

## AMA-YPS Handbook Review: HOD Reference Committee B (legislation)

Full text at <http://www.ama-assn.org/ama1/pub/upload/mm/475/refcomb.pdf>. Recommendations are preliminary until ratified by the AMA-YPS Assembly on June 12, 2009. Recommended AMA-YPS Positions: Support, Active Support, Oppose, Active Oppose, Monitor

RESOLUTION/Report	ACTION REQUESTED	YPS POSITION	FINAL HOD ACTION
<b>BOT Report 7:</b> Shadegg Bill (Health Care Choice Act)	<p>The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 215 (A-08), and that the remainder of this report be filed:</p> <p>That our American Medical Association reaffirm AMA Policy H-165.856, "Health Insurance Market Regulation."</p> <p>Fiscal Note: \$0</p>	Support	Adopted
<b>BOT Report 8:</b> Fairness in Medical Imaging Interpretation	<p>The AMA Board of Trustees recommends that the following be adopted and the remainder of this report be filed:</p> <ol style="list-style-type: none"> <li>1. That the American Medical Association continue to work with CMS to ensure that fair Medicare accreditation standards for advanced imaging services are adopted by the selected accrediting organizations. (Directive to Take Action)</li> <li>2. That the AMA encourage Congress and the Administration to allow the MIPPA-mandated Medicare accreditation program be fully implemented and evaluated before further changes to Medicare's imaging standards and payments are made. (Directive to Take Action)</li> <li>3. That the AMA monitor the two-year Medicare appropriateness program, scheduled to begin in 2010, and work with the CMS to develop appropriateness (and exceptions) criteria if it decides to move forward with a permanent program. (Directive to Take Action)</li> <li>4. That the AMA continue to work with specialty societies to correct payer and RBM policies that unfairly exclude qualified physicians from providing imaging services.</li> </ol> <p>Fiscal Note: Less than \$500</p>	Support/Monitor	Adopted as amended; see <a href="http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-b-annotated.pdf">http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-b-annotated.pdf</a> for exact language
<b>BOT Report 10:</b> Legal Protections for Peer Review (BOT Report 18, A-08)	<p>The Board of Trustees recommends that our American Medical Association adopt the following definition of peer review, including the definitions of the structural elements that support medical peer review process in lieu of Board of Trustees Report 18 (A-08), (New HOD Policy); and that the remainder of this report be filed.</p> <p><u>Definition and Purpose of Peer Review</u> Peer review is the task of self-monitoring and maintaining the administration of patient safety and quality of care, consistent with optimal standards of practice. It is the mechanism by which the medical profession fulfills its obligation to ensure that its members are able to provide safe and effective care. The responsibility assigned to and scope of peer review is the practice of medicine; ie, professional services administered by a physician and the portion of care under a physician's direction. Therefore, elements of medical care, which describe the knowledge, skills, attitudes, and educational experiences of physicians and provide the foundation of physician activities, are subject to peer review and its protections. Those elements include, but are not limited to the following: patient care, medical knowledge,</p>	Support	Adopted as amended; see <a href="http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-b-annotated.pdf">http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-b-annotated.pdf</a> for exact language

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	<p>interpersonal and communication skills, practice-based learning and improvement, and systems-based practice. Activities that comprise medical care are subject to the scope and rigor of peer review and entitled to the protections and privileges afforded by peer review law.</p> <p>Peer review goes beyond individual review of instances or events; it is a mechanism for assuring the quality, safety, and appropriateness of hospital services. The duties of peer review are: addressing the standard of care, preventing patient harm, evaluating patient safety and quality of care, and ensuring that the design of systems or settings of care support safety and high quality care. Accountability to patients and their care, to the medical profession and colleagues, and to the institution granting privileges is inherent to the peer review process.</p> <p><u>Composition of the Peer Review Committee</u> Peer review is conducted in good faith by physicians who are within the same geographic area or jurisdiction and medical specialty of the physician subject to review to ensure that all physicians consistently maintain optimal standards of competency to practice medicine. Physicians outside of the organization that is convening peer review may participate in that organization's peer review of a physician if the reviewing physician is within the same geographic area or jurisdiction and medical specialty as the physician who is the subject of peer review.</p> <p><u>Definitions</u></p> <p><u>Good Faith Peer Review.</u> Peer review conducted with honest intentions that assess appropriateness, medical necessity, and efficiency of services to assure safe, high-quality medical care is good faith peer review. Misfeasance (i.e., abuse of authority during the peer review process to achieve a desired result other than improved patient care), or misuse of the peer review process, or peer review that is politically motivated, manipulated to achieve economic gains, or due to personal vendetta is not considered a good faith peer review.</p> <p><u>Medical Peer Review Organizations.</u> Any panel, committee, or organization that is composed of physicians or formed from a medical staff or formed by statute, such as physician wellness peer review boards, which engages in or utilizes peer reviews concerning the care and treatment of patients for the purposes of self-monitoring and maintaining the administration of patient safety and quality of care consistent with optimal standards of practice is a medical peer review organization. The responsibility of a medical peer review organization is to ensure: (1) that all physicians consistently maintain optimal standards of competency to practice medicine; and (2) the quality, safety, and appropriateness of patient care services. The medical peer review committee's obligations include review of allegations of infirmity (e.g., fitness to practice medicine), negligent treatment, and intentional misconduct. Peer</p>		

