billing by non-licensed clinician, blurring of line between education and the professional compensation for time, expertise and treatment of pts). BOT report 40 recommends non adoption of Resolution 812-I-17 based on the issues identified above and discussed in the report.

CMS 01 Council on Medical Service Sunset Review of 2008 AMA House Policies
10-year Sunset review of 106 (I hope I counted correctly ☺) policies assigned to CMS. Policies recommended to be retained, retained in part/ amended, or rescinded seem appropriate.

CMS/CSAPH Joint Report 01 Coverage for Colorectal Cancer Screening
Original resolution from Georgia I-17 asked the AMA to develop model national policy to remove all cost sharing associated with screening colonoscopies in commercial and Medicare Advantage insurance products. Report summarizes current policy, sources of coverage confusion, and presents 8 policy recommendations regarding CRC screening: 7 recommendations are reaffirmations of current policies; 1 is new policy (development of a coding guide)

102 Effectiveness of Risk Assessment Models in Representing Healthcare Resources Expended for Infants and Children
Resolution from AAP seeks to have the AMA advocate that risk adjustment methodologies used by insurers and APMs be transparent and that they reflect the complex conditions and social determinants of health (SDOH) in all age groups to include infants, children, and adolescents. These groups can have complex and unique risk strata that may not be accurately represented in current risk adjustment methodologies. Although we have AMA policy related to this issue, current policies do not stipulate SDOH in risk stratification nor does current policy address the problems inherent with the use of standard combined populations of adults and children in risk adjustment methodologies.

103 Oppose Medicaid Eligibility Lockout
Resolution introduced by NY that requests the AMA oppose exclusion of Medicaid benefits to Medicaid eligible persons due to failure/inability of those eligible individuals to meet administrative deadlines.

104 Emergency Out of Network Services

Resolution introduced by NY requests the AMA pursue legislation/regulation to require eligible health plans to pay physicians for emergency out of network care at least at the 80th percentile for a particular geo-zip (Fair Health database). Seems reasonable, although may be re-affirmation of current policy.

106 Prohibit Retrospective ER Coverage Denial

Resolution introduced by NY requests the AMA work to ensure enforcement of state and federal laws requiring health insurance companies to cover emergency room care when a patient believes s/he is in need of immediate medical attention. This resolution also requests imposing financial penalties on insurers for non-compliance. This resolution does not appear to be reaffirmation of current policy due to advocacy mandate.

107 Opposition to Medicaid Work Requirement

Resolution from NY requesting reaffirmation of policy H-290.961 which opposes work requirements as a criterion for Medicaid eligibility.

110 Return to Prudent Layperson Standard for Emergency Services

Resolution introduced by Missouri requesting the AMA oppose denial of payment for emergency services based solely on diagnostic coding and support the use of the prudent layperson standard. This appears to be re-affirmation of current policy…

111 Medicare Coverage for Dental Services

Resolution introduced by the American College of Cardiology requesting the AMA promote and support legislative action to include preventive and therapeutic dental services as standard benefits to Medicare recipients. Based on recent amendments to Medicare that cover preventive services (that embrace value-based care), recognizing the importance of oral health to overall well-being, and the association of periodontal disease to HTN and heart disease…this resolution seems to address a significant health care gap for Medicare pts. *How do/would dentists feel about this proposed resolution?

113 Survivorship Care Plans

Resolution introduced by ASCO requesting the AMA study challenges in coding/ billing for cancer survivorship care, and in collaboration with other specialty societies develop and implement survivorship care guidelines. Also requests collaboration with CMS to provide standards of care and reimbursement for survivorship care plans. This resolution identifies gaps in care and appears to seek to coordinate/integrate care and planning for the significant multidimensional needs of patients impacted by cancer survivorship.

114 Inclusion of Bundled Payments Care Improvement (BPCI) Post-Acute only Model 3 in Advanced BPCI

Resolution introduced by AMDA that seeks to have the BPCI Model 3 Post Acute care bundle included in the Advanced BPCI program. The Advanced BPCI did not include initiation of bundles in SNFs, where previously CMS had allowed bundled payments to be initiated there for certain diagnoses under the BPCI program. BPCI Model 3 has generated efficiencies, savings and better patient outcomes and inclusion of this model in the Advanced BPCI would allow physicians in SNFs and SNFs to initiate episodes of care bundles. Seems reasonable and needed for those participating in downside risk arrangements. However, many other advanced APMs are running into similar problems - they are still being evaluated by CMS. The BPCI initiative has 48 bundles, while the advanced version has just 29 - There may be a reason why. There is another opening in 2020 for this program - might be something to shoot for. *Supportive generally, with recommendation to listen to testimony due to complexity of issue.

115 Expanding On-Site Physician Home Health Care to Low-Income Families and the Chronically Ill

Resolution introduced by Maryland that seeks to expand current AMA policy H-210.981 On-site Physician Home Health Care to now include low income patients and socioeconomic status.

