DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2026 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Society.

MEDICAL SOCIETY OF VIRGINIA HOUSE OF DELEGATES
Report of Reference Committee 1

Dr. Bobbie Sperry, Chair

Present Members: Dr. Peter Netland, Dr. Raziuddin Ali, Dr. Jacqueline Fogarty, Dr. Kira Dubester, Dr. Zerline Chambers-Kersey, Dr. Jan Willcox, Bobby Cockram Jr., DMSC, PA-C, Dr. Joe Hutchison, Vaishnavi Nemani

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The Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION
26-101: Medical Society of Virginia Proposed 2027 Budget
26-102: MSV 2026 Policy Compendium Ten-Year Review
26-103: Amending MSV Policy 15.3.01 To Reflect Evolving Member Needs in Modern Political Climate

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED
26-110: Supporting Resident and Fellow Physician Unionization & Collective Bargaining
26-111: Preventing Genetic Discrimination by Insurers
26-117: Supporting Development of a Virginia Medicaid Nutrition Benefit for Individuals with Diet-Related Chronic Conditions

RECOMMENDED FOR NOT ADOPTION
26-104: Medical Liability Guardrails to Protect Patients, Physicians, and Access to Care
26-114: Patient Protections for Predispute Arbitration
26-115: Procedural Safeguards for Payer Payment-Integrity Actions

RECOMMENDED FOR AMENDMENT TO CURRENT POLICY IN LIEU OF
26-105: Opposition To Refiling of Medical Malpractice Actions Due To Voluntary Nonsuit Without Penalty
26-108: Performance-Based Sunset of Low-Yield Prior Authorization Requirements
26-109: Safeguards For Artificial Intelligence and Automated Decision-making in Health Insurance
26-118: Ensuring Healthcare Access for People Living with HIV

RECOMMENDED FOR REFERRAL TO THE BOARD OF DIRECTORS FOR ACTION
26-107: Transparency and Accountability for the 340B Drug Pricing Program
26-112: Improving Access to Forensic Medical Evaluations for Asylum Seekers

RECOMMENDED FOR REAFFIRMIRMATION OF EXISTING POLICY IN LIEU OF
26-106: Preventing Vision Loss Through a Uniform Adult Medicaid Vision-Material Benefit in Virginia – Reaffirm MSV Policy 10.1.18 – *Insurance Coverage for Medical Conditions*
26-113: Prevention Of Automatic Downcoding and Transparency in Downcoding Decisions –Reaffirm MSV Policy 10.3.16- *Third Party Payer Fair Business Practice Principles*
26-116: Recognizing Progressive Childhood Myopia as a Clinical Disease – Reaffirm MSV Policy 10.1.18 - *Insurance Coverage for Medical Conditions* and MSV Policy 40.1.16 - *Public Health Research and Social Determinants of Health*

1) 26-101 MSV PROPOSED 2027 BUDGET

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **Resolution 26-101 be Adopted.**

This resolution presents the proposed FY2027 budget for the Medical Society of Virginia as approved by the MSV Finance Committee, the MSV Executive Committee, and the MSV Board of Directors. The resolution was presented by MSV Secretary-Treasurer Dr. Stephen Lewis.

No testimony was heard by your Reference Committee.

Your Reference Committee expressed a lack of clarity as to SafeHaven™ revenues and whether they had increased or decreased in the previous fiscal year. Staff clarified that although SafeHaven™ revenue fell below projections, new grant funding from the Rural Health Transformation fund increased overall program revenue by $50,000.

Accordingly, your Reference Committee recommends that Resolution 27-101 be Adopted.

2) 26-102 2026 MSV POLICY COMPENDIUM 10-YEAR REVIEW

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **Resolution 26-102 be Adopted.**

RESOLVED, that the Medical Society of Virginia adopt the recommendations in the enclosed report.

The resolution was presented by Madame Speaker, Dr. Michele Nedelka.

Your Reference Committee heard testimony suggesting technical amendments to Policy 10.1.06 to correct the organizational name of American College of Obstetricians and Gynecologists. Madame Speaker suggested that such an edit can be made informally via staff discretion and that np formal amendment would be necessary.

Online comments were received for this resolution. Comments suggested amending MSV Policy 10.1.06 and MSV Policy 15.4.03.

Your Reference Committee discussed that all proposed amendments were clerical in nature and could be made with staff discretion without formal amendments being introduced.

Accordingly, your Reference Committee recommends that Resolution 26-102 be Adopted.

3) 26-103 AMENDING MSV POLICY 15.3.01 TO REFLECT EVOLVING MEMBER NEEDS IN MODERN POLITICAL CLIMATE

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **Resolution 26-103 be Adopted.**

RESOLVED that MSV Policy 15.3.01 – Medical Malpractice Cap on Damages be amended to read, "The Medical Society of Virginia supports maintaining ~~the~~ a cap on professional medical liability awards ~~at a level consistent with the Code of the Commonwealth § 8.01-581.15~~ and seeks legislation that would implement a cost-effective alternative to address cases involving substantial medical expenses. Furthermore, the Medical Society of Virginia opposes efforts to ~~extend the cap or attempts to increase, stack, or~~ repeal ~~the~~ a cap structure in Virginia~~, including any attempt to add on an inflation factor~~. The Medical Society of Virginia supports strengthening protections for individual providers, including but not limited to pursuing personal asset protections."

Your Reference Committee heard supportive testimony regarding the need for flexibility in responding to a changing stakeholder environment and maintaining a seat at the table during medical malpractice negotiations. Your Reference Committee heard supportive testimony regarding the importance of flexibility in building and maintaining a coalition, recognizing that positions of key stakeholders have not been shared with the MSV and are likely to evolve in response to legislative initiatives not yet known.

Your Reference Committee heard supportive testimony regarding national trends in medical malpractice damage caps and Virginia's position as an outlier. Your Reference Committee heard testimony citing member feedback questioning the value of a total damages cap when coverage up to the cap may be unaffordable or unavailable in the marketplace. Testimony emphasized that the new resolution provides MSV with flexibility to respond to these questions while keeping policy aligned with member feedback and the needs of the profession.

Your Reference Committee heard supportive testimony emphasizing that flexibility does not diminish MSV's commitment to defending the current cap and maintaining the status quo but allows MSV to continue pursuing that goal while responding to a changing stakeholder environment and evolving member perspectives.

Your Reference Committee heard opposing testimony regarding the importance of maintaining current policy and preserving the existing total damages cap. Testimony expressed concern that changes to MSV's policy could threaten internal medicine, primary care, and private practice, and cautioned that allowing flexibility in negotiations could lead to further changes to the current cap.

Online comments were received for this resolution. One comment questioned whether the proposed language should be amended to retain reference to a total cap.