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	<p>review protections and privilege should extend to investigation and subsequent correction of negligent treatment and intentional misconduct.</p> <p><u>Proceedings.</u> Proceedings include all of the activities and information and records of a peer review committee. Proceedings are not subject to discovery and no person who was in attendance at a meeting of a peer review organization shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such organization or as to any findings, recommendations, evaluations, opinions, or other actions of such organization or any members thereof. However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil action merely because they were presented during proceedings of a peer review organization, nor should any person who testifies before a peer review organization or who is a member of a peer review organization be prevented from testifying as to matters within his/her knowledge; but such witness cannot be asked about his/her testimony before a peer review organization or about opinions formed by him/her as a result of the peer review organization hearings.</p> <p><u>Peer Review Activity.</u> Peer review activity means the procedure by which peer review committees or quality assessment and assurance committees monitor, evaluate, and recommend actions to improve and ensure the delivery and quality of services within the committees' respective facilities, agencies, and professions, including recommendations, consideration of recommendations, actions with regard to recommendations, and implementation of actions.</p> <p><u>Peer Review Records.</u> Peer review records mean all complaint files, investigation files, reports, and other investigative information relating to the monitoring, evaluation, and recommendation of actions to improve the delivery and quality of health care services, licensee discipline, or professional competence in the possession of a peer review committee or an employee of a peer review committee.</p> <p><u>Privilege.</u> The proceedings, records, findings, and recommendations of a peer review organization are not subject to discovery. Information gathered by a committee is protected. Purely factual information, such as the time and dates of meetings and identities of any peer review committee attendees is protected. Peer review information otherwise discoverable from "original sources" cannot be obtained from the peer review committee itself. In medical liability actions, the privilege protects reviews of the defendant physician's specific treatment of the plaintiff and extends to reviews of treatment the physician has provided to patients other than the plaintiff.</p>		