*While generally supportive, not sure the proponents make the case for low-income in the whereas clauses, and existing policy does account for economic status in part (e.g., in (7) of the existing policy).

116 Ban on Medicare Advantage "No Cause" Network Terminations
Resolution from the NED that requests AMA advocate for legislation to manage the consequences of "no cause" network terminations from Medicare Advantage plans.

117 Supporting Reclassification of Complex Rehabilitation Technology
This resolution sponsored by Texas requests that the AMA advocate to CMS to reclassify CRT as a separate payment category to improve access to this specialized equipment for those with chronic medical conditions and/or disabilities. According to the whereas clauses CRT is classified as DME by CMS, which results in limited or no access to CRT for patients in need and for those in long term care facilities under Medicare Part A. Resolution appears to identify a gap in coverage for these vulnerable patients and requests advocacy action. Does not appear to be reaffirmation due to the more comprehensive directive for action requested on this issue.

CONSENT CALENDAR FOR DENIAL

105 Use of High Molecular Weight Hyaluronic Acid
Resolution introduced by NY that requests AMA advocate for reimbursement and national coverage for intraarticular injections of high molecular weight hyaluronic acid for the treatment of osteoarthritis of the knee. Would specific treatment recommendations best be accomplished by a specialty organization? Should the AMA be determining 'appropriate care and treatment' for patients with a specific orthopedic diagnosis?

109 Medicaid Coverage of Fitness Facility Memberships
Resolution introduced by the MSS requesting Medicaid coverage of fitness facility memberships as a standard preventive health benefit for pts.

RESOLUTIONS FOR DISCUSSION

At the 2017 Annual Meeting, the House of Delegates adopted Policy D-165.934, "Studying Mechanisms Including a Public Option to Improve Health Insurance Marketplace Affordability, Competition and Stabilization." The policy states that "our American Medical Association (AMA) will study:

(1) mechanisms to improve affordability, competition and stability in the individual health insurance marketplace; and

(2) the feasibility of a public option insurance plan as a model as a part of a pluralistic health care system to improve access to care."

In response to Policy D-165.934, the Council is presenting two reports (CMS 02 and CMS 03) at the 2018 Annual Meeting: 1) CMS 02 "Improving Affordability in the Health Insurance Exchanges" is focused on improving affordability in the individual health insurance marketplace, and 2) CMS Report 3 "Ensuring Marketplace Competition and Health Plan Choice" which is focused on ensuring marketplace competition and health plan choice, and reviews approaches to a public option. The two reports are briefly ☺ reviewed as follows….

CMS 02 Improving Affordability in the Health Insurance Exchanges
This report addresses improving the affordability, competition, and stability in the individual insurance market. The report reviews current coverage issues on the health insurance exchanges and makes policy recommendations in an attempt to address them. One item however is not addressed and that is increasing first dollar cost-sharing (deductibles. Co-insurance, co-pays) that can be prohibitive for patients. Premium credits and reinsurance protects the insurer, not necessarily the patient. Premium costs may be mitigated by the policies recommended, but comprehensive first dollar costs are not: therefore significant affordability issues still remain.

*Should we suggest that CMS produce another report to address first dollar coverage, or send this back (since insurance affordability and first dollar coverage go hand-in-hand)?

Specific policy recommendations by CMS include the following:

1. That our American Medical Association (AMA) support adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits. (New HOD Policy)

2. That our AMA support expanding eligibility for premium tax credits up to 500 percent of the federal poverty level. (New HOD Policy)

3. That our AMA support providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income. (New HOD Policy)

4. That our AMA encourage state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections. (New HOD Policy)

5. That our AMA support the establishment of a permanent federal reinsurance program. (New HOD Policy)

CMS 03 Ensuring Marketplace Competition and Health Plan Choice

This report provides background on health plan choice and competition in the Affordable Care Act (ACA) marketplaces, highlights regulatory and legislative activity that could have marketplace impacts, outlines various approaches to ensuring marketplace coverage options, summarizes relevant AMA policy, and presents policy recommendations.

The report expresses concern that public option proposals that rely on Medicaid and/or Medicare payment rates and/or tie physician participation in Medicare and/or Medicaid to a public option could negatively impact physician practices and physician practice sustainability, as well as patient access to care and choice of health. As such, the Council recommends the reaffirmation of Policy H-165.838, which states that health insurance coverage options offered in a health insurance exchange should be self- supporting; have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.

*The majority of recommendations seem reasonable, however this report specifically cites recommendations for the health insurance exchanges. The recommendations made (they be self-supporting; have solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians) would appear to benefit insurers and perhaps physician practices, however patient access and affordability would still remain problematic.