Your Reference Committee discussed the significance of medical liability reform on the future practice of medicine in Virginia, noting increased severity for certain specialties such as obstetrics, who are already seeing some of the highest premiums amongst their peers and what reform might mean for areas of the Commonwealth already experiencing issues in access to care.

Your Reference Committee discussed the rigid nature of the current policy and what maintaining it would mean as far as limiting leadership's capacity to mitigate potential damage of anticipated legislative proposals.

Your Reference Committee discussed the historical circumstances that resulted in the creation of the Virginia Birth-Related Neurological Injury Fund and the importance of connecting the threads of the

current conversations around liability reform to real-world access to care issues for patients. Members discussed the inevitability of reform given the political pressures in the General Assembly and ultimately agreed that the resolution provides the best framework for MSV leadership to negotiate an outcome that mitigates damage should circumstance necessitate negotiation.

Accordingly, your Reference Committee recommends that Resolution 26-103 be Adopted.

4) 26-104 MEDICAL LIABILITY GUARDRAILS TO PROTECT PATIENTS, PHYSICIANS, AND ACCESS TO CARE

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **Resolution 26-104 be Not Adopted.**

RESOLVED, that the Medical Society of Virginia support a reasonable statute of limitations for medical malpractice claims, such that any action must be filed no later than three years after the date of injury or one year after the date the claimant discovered, or reasonably should have discovered, the injury, whichever period is later, and be it further

RESOLVED, that the Medical Society of Virginia supports the principle that defendant physicians in medical malpractice actions remain jointly liable for all economic damages awarded to the plaintiff, as well as for any punitive damages assessed against the defendants, and be it further

RESOLVED, that the Medical Society of Virginia support minimum qualification and disclosure requirements for medical expert witnesses, including appropriate board certification or equivalent expertise, current clinical or academic experience in the relevant specialty, appropriate medical licensure, disclosure of the frequency of expert-witness testimony and the percentage of income derived from such activities, and disclosure of any actual or potential conflicts of interest, and be it further

RESOLVED, that the Medical Society of Virginia supports reasonable safe-harbor protections for physicians and other clinicians who provide care consistent with applicable evidence-based clinical guidelines and accepted standards of care, while preserving appropriate avenues for compensation when negligence occurs, and be it further

RESOLVED, that the Medical Society of Virginia support policies protecting physicians from the forced loss of essential personal assets, including primary residences and retirement accounts, in satisfaction of medical liability judgments, while preserving fair and appropriate compensation for patients injured by negligence, and be it further

RESOLVED, that the Medical Society of Virginia supports a reasonable sliding-scale structure for attorney fees in medical malpractice cases that preserves meaningful access to legal representation for injured patients while discouraging excessive or economically inefficient litigation.

Your Reference Committee heard supportive testimony regarding maintaining and strengthening current policy supporting the total damages cap while recognizing the need to address emerging threats. Your Reference Committee heard supportive testimony on refining current policy to explicitly identify additional tort reform priorities, emphasizing that these specific elements would clarify MSV's broader tort reform priorities rather than focusing primarily on the total damages cap.

Your Reference Committee heard testimony recommending technical amendments to update the first resolved clause to reflect Virginia's current two-year statute of limitations, rather than the three years

currently stated. Testimony also recommended striking the fifth resolved clause, noting that its intent was already addressed by the fourth resolved clause.

Your Reference Committee heard opposing testimony that the language as submitted was too rigid and prescriptive and would not allow MSV leadership the adequate flexibility to mitigate damage of impending liability reform efforts in the General Assembly.

Online comments were received for this resolution. Online comments suggested this resolution be withdrawn and resubmitted next year with corrected references to current MSV policy.

Your Reference Committee discussed concerns that much of the resolution as submitted would be duplicative of, and sometimes conflicting with, current MSV Policy 15.2.05 – Tort Reform. Additionally, your Reference Committee expressed its belief that the language of Resolution 26-103, for which it recommended adoption, allowed for the organization to support the majority of the policy tenets promulgated by this resolution. Therefore, the members agreed that adopting Resolution 26-103 in lieu of this resolution would be appropriate.

Accordingly, your Reference Committee recommends that Resolution 26-104 be Not Adopted.

5) 26-105 OPPOSITION TO REFILING OF MEDICAL MALPRACTICE ACTIONS DUE TO VOLUNTARY NONSUIT WITHOUT PENALTY

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **MSV Policy 15.2.06 be Amended in Lieu of Resolution 26-105.**

RESOLVED, that the Medical Society of Virginia opposes the ability of a medical malpractice plaintiff to refile a lawsuit without penalty after a voluntary nonsuit in cases where a physician or physician assistant is a defendant.

Your Reference Committee heard testimony about the undue burden that the re-filing of medical malpractice lawsuits following a voluntary non-suit places on physicians. Your Reference Committee heard a personal anecdote as to how this process had negatively affected a physician colleague.

Your Reference Committee discussed MSV Policy 15.2.08, which outlines the society's positions on several tort reforms. Members discussed how existing policy could easily be amended to meet the spirit of the resolution without creating standalone policy specific to this type of reform.

Accordingly, your Reference Committee recommends that MSV Policy 15.2.08 be Amended in Lieu of Adopting Resolution 26-105:

15.2.06- Tort Reform

The Medical Society of Virginia believes that malpractice issues should be resolved in an efficient, fair and less costly manner. Therefore, the Medical Society supports:

1. Alternative dispute resolution such as processes including mediation and arbitration, that are designed to divert claims from the civil justice system and resolve them more quickly and more cost effectively;

2. Uniform standards for medical liability claims including: a. Mandatory offsets for collateral sources, such as health insurance.

3. Requiring an expert witness certification stating that the standard of care was violated prior to serving a medical malpractice lawsuit.

4. Preserve equal access to the treating physicians and their health records for the plaintiff's and the defendant's attorneys.

5. Legislation that would prohibit a plaintiff from re-filing a case without penalty following a voluntary non-suit.

~~*5.*~~ *6. Procedural and evidentiary legislation that better enables fairness and equity in the defense of a medical liability case, which may include legislative initiatives from the following:*

a. Amending the "dead man's statutes" to clarify that a treating physician may testify as to the health care and professional services rendered to a deceased patient;

b. Amending Va. Code §8.01-399 regarding physician communications to eliminate the requirement that documentation must be contemporaneously entered in the patient's chart during the course of treatment;

c. Clarifying venue statutes to create a preference that medical malpractice cases filed in the jurisdiction where the care is rendered;

d. Amending the "dead man's statute" to create an exception so that a defendant physician may introduce evidence of habit and custom when lacking documentation in defense of a wrongful death action; and

Furthermore, the Medical Society of Virginia opposes adoption of a comparative negligence doctrine, and believes that in a claim for contributory negligence, the negligence of the plaintiff does not have to coincide in time with that of the defendant.

6) 26-106 PREVENTING VISION LOSS THROUGH A UNIFORM ADULT MEDICAID VISION-MATERIAL BENEFIT IN VIRGINIA

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends **that MSV Policy 10.1.18 Be Reaffirmed in Lieu of Resolution 26-106.**

RESOLVED, that the Medical Society of Virginia supports establishing a uniform Virginia Medicaid adult vision-material benefit covering medically necessary eyeglasses and simple frames, replacement eyewear when medically necessary, contact lenses when eyeglasses cannot adequately treat the condition, and low-vision aids.

Your Reference Committee heard supportive testimony regarding raising standards of care and building a healthier and more equitable Commonwealth. Testimony expressed varying coverage for medical conditions related to vision loss across Virginia Medicaid Managed Care Organizations. Additional supportive testimony expressed a desire to ensure that vision screenings would also be covered.

Your Reference Committee discussed how current policy supporting commercial and government-sponsored insurance coverage for all medical conditions recognized by national specialty organizations already gives MSV leadership the latitude to support legislation mandating a uniform adult vision material benefit without passing standalone policy.

Accordingly, your Reference Committee recommends that MSV Policy 10.1.18 be Reaffirmed in Lieu of Resolution 26-106:

10.1.18- Insurance Coverage for Medical Conditions

The Medical Society of Virginia affirms the need for government and commercial insurance plans to refer to a nationally recognized medical association or organization, such as the American Academy of Dermatology, in defining what is a medical condition versus a cosmetic condition, and be it further,

The Medical Society of Virginia affirms the need for government and commercial coverage for diagnostic evaluation and treatment of all conditions which have been recognized by a national medical association or organization as a medical condition.

The Medical Society of Virginia supports insurance coverage for early prescription refills of eyedrops and other essential medications when deemed medically appropriate.

7) 26-107 TRANSPARENCY AND ACCOUNTABILITY FOR THE 340B DRUG PRICING PROGRAM

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **Resolution 26-107 be Referred to the Board for Action.**

RESOLVED, that the MSV support legislation that enforces the 340b drug pricing program at the state level by requiring pharmaceutical manufacturers and wholesalers to offer discounts to qualifying entities according to HRSA guidelines, and be it further

RESOLVED, that the MSV support legislation to require qualifying entities to disclose 340B savings and demonstrate how those savings benefitted target patient populations.

Your Reference Committee heard supportive testimony regarding the need for oversight of the 340b program while preserving discounts for those who need it.

Your Reference Committee heard opposing testimony regarding the resolution merely addressing manufacturers and not hospitals and pharmacies. Your Reference Committee heard opposing testimony recognizing potential abuse of the 340b program but lamenting that the state had little oversight over the federal program. Your Reference Committee heard opposing testimony regarding this issue being deliberated recently at the AMA and recommending the issue be referring to the Virginia AMA delegation.

Your Reference Committee discussed the inherent complexity of this issue and the lack of clarity on how much state advocacy could affect the implementation and execution of a federal program.

Your Reference Committee discussed the possibility of referring the resolution to the Board for report. Counsel noted that Virginia's Department for Medical Assistance Services is already conducting a formal

mandated workgroup investigating the state's latitude to regulate the program and recommended that the Board not use valuable staff resources to duplicate the work being conducted by the state.

Your Reference Committee discussed the possibility of referring the resolution directly to the AMA delegation but given a lack of recent precedent for sch a deferral, ultimately resolved to defer the resolution to the Board for action with the intent that the Board could ask that the AMA delegation consider a resolution at the national level to address the spirit of this resolution.

Accordingly, your Reference Committee recommends that Resolution 26-107 be Referred to the Board for Action.

8) 26-108 PERFORMANCE-BASED SUNSET OF LOW-YIELD PRIOR AUTHORIZATION REQUIREMENTS

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **MSV Policy 10.10.03 be Amended in Lieu of Resolution 26-108.**

RESOLVED, that the Medical Society of Virginia supports requiring health plans to periodically review and discontinue prior authorization requirements with consistently high approval rates unless the plan demonstrates continued clinical or economic value.

Your Reference Committee heard supportive testimony regarding the necessity to implement a specific standard for periodic review of prior authorization requirements to prevent delays in care. More specifically, your Reference Committee heard supportive testimony suggesting some more specific standards, including removing prior authorization requirements for drugs and procedures with at least 90% approval rates.

Online comments were received for this resolution. One comment suggested having language added to reflect stronger, more objective reporting. One comment suggested adding language to have prior authorization creators submit data to a neutral party to assess the substance of prior authorizations issued. No oppositional online comments were received.

Your Reference Committee discussed how the MSV already has extensive policy on improving prior authorization laws and practices in the Commonwealth, though no language specific to low-yield prior authorization reviews. Your Reference Committee discussed if the spirit of the resolution could be added to existing policy. Your Reference Committee read the resolved clause of the resolution and decided that it could be easily inserted into MSV Policy 10.10.03. Your Reference Committee briefly debated whether specific guidelines should be added to policy language but opted to keep language flexible.

Accordingly, your Reference Committee recommends that MSV Policy 10.10.03 be Amended, in Lieu of Resolution 26-108:

10.10.03- Improve Upon the Current Prior Authorization Law in the State of Virginia

The Medical Society of Virginia will continue to work with Insurers and request they be more open and transparent about their approval (and rejection) processes and insist that they release information identifying the common evidence-based parameters for insurers' approval of the 10 most frequently

prescribed chronic disease management prescription drugs, as required by the 2015 law § 38.2-3407.15:2., and be it further

that the Medical Society of Virginia, work to require insurance companies, pharmacy benefit managers (PBM's) and other entities involved to upgrade the electronic approval of prescription requests, which has been shown to bring cost savings in other states within a few years of its implementation, and be it further

that the Medical Society of Virginia join the American Medical Association to aid in prior authorization reform with a goal of building a dialogue between providers, health plans and their third parties eliminate needless administrative waste from the system. and be it further

that the Medical Society of Virginia supports requiring health plans to periodically review and discontinue prior authorization requirements with consistently high approval rates unless the plan demonstrates continued clinical or economic value.