The report on recommends the following be adopted:

1. That our American Medical Association (AMA) support health plans offering coverage options for individuals and small groups competing on a level playing field, including providing coverage for pre-existing conditions and essential health benefits. (New HOD Policy)

2. That our AMA oppose the sale of health insurance plans in the individual and small group markets that do not comply with Affordable Care Act requirements, including those related to pre-existing condition protections and essential health benefits, except in the limited circumstance of short-term limited duration insurance offered for no more than three months. (New HOD Policy)

3. That our AMA reaffirm Policy H-165.838, which states that health insurance coverage options offered in a health insurance exchange should be self-supporting; have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians. (Reaffirm HOD Policy)

4. That our AMA support requiring the largest two Federal Employees Health Benefits Program (FEHBP) insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation. (New HOD Policy)

5. That our AMA reaffirm Policy D-180.986, which states that our AMA will encourage local, state, and federal regulatory authorities to aggressively pursue action against "sham" health insurers. (Reaffirm HOD Policy)

6. That AMA Policy H-165.882 be rescinded. (Rescind HOD Policy). It is superceded by Policy 180.986 above

7. That AMA Policy D-165.934 be rescinded. (Rescind HOD Policy). Study has been accomplished through this report.

CMS 07 Insulin Affordability

CMS Report 07 was developed in response to Resolution 826 from I-17and requested the AMA convene a summit to highlight the increases in insulin costs and identify solutions. The resolution sought to
(1) reduce pt. cost sharing for insulin
(2) pursue solutions to reduce patient cost sharing for insulin and ensure patients benefit from rebates at the point of sale;
(3) work with health insurance companies and federal agencies to stabilize drug formularies and reduce non-medical switching by encouraging plans to cover insulin products at the same cost listed on a drug formulary throughout the entire plan year;
(4) encourage insulin price and cost transparency among pharmaceutical companies, PBMs and health insurance companies; and
(5) work with electronic medical record vendors and insurance companies to integrate current formularies and price information into all EHR systems so physicians and patients can make informed decisions on insulin products to reduce cost burdens on patients.

The report extensively discussed the background details on insulin availability and costs, government and legal actions that have been taken to address insulin affordability, opportunities that have been identified to address affordable alternatives, and improving transparency. The report also presented the AMA work (historical and ongoing) concerning prescription drug pricing and costs, generally. The Council made 11 recommendations (to be adopted in lieu of Resolution 826 I-17): 3 new HOD policy recommendations; 2 Directives to Take Action; and 6 recommendations that were reaffirmations of current policy.

*Should we have policy addressing a specific prescription drug class, or one that is more general?

101 Medicaid Reform

Resolution introduced by Louisiana seeks to have the AMA support reform of Medicaid such that there would be expanded individual choice, individual opportunity, and individual and governmental responsibility. (not clear what this means…??)
Resolution also requests that the AMA support reform of the Medicaid health care delivery model that provides the individual patient the opportunity and responsibility to make wise choices in their own health care delivery model, and to share the financial savings when using the Medicaid healthcare delivery system wisely. Finally, the resolution proposes 4 options to consider that encourage pluralism and patient choice in the /Medicaid healthcare delivery model.

*May be helpful to listen to testimony to better understand this resolution.

108 Expanding AMA's Position on Healthcare Reform Options

Resolution introduced by the MSS requesting the AMA rescind policy language regarding opposition to single payer financing mechanisms in its policy Evaluating Health System Reform Proposals as well as in policy Health System Reform Legislation. Rationale given included the restrictions such policy would have of the AMA's participation in national conversations regarding all options of healthcare reform. A majority of surveyed physicians support a single payer option. *Should the option for single payer be discussed? Should we have policy that allows open dialogue/participation on this topic?

112 Enabling Attending Physicians to Waive the Three-midnight Rule for Patients Receiving Care within Downside Risk Sharing Accountable Care Organizations and Advance Bundled Payments Care Improvement Programs

Resolution introduced by the Society for Post-Acute and Long-Term Care Medicine (AMDA) that requests that any physician caring for Medicare recipients in any setting be allowed to waive the 3 midnight inpatient stay requirement for initiation of SNF care when the physician and SNF are both participating in any downside risk sharing arrangement with Medicare (Medicare ACO, Advanced BPCI, Track 1+, or other). This resolution seems to make sense, however discussion may be helpful. Are there unintended consequences with this resolution?

*Would savvy patients be attracted to such programs so as to not risk financial burdens if they do not meet the ever- changing diagnostic criteria for 3 midnight stay? Would those physicians and programs not involved in ACOs, or those that do but choose not to so participate, be at a competitive disadvantage in taking care of Medicare patients? Would long standing physician patient relationships suffer as a consequence that is based purely on financial decisions made by ACOs? On the other hand, these resolves do make sense for the ACOs and their patients; the potential pitfalls for those unaffiliated will need to be flushed out.