9) 26-109 SAFEGUARDS FOR ARTIFICIAL INTELLIGENCE AND AUTOMATED DECISION-MAKING IN HEALTH INSURANCE

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **MSV Policy 10.4.03 be Amended in Lieu of Resolution 26-109.**

RESOLVED, that the Medical Society of Virginia support legislation and regulation requiring health insurance carriers, pharmacy benefit managers, Medicaid managed care organizations, utilization-review entities, and their contractors to disclose when artificial intelligence, algorithms, or other automated decision-making systems materially influence coverage, prior-authorization, claims-payment, or utilization-management decisions, and be it further

RESOLVED, that the Medical Society of Virginia support prohibiting an automated decision-making system from independently issuing a final adverse determination involving medical necessity without individualized review of the pertinent patient record by an appropriately qualified human physician who is not financially incentivized to deny care, and be it further

RESOLVED, that the Medical Society of Virginia support requiring automated coverage and payment systems to use accurate and current evidence-based criteria, provide patients and treating physicians with the specific clinical and coverage reasons for adverse determinations, and preserve timely appeal and direct physician-to-physician review rights, and be it further

RESOLVED, that the Medical Society of Virginia support regular independent evaluation of payer automated decision-making systems for accuracy, reliability, security, algorithmic bias, disparate impact, and performance deterioration, together with public plan-level reporting of their uses, approval and denial rates, appeal and reversal rates, and decision turnaround times with appropriate patient-privacy protections, and be it further

RESOLVED, that the Medical Society of Virginia support preserving payer accountability for decisions materially influenced by automated systems, preventing the transfer of resulting liability or new administrative costs to treating physicians or patients, and applying these safeguards to all health plans and utilization-review arrangements within the Commonwealth's regulatory authority while supporting comparable federal protections for other plans.

Your Reference Committee heard supportive testimony regarding the proliferation of AI across industries including insurance and the need for transparency as to when AI is being utilized across the continuum of care. Your Reference Committee heard testimony that recommended language changes to be more specific about how the policy applies to health plan contractors and subcontractors.

Your Reference Committee discussed if the protections outlined in the resolution were addressed anywhere in current MSV policy. Staff identified MSV Policy 10.4.03, which extensively outlines the principles of managed care supported by the society. After reviewing the current policy at length, the Reference Committee felt that the policy could more specifically address some of the principles of the resolution, including issues of liability and automated systems.

Your Reference Committee discussed proposed amendment language at length to ensure that it matched the spirit of the resolution while addressing the clarifications and concerns outlined in opposing testimony.

Accordingly, your Reference Committee recommends that MSV Policy 10.4.03 be Amended in Lieu of Resolution 26-109:

10.4.03- Principles of Managed Care

Introduction

In an ideal world the needs of patients might best be served by free market competition and free choice by physicians and patients between alternative delivery and financing systems, with the growth of each system determined not by preferential regulation and subsidy, but by the number of persons who prefer that mode of delivery or financing. Unfortunately, in the real-world unfettered capitalism may not adequately protect the health care needs of Virginia's citizens, both sick and healthy, individual and corporate.

As this state's health care market place becomes increasingly dominated by health plans that utilize various managed care techniques that include decisions regarding coverage and the appropriateness of health care, it is a vital state governmental function to protect patients from unfair managed care practices.

Increasingly, it appears that insurance companies and other managed care organizations are aggressively discontinuing physicians from their networks, making inappropriate decisions to refuse, limit, or terminate health care services, and restricting patient's ability to make choices concerning their health care decisions and providers. It is essential to assure fairness in managed plans and to provide mechanisms for delineating necessary protections for both physicians and patients.

Therefore, The Medical Society of Virginia feels strongly that Virginia should adopt legislation which would require that managed care plans assure fairness to patients and providers. This would include state standards for certification of qualified managed care plans and utilization review programs as well as standards to ensure patient protection, physician and provider fairness, utilization review safeguards and coverage options for all patients, including the ability to enroll in a point of service plan. There should be a certification process with periodic reviews and recertification requirements.

Requirements for meeting the standards of certification should include the criteria articulated throughout the rest of this document.

Definitions

"Managed" care is defined as: systems or techniques generally used by third party payers or their agents to control access and payment for health care services.

Managed care techniques include: (a) Prior, concurrent, and retrospective review of the medical necessity and appropriateness of services and/or site of services. (b) Financial incentives or disincentives related to the use of specific providers, services, or service sites. (b2) Limitations on the numbers and types of providers included in the plan and mechanisms to initially exclude or, later, to deselect providers from plans, (c) Controlled access to and coordination of services by a gatekeeper (d) Payer efforts to identify treatment alternatives and modify benefit restrictions for high-cost patients (high-cost case management).

A. Utilization Review

The medical protocols and review criteria used in any utilization review or utilization management program must be developed by physicians. Public and private payers should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed. <u>The use of artificial intelligence by health insurers and other utilization review entities in coverage, prior authorization, claims payment, and utilization management decisions shall be disclosed to patients, physicians, and Pas, and any adverse determination shall state the specific clinical and coverage reasons for the decision. Automated decision-making systems used by these entities shall undergo regular independent evaluation for accuracy, reliability, security, algorithmic bias, disparate performance, and impact over time, and their use and outcomes shall be publicly reported.</u>

A physician of the same branch of medicine (allopathic or osteopathic) and specialty must be involved in any decision by a utilization management program to deny or reduce coverage for services based on questions of medical necessity. All health plans conducting utilization management or utilization review should establish an appeals process whereby physicians, other health care providers, and patients may challenge policies restricting access to specific services and decisions to deny coverage for services, and have the right to review of any coverage denial based on medical necessity by a physician consultant who is of the same specialty and has appropriate expertise and experience in the field.

A physician whose services are being reviewed for medical necessity should be provided the identity of the reviewing physician on request. Any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of services should be licensed to practice medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the reviewed service and should be professionally and individually accountable for his or her decisions. The names and credentials of individuals conducting necessity or appropriateness reviews must be available upon request.

Any health plan or utilization management firm conducting a prior authorization program should act within two business days after receipt of any patient or physician request for prior authorization and respond by phone within one business day after receipt of other questions regarding medical necessity of services. Plans may not require prior authorization for emergency care. Prior approval decisions should be valid unless based on fraud or incorrect information.

All health plans should establish a formal mechanism for participating physicians to have meaningful input into the plans' medical policies, including coverage and utilization review criteria. Health plans must safeguard medical record confidentiality and are responsible for making sure that patients sign the forms consenting to disclosure of medical information if prior authorization is required for any procedures or services.

B. Gatekeepers, Limited Provider Panels, and Financial Disincentives

Health care plans should be required to limit appropriately those arrangements in which the providers have a financial incentive to limit or deny services, including referrals for patients to specialists. Any financial arrangements that may tend to limit the services offered to patients, or contractual provisions

that may restrict referral or treatment options, should be required by law to be fully disclosed to patients and prospective enrollees by all plans utilizing such arrangements.

Regulations protecting patients from under-referral for financial gain are just as desirable as regulations to limit physician self-referral because of concern about overutilization for financial gain. Physicians and managed care organizations must disclose to their patients any financial inducements or contractual agreements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients or restrict referral or treatment options. Physicians may satisfy their disclosure obligations by assuring that the managed care plan adequate makes full disclosure of all such arrangements to patients enrolled in the plan. Physicians must also inform their patients of medically appropriate treatment options regardless of their cost or the extent of their coverage.

Physicians should have the right to enter into whatever contractual arrangements with health care systems they deem desirable and necessary, but should be aware of the potential for some types of systems to create undesirable conflicts of interest because of financial incentives to withhold medically indicated services.

Physicians must not allow such financial incentives to influence their judgment of appropriate therapeutic alternatives or deny their patients access to appropriate services, including referrals to specialists, based on such inducements. Physician payments that provide an incentive to limit the utilization of services should not link financial rewards with individual treatment decisions over periods of time insufficient to identify patterns of care nor should they expose the physician to excessive financial risk for services provided by physicians or institutions to whom he or she refers patients for diagnosis or treatment. When risk sharing arrangements are relied upon to deter excess utilization, physician incentive payments should be based on performance of groups of physicians rather than individual physicians, and should not be based on performance over short periods of time.

Alternative private health benefit plans, with different schedules of deductibles, coinsurance and premiums, should be available to enrollees so that they are aware of the financial tradeoffs associated with different plans. Both private and public third-party payment systems should use deductibles and coinsurance as financial incentives for health care recipients to use health care resources in an appropriate manner. However, cost-sharing should not result in an undue financial burden for the health care recipient, and should not act to prevent access to needed care.

Physicians, other health professionals, and third-party payers through their reimbursement policies, should continue to encourage use of the least expensive care settings in which medical and surgical services can be provided safely and effectively with no detriment to quality. Evaluation of "Quality" should place some value on the continuity of the patient-physician relationship.

With the increased specialization of modern health care, it may be advantageous for each patient to have a single physician to help coordinate the medical care of the patient and to act as the repository for all of the medical information on the patient. The physician is best suited by professional preparation to assume this leadership role. It may be appropriate to utilize appropriate financial mechanisms to encourage patients to take optimum advantage of such a primary care provider. It may not be medically appropriate or cost effective to require that all medical care be provided by, or with permission from, one's primary care provider.

Specialty physicians should have formal and meaningful input into developing each plan's policies on appropriateness of referrals to specialists.

All restrictive plans should notify physicians annually of their opportunity to apply for plan credentials; establish credentialing standards with input from physicians and make them available to applicants and enrollees. Selection criteria must be based on professional competence and quality of care and, in general, no single criterion, including specialty, should provide for the sole basis for selecting, retaining,

or excluding a physician from a health delivery or financing system. Profiling must be adjusted for the individual physician's case mix.

Physicians cannot be removed from a plan because their patients have rare, unusual or highly complex conditions which require specialized care and that are expensive to treat. Nor can they be removed under a contract that allows termination "without cause" or terminated or denied participation without explanation of reasons for the decisions, and an opportunity to appeal.

All plans should demonstrate adequate access to physicians and other providers, including specialists, to ensure timely, high-quality service.

C. High-Cost Case Management

The primary goal of high-cost case management or benefits management programs should be to help to arrange for the services most appropriate to the patient's needs. Cost containment is a legitimate but secondary objective. In developing an alternative treatment plan, the benefits manager should work closely with the patient, attending physician, and other relevant health professionals involved in the patient's care.

When inordinate amounts of time or effort are involved in providing case management services required by a third-party payer which entail coordinating access to other health care services needed by the patient, or in complying with utilization review requirements, the physician may charge the payer or the patient for the reasonable cost incurred. "Inordinate" efforts are defined as those more costly, complex and time-consuming than the completion of standard health insurance claim forms, such as obtaining pre admission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage."

D. Disclosure

All health benefit plans should be required to clearly and understandably communicate to enrollees and prospective enrollees in a standard disclosure format those services which they will and will not cover and the extent of coverage for the former. The information disclosed should include the proportion of plan income devoted to utilization management, marketing, and other administrative costs, and the existence of any review requirements, financial arrangements or other restrictions that may limit services, referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patients. It is the responsibility of the patient and his or her health benefits plan to inform the treating physician of any coverage restrictions imposed by the plan.

E. Liability

All health plans or any other agent utilizing managed care techniques, the medical director, ~~and~~ any involved reviewers, ~~should~~ shall be subject to legal action for any harm incurred by the patient resulting from application of such techniques, including decisions made or materially influenced by artificial intelligence or other automated decision-making systems. Health plans or agents remain accountable for such decisions whether the system is developed or operated by the plan or agent. Such plans or agents should also be subject to legal action for any harm to enrollees resulting from failure to disclose prior to enrollment any coverage provisions; review requirements; financial arrangements; or other restrictions that may limit services, referral, or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient.

F. Consumer Choice

Employers, health plans or networks must allow for patients' choice of physician and system of health care delivery.

Any sponsor (e.g., employer, regional alliance, insurance pool) who offers a restrictive health benefit plan must make available a variety of types of plans including HMO's, traditional insurance plans, or a benefit payment schedule, establishing up front a set amount that will be paid for each covered service.

At the time of enrollment in a plan that restricts access, and at least one year thereafter, each patient shall be offered the opportunity to pay an additional premium for a "point of service" plan that will entitle him or her to reimbursement for services obtained outside the network or outside any restrictive referral rules. "Out- of - network" or "point of service" plans include plans that may reimburse for any non-covered service whether it is provided inside or outside the patient's plan.

The additional premium for point of service coverage must reflect the actuarial value of such coverage. A point of service plan may require a reasonable copayment.

Individuals' and employers' rights to pay for services outside of the health plan or benefit package should be expressly preserved.

In order for consumers to make fully informed decisions it is imperative that all plans disclose to prospective enrollees clear and accurate information, in a standardized format, on coverage exclusions; prior authorization or other review requirements that might result in nonpayment for a given procedure or service; financial arrangements that reward hospitals, physicians and other providers for delivering less care, or that limit referrals to other providers; the enrollees own liability for coinsurance or for payments for out-of-plan services; the plan's administrative expenditures as a percentage of total premiums, and enrollee satisfaction statistics.

Miscellaneous

A state agency must periodically review and revise, if necessary, established standards.

10) 26-110 SUPPORTING RESIDENT AND FELLOW PHYSICIAN UNIONIZATION & COLLECTIVE BARGAINING

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **Resolution 26-10 be Adopted as Amended.**

RESOLVED, that the Medical Society of Virginia recognize resident and fellow physicians as both learners and employees and support their right to determine freely whether to form, join, or decline to join a labor organization and, when they choose representation, to bargain collectively without intimidation, interference, discrimination, or retaliation, and be it further

RESOLVED, that the Medical Society of Virginia support legislation and other lawful measures ensuring that resident and fellow physicians employed by Virginia public institutions have rights and protections to organize and bargain collectively that are substantially equivalent to those available to similarly situated private-sector resident and fellow physicians, and be it further

RESOLVED, that the Medical Society of Virginia encourage Virginia graduate medical education institutions to respect resident and fellow physicians' organizing choices, refrain from intimidation, interference, discrimination, or retaliation, and, when a representative is lawfully selected, bargain in good faith over terms and conditions of employment while preserving accreditation-based academic standards and uninterrupted access to essential patient care.

Your Reference Committee heard supportive testimony advocating for protections against adverse retaliation and emphasizing the need to support young physicians as corporate entities proliferate hospitals and health systems. Your Reference Committee also heard supportive testimony outlining the demanding work hours with little control over schedules.

Your Reference Committee heard supportive testimony regarding allowing residents and fellows to unionize, creating a tangible impact in advocating for their patients. Your Reference Committee heard additional supportive testimony regarding collective bargaining not being met with adverse effects and not mandating collective bargaining.

Your Reference Committee heard oppositional testimony regarding the adversarial relationship unionization creates when the relationship between a resident and an attending should be one of collaboration.

Your Reference Committee discussed the testimony at length and universally agreed that, given the increasingly corporate environment within which medicine is operating, it was important that the MSV establish concrete policy advocating for individual provider and protections for them from creeping corporate influences. Your Reference Committee also discussed Virginia's difficulties with losing graduating medical students to residency in other states and that more needed to be done to incentivize Virginia medical students to stay for residency in Virginia while attracting graduating medical students from other states as well.

However, your Reference Committee found the resolution as submitted to be very prescriptive and universally aligned with staff language recommendations that offered brevity while maintaining the core tenets of the resolution.

Accordingly, your Reference Committee recommends that Resolution 26-110 be Adopted as Amended:

~~*RESOLVED, that the Medical Society of Virginia recognize resident and fellow physicians as both learners and employees and support their right to determine freely whether to form, join, or decline to join a labor organization and, when they choose representation, to bargain collectively without intimidation, interference, discrimination, or retaliation, and be it further*~~

RESOLVED, that the Medical Society of Virginia support<u>s the right of</u> ~~legislation and other lawful measures ensuring that~~ resident and fellow physicians employed by Virginia public ~~institutions have rights and protections~~ to organize and bargain collectively <u>and supports the right of resident and fellow physicians to determine freely whether to for, join, or decline to participate in a collective bargaining entity.</u> ~~that are substantially equivalent to those available to similarly situated private-sector resident and fellow physicians, and be it further~~

~~*RESOLVED, that the Medical Society of Virginia encourage Virginia graduate medical education institutions to respect resident and fellow physicians' organizing choices, refrain from intimidation, interference, discrimination, or retaliation, and, when a representative is lawfully selected, bargain in good faith over terms and conditions of employment while preserving accreditation-based academic standards and uninterrupted access to essential patient care.*~~

11) 26-111 PREVENTING GENETIC DISCRIMINATION BY INSURERS

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **Resolution 26-111 be Adopted as Amended.**

RESOLVED, that the Medical Society of Virginia supports legislative efforts prohibiting life, disability, and long-term care insurers from using an individual's genetic information in underwriting, eligibility, coverage, or premium determinations.

Your Reference Committee heard supportive testimony regarding protecting genetic discrimination from life insurance premium increases, specifically citing Florida enacting similar laws. Your Reference Committee heard supportive testimony regarding not limiting preventative care for Virginians. Your Reference Committee heard supportive testimony regarding ensuring Virginians don't miss out on receiving preventative care.

Your Reference Committee heard testimony regarding adding "legislative and/or regulatory" to this and similar resolutions that are asking MSV to support legislative efforts.

Your Reference Committee briefly discussed the merits of the resolution and the lack of concrete policy on insurer discrimination. While the MSV has policy on access to care without discrimination, it was unclear if that policy encompassed access to coverage.

Therefore, your Reference Committee recommends that Resolution 26-211 be Adopted as Amended:

RESOLVED, that the Medical Society of Virginia opposes ~~supports legislative efforts prohibiting~~ life, disability, and long-term care insurers ~~from~~ using an individual's genetic information in underwriting, eligibility, coverage, or premium determinations.

12) 26-112 IMPROVING ACCESS TO FORENSIC MEDICAL EVALUATIONS FOR ASYLUM SEEKERS

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **Resolution 26-112 be Referred to the Board for Action.**

RESOLVED, that the Medical Society of Virginia supports efforts to train and recruit physicians to conduct medical and psychiatric forensic evaluations for asylum seekers in Virginia using continuing medical education opportunities, communication channels, and existing resources, including, but not limited to, the Asylum Medicine Training Initiative, and be it further

RESOLVED, that the Medical Society of Virginia supports medical student initiatives related to asylum medicine and forensic medical evaluation through methods including but not limited to, supporting educational initiatives and recruitment efforts for student asylum clinics.

Your Reference Committee heard supportive testimony regarding the powerful impact physicians can have outside the clinic as it relates to documenting asylum seekers and the critical care gap it can close.

Your Reference Committee heard testimony regarding applying for grants from asylum-seeking specific organizations in lieu of adding this resolution to the MSV Policy Compendium.

Your Reference Committee heard opposing testimony regarding applying for grants from asylum-seeking specific organizations in lieu of adding this resolution to the MSV Policy Compendium.

Online comments were received for this resolution. One comment suggested omitting everything after "resources" in the first resolve as it is not typical MSV practice to name external entities.

Your Reference Committee discussed the consideration of this resolution as a CME offering as it supports efforts to train physicians to conduct medical and psychiatric forensic evaluations. Your Reference Committee also discussed whether referral to the Board would satisfy the desired outcome of the authors and agreed that the outcome would more than satisfy the spirit of the resolution.

Accordingly, your Reference Committee recommends that Resolution 26-112 be Referred to the Board for Action.

13) 26-113 PREVENTION OF AUTOMATIC DOWNCODING AND TRANSPARENCY IN DOWNCODING DECISIONS

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **MSV Policy 10.3.16 be Reaffirmed in Lieu of Resolution 26-113.**

RESOLVED, that MSV support the creation of legislation to address the issues of downcoding for the practice of medicine such that there is transparency in downcoding decisions, the right to appeal and to have a peer to peer review process, reimbursement based on E/M coding guidelines and timely resolution of reviews and appeals.

Your Reference Committee heard supportive testimony stating that Virginia passed legislation last year regarding downcoding. Supportive testimony was also heard stating that Virginia physicians needed to recognize the impacts of obstetrics billing changes and how downcoding would affect reimbursement.

Your Reference Committee heard opposing testimony stating that this should not be a matter of legislation but rather a class action lawsuit.

Online comments were received for this resolution. One comment suggested that more specificity needed to be added particularly for which specialties have downcoding issues.

Your Reference Committee discussed how the MSV was able put forward and pass legislation in Virginia based on its existing policy concerning carrier fair business practices.

Accordingly, your Reference Committee recommends that MSV Policy 10.3.16 be Reaffirmed in Lieu of Resolution 26-113:

10.3.16- Third Party Payer Fair Business Practice Principles

Medical Society of Virginia supports the following fair business practices:

I. Payment issues:

A. Place a time limit for full payment of clean claims,

B. Disclose to the contracted practice the processing procedure for claims approval,

C. Prohibit the arbitrary bundling of unbundled claims,

D. Prohibit automatic or arbitrary downcoding of claims and request the review of such acts by the Virginia Commissioner of Insurance,

E. Prohibit the garnishment of payment on Explanation of Benefits (EOB),

F. Limit the time for retroactive denial of payments when requesting a refund from a physician after the time the service was provided,

G. Publish the contracted prices to be paid for claims 3 months prior to their effective date, and,

H. Publish the contracted adjudication guidelines three months in advance of their effective

I. Prohibit health plans from fining physicians or denying/ withholding payment in instances of patient non-compliance with health plan referral requirements.

II. Contract Issues:

A. Require a reasonable time limit for physicians to receive certification in order to be paid by the plan, or require the plan to pay for the services while waiting for certification,

B. Prohibit the "Most Favored Nation" clause from contracts, and,

C. Prohibit retaliation against physicians or groups who do not accept certain contracts offered by insurers.

III. Physician Due Process:

A. Require a reasonable time limit to receive a precertification authorization for treatment,

B. Provide physicians access to their profiling data, and,

C. Provide procedural due process to physicians expelled from a health plan to include adequate notification of removal, explanation of the reasons for the removal, and the ability to contest the proposed removal through an external appeals process.

IV. Patient Issues:

A. Require that precertification by telephone be toll free for physicians and patients,

B. Require a managed care organization (MCO), health plan, dental plan, or pharmacy benefits manager using a formulary to disclose to its members and participating physicians their initial formulary and annually thereafter, the frequency of formulary changes and a description of the process for developing the formulary and evaluating new therapies,

C. Require any carrier using a restrictive formulary for prescription medications to allow patients to obtain, without penalty to the physician and the patient and in a timely manner, specific drugs and medications not included in the formulary when the formulary's equivalent has been clinically ineffective or when the physician treating the patient believes the formulary's medication causes, or is reasonably expected to cause adverse or harmful reactions in the patient,

D. Eliminate the necessity for approval or referral from the primary care physician in order for patients to be covered for after-hours urgent care or emergency service in accordance with the prudent layperson statute,

E. Require MCOs to educate their members on after-hours medical care,

F. Require insurance companies to log in appeals at the time of their receipt,

G. That health plans not encourage short-term mail order prescriptions and not financially penalize those who have prescriptions filled locally,

H. Create an objective and timely process for considering the authorization of investigational treatments and for evaluating coverage of innovative technologies, drugs, devices, and procedures.

The Medical Society of Virginia believes that any third-party payer should not interfere in the physician patient-relationship and will strongly oppose any business practices that may compromise the care of patients.

14) 26-114 PATIENT PROTECTIONS FOR PREDISPUTE ARBITRATION

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **Resolution 26-114 be Not Adopted.**

RESOLVED, that the Medical Society of Virginia support state legislation prohibiting any Virginia health care facility, state-regulated health plan, or other non-physician-owned corporate health care entity from requiring a patient to execute a predispute binding arbitration agreement or predispute class-action waiver as a condition of receiving medically necessary care, admission, enrollment, continued care, or continued coverage, and be it further

RESOLVED, that the Medical Society of Virginia support minimum patient-protective standards for any patient-facing predispute arbitration agreement used in health care, including that the agreement be presented separately from clinical consent forms, clearly explain the meaning of the waiver of court, jury, class-action, and appellate rights in plain language, and provide a meaningful opportunity to decline or rescind consent without jeopardizing access to medically necessary care, admission, enrollment, continued care, or continued coverage.

Your Reference Committee heard supportive testimony stating that patients are being taken advantage of in pre-dispute arbitrating and that Colorado and Illinois had passed legislation offering patient protections.

An online comment was received for this resolution. One comment suggests presenting this resolution to the Virginia Trial Lawyers Association, as it relies heavily on contract law. One comment suggests providing data on how often physicians use arbitration clauses in Virginia.

Your Reference Committee discussed the specificities of the resolution and the lack of evidence for this specific problem in Virginia. Your Reference Committee also discussed that while this issue is important, there is already a lot of federal oversight on this issue and would like to see additional research and specific evidence. Counsel also mentioned legal complications with existing EMTALA statute and regulations.

Accordingly, your Reference Committee recommends 26-114 be Not Adopted.

15) 26-115 PROCEDURAL SAFEGUARDS FOR PAYER PAYMENT-INTEGRITY ACTIONS

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **Resolution 26-115 be Not Adopted.**

RESOLVED, that the Medical Society of Virginia support state legislation, regulation, or Medicaid managed care contracting standards requiring notice to affected enrollees, continuity-of-care protections, and transition assistance for patients in an active course of treatment when a provider is removed from network participation or payment is suspended "for cause" based on SIU or other payment-integrity program findings before final adjudication, unless the carrier or Medicaid managed care organization documents an immediate patient safety risk, and be it further

RESOLVED, that our Medical Society of Virginia supports policies prohibiting recovery-linked compensation arrangements for SIU contractors or payment-integrity vendors when such arrangements may influence recommendations that result in provider removal or other actions that materially affect patient access to care.

Your Reference Committee heard supportive testimony regarding special investigation units at insurance companies and the broad authority they have to drop doctors "for cause" and leave patients in the dark. Your Reference Committee heard supportive testimony regarding the steps these departments take to make their decisions, the need to have transition of care protections, and how patients should not be caught in the middle of disputes.

Your Reference Committee heard testimony regarding the need to clarify SIUs addressed specifically as "Special Investigation Units."

Online comments were received for this resolution. One comment is concerned with the potential redundancy of the second resolved clause, stating it can end after "vendors."

Your Reference Committee discussed existing MSV policy on the principles of managed care and recent reforms pertaining to regulating Managed Care Organizations. Members believed that many of the desired positions outlined in the lengthy resolution were already addressed in current policy. Members discussed reaffirming that policy in lieu of this resolution; however, because they recommend amending said policy in lieu of another resolution, the most prudent option for this resolution was to recommend it be not adopted.

Accordingly, your Reference Committee recommends that Resolution 26-115 be Not Adopted.

16) 26-116 RECOGNIZING PROGRESSIVE CHILDHOOD MYOPIA AS A CLINICAL DISEASE

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **MSV Policy 10.1.18 and MSV Policy 40.1.16 be Reaffirmed in Lieu of Resolution 26-116.**

RESOLVED, that the Medical Society of Virginia recognize progressive childhood myopia as a clinical disease with long-term ocular, functional, and psychosocial morbidity rather than solely as a routine refractive condition, and be it further

RESOLVED, that the Medical Society of Virginia support state-level surveillance by the Virginia Department of Health or other appropriate state entities to collect and report standardized data on pediatric myopia prevalence, severity, and progression, and be it further

RESOLVED, that the Medical Society of Virginia support Medicaid, FAMIS, and state-regulated private insurance coverage for evidence-based myopia-control evaluation and therapies when medically necessary and prescribed by an appropriately licensed clinician.

Your Reference Committee heard supportive testimony regarding the AMA's policy on this issue and how the classification of myopia as a disease will allow Virginia to develop and correct data to better understand and address it.

Your Reference Committee heard opposing testimony about the MSV recognizing a new disease without a larger coalition or endorsement to lead the efforts. Your Reference Committee also mentioned that the AMA just passed similar resolutions and if there would be any difference between the MSV's and AMA's language.

Your Reference Committee discussed extensively discussed AMA resolution 411 (policy H-440.786), which focuses on myopia management and its classification. They discussed myopia becoming a growing trend and central theme of current public health issues. Your Reference Committee discussed insurance coverage which is included in MSV Policy 10.1.18 and MSV Policy 40.1.16 and the pitfalls of adding specific medical conditions to current policy contributing to a Christmas tree effect. Your Reference Committee discussed MSV Policy 40.1.16 potentially missing references to economic outcomes. They discussed the Medical Students Section's great efforts on their research and bringing the importance of this issue to the House of Delegates.

Accordingly, your Reference Committee recommends that MSV Policy 10.1.18 and MSV Policy 40.1.16 be Reaffirmed in Lieu of Resolution 26-116:

10.1.18- Insurance Coverage for Medical Conditions

The Medical Society of Virginia affirms the need for government and commercial insurance plans to refer to a nationally recognized medical association or organization, such as the American Academy of Dermatology, in defining what is a medical condition versus a cosmetic condition, and be it further,

The Medical Society of Virginia affirms the need for government and commercial coverage for diagnostic evaluation and treatment of all conditions which have been recognized by a national medical association or organization as a medical condition.

The Medical Society of Virginia supports insurance coverage for early prescription refills of eyedrops and other essential medications when deemed medically appropriate.

40.1.16- Public Health Research and Social Determinants of Health

The Medical Society of Virginia supports the Virginia Department of Health in current and future data collection that accurately captures rates of disease prevalence, diagnosis, treatment, morbidity, and mortality among varying demographics, and supports continued research into the social determinants of health in the Commonwealth

17) 26-117 SUPPORTING DEVELOPMENT OF A VIRGINIA MEDICAID NUTRITION BENEFIT FOR INDIVIDUALS WITH DIET-RELATED CHRONIC CONDITIONS

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **Resolution 26-117 be Adopted as Amended.**

RESOLVED, that the Medical Society of Virginia support the Department of Medical Assistance Services' development and implementation of a Medicaid managed care in-lieu-of-services nutrition benefit for Medicaid members with diet-related chronic conditions, consistent with the recommendation of the Virginia Joint Commission on Health Care, and be it further

RESOLVED, that the Medical Society of Virginia advocate to the Virginia General Assembly for the appropriation of funding necessary to implement the nutrition in-lieu-of-services benefit following its development by the Department of Medical Assistance Services, and be it further

RESOLVED, that the Medical Society of Virginia support state investment in expanding evidence-based Food is Medicine interventions, including produce prescription programs, to additional regions of the Commonwealth.

Your Reference Committee heard supporting testimony regarding seeing the issue as not a social issue, but as a chronic disease that requires consistent treatment. Your Reference Committee also heard that developing a Medicaid nutrition benefit builds on the food as medicine plans.

Your Reference Committee heard opposing testimony with concern to the whereas clause citing incorrect information and information in the resolved clause being conflated.

Your Reference Committee discussed not referencing any official "Food is Medicine" organization as it is not the policy of the MSV to endorse specific products or trademarks. Additionally, your Reference Committee members believed that the language of the first resolved clause could be supported by nature of adopting the second resolved clause as amended.

Accordingly, your Reference Committee recommends that Resolution 26-117 be Adopted as Amended:

~~*RESOLVED, that the Medical Society of Virginia support the Department of Medical Assistance Services' development and implementation of a Medicaid managed care in-lieu-of-services nutrition benefit for Medicaid members with diet-related chronic conditions, consistent with the recommendation of the Virginia Joint Commission on Health Care, and be it further*~~

~~*RESOLVED, that the Medical Society of Virginia advocate to the Virginia General Assembly for the appropriation of funding necessary to implement the nutrition in-lieu-of-services benefit following its development by the Department of Medical Assistance Services, and be it further*~~

RESOLVED, that the Medical Society of Virginia support state investment in expanding evidence-based ~~Food is Medicine~~ interventions such as food as medicine and~~, including~~ produce prescription programs, to additional regions of the Commonwealth.

18) 26-118 ENSURING HEALTHCARE ACCESS FOR PEOPLE LIVING WITH HIV

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **MSV Policy 10.6.07 be Amended in Lieu of Resolution 26-118.**

RESOLVED, that the Medical Society of Virginia supports adopting a broad definition of the medical frailty exception to Medicaid work requirements that includes people living with HIV, and that this is a permanent exemption for unchanging conditions such as HIV, and be it further

RESOLVED, that the Medical Society of Virginia supports increasing funding to the Virginia Medication Assistance Program (VA MAP) and the Virginia Ryan White program in order to bolster their safety net efforts.

Your Reference Committee heard supportive testimony regarding patients appearing healthy but falling out of compliance if Medicaid coverage is lost, particularly if they only have access to public programs, which have been cut. Your Reference Committee heard supportive testimony regarding the need to keep HIV+ patients enrolled in Medicaid coverage.

Your Reference Committee heard opposing testimony regarding the potential fraud associated with treating patients who are relatively healthy but would be included under this resolution. Your Reference Committee heard opposing testimony regarding the issue of the term "medically frail" and "frailty." Your Reference Committee heard additional opposing testimony regarding keeping too many patients on Medicaid by classifying them as frail.

Your Reference Committee extensively discussed the meaning of the word "frailty" and whether it should be included in the policy language. Members discussed mentioning "chronic illnesses" instead of frailty. Your Reference Committee discussed the intricacies of federal work requirements and what policies may look like should that be up for debate in the future. They discussed adding in community service or education to the language surrounding work requirements to ensure that these exemptions also applied to those requirements.

Accordingly, your Reference Committee recommends that MSV Policy 10.6.07 be Amended in Lieu of Resolution 26-118:

10.6.07- Opposing Work Requirements for Virginia Medicaid Eligibility

The Medical Society of Virginia opposes work requirements, including community service and education requirements, as a condition of eligibility for Medicaid. Should federal work requirements exists, the Medical Society of Virginia supports exceptions for a broad range of chronic illnesses and diseases that might otherwise interfere with a person's ability to meet those requirements.

Madame Speaker, Your Reference Committee Chair has certified this Report by signature as follows:

I, Dr. Bobbie Sperry, as Chair of Reference Committee #1, offer my signature to confirm that I have verified the attached draft of this report for accuracy of our Committee's discussion and proceedings.

October 16th, 2026

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