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	<p><u>Confidentiality.</u> Peer review records and deliberations are confidential and may not be disclosed outside of the judicial process.</p> <p><u>Peer Review Immunity.</u> To encourage physician participation and ensure effective peer review, entities and participants engaged in peer review activities should be immune from civil damages, injunctive or equitable relief, and criminal liability.</p> <p>Fiscal Note: \$4580.00 -Cost of implementing and supporting advocacy efforts.</p>		
<b>BOT Report 17:</b> New Strategies to Achieve Antitrust Reform (Resolution 221, A-08)	<p>The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 221 (A-08) and the remainder of this report be filed:</p> <p>1. That our American Medical Association reaffirm Policy H-385.976, "Physician Collective Bargaining," which recommends that our AMA enhance physicians' collective bargaining abilities within existing antitrust laws and continue "meeting with the Justice Department and FTC to enhance their understanding of the unique nature of medical practice and to seek interpretations of the antitrust laws which reflect that unique nature," and AMA Policy D-383.985, which suggests that our AMA "reopen a dialogue with the Department of Justice and the Federal Trade Commission concerning more flexible approaches to physician network joint ventures." (Reaffirm HOD Policy).</p> <p>Fiscal Note: Estimated Staff Cost \$4,580</p>	Support	Adopted
<b>BOT Report 20:</b> Michigan Patient Compensation as Tort Reform Alternative (Resolution 219, A-08)	<p>1) The Board of Trustees recommends that Resolution 219 (A-08) not be adopted and the remainder of the report be filed.</p> <p>Fiscal Note: Less than \$500.</p>	Support	Adopted
<b>BOT Report 23:</b> Council on Legislation Sunset Review of 1998 and 1999 House Policies	<p>The Board of Trustees recommends that the House of Delegates policies listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.</p>	Support	Adopted
<b>BOT Report 28:</b> Collaborative Practice Agreements between Physicians and Advance Practice Nurses and the Physician to Advance Practice Nurse	<p>The Board of Trustees recommends that the following be adopted in lieu of Resolutions 716 (A-08) and 211 (I-08) and the remainder of the report be filed:</p> <p>1. That our American Medical Association continue to work with the Federation in developing necessary state advocacy resource tools to assist the Federation in: (a) addressing the development of collaborative practice agreements by practicing physicians; and (b) responding to or developing state legislation or regulations governing collaborative practice agreements, and that the AMA make these tools available on the AMA Advocacy Resource Center Web site. (Directive to Take Action)</p>	Support	Adopted as amended with a change in title; see <a href="http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-b-annotated.pdf">http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-b-annotated.pdf</a> for exact language

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Supervisory Ratio (Res. 716, A-08 and Res. 211, I-08)	<p>2. That our AMA support the development of methodologically valid research comparing the methods of physician-APRN collaboration and their respective effectiveness. (New HOD Policy)</p> <p>3. That our AMA reaffirm Policy H-160.950, which states “[o]ur AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of NPs: (1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings. (2) The physician is responsible for managing the health care of patients in all practice settings. (3) Health care services delivered in an integrated practice must be within the scope of each practitioner’s professional license, as defined by state law. (4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients. (5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients’ condition, as determined by the supervising/collaborating physician. (6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts. (7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients’ condition. (8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner. (9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner. (10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other’s contributions to patient care. (11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other’s practice patterns. (CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240 and Reaffirmation A-00).” (Reaffirm HOD Policy)</p> <p>4. That our AMA reaffirm Policy H-35.975, which states “[t]hat the AMA endorse the principle that the appropriate ratio of physician to physician extenders should be determined by physicians at the practice level, consistent with good medical practice, and state law where relevant.” (Reaffirm HOD Policy)</p> <p>Fiscal Note: \$10,836 to conduct state advocacy efforts, including the development of state advocacy resource tools</p>		
<b>Resolution 201:</b> Americans’ Health (FL)	RESOLVED, That our American Medical Association make improving health through increased activity and proper diet a priority (Directive to Take Action); and be it further	RECOMMENDED FOR REAFFIRMATION CONSENT	Adopted

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	<p>RESOLVED, That our AMA propose legislation calling on the federal government and state governments to develop new and innovative programs in partnership with the private sector that encourage personal responsibility for proper dietary habits and physical activity of individual Americans (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA continue to work in conjunction with the American College of Sports Medicine, American Heart Association, US Department of Health and Human Services and any other concerned organizations to provide educational materials that encourage a healthier America through increased physical activity and improved dietary habits. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$6,120.</p>	<p>CALENDAR</p> <p>Support</p>	
<p><b>Resolution 202:</b> Federal EMR Incentive Program is Non-Compliant With AMA's Principles (FL)</p>	<p>RESOLVED, That our American Medical Association finds that the Electronic Medical Record (EMR) incentive program passed in the American Recovery and Reinvestment Act of 2009 undermines the economic viability of non-participating physicians by failing to provide payments to non-participating doctors, by financially penalizing non-participating doctors, and by providing inadequate funds to cover the costs of implementation in physician practices (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA Board of Trustees communicate to the federal government that the Electronic Medical Record (EMR) incentive program should be made compliant with AMA principles by removing penalties for non-compliance and by providing inflation-adjusted funds to cover all costs of implementation and maintenance of EMR systems. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$4,580.</p>	<p>Support</p>	<p>Substitute Resolution 202 adopted in lieu of Resolutions 202, 221 and 223; see <a href="http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-b-annotated.pdf">http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-b-annotated.pdf</a> for exact language</p>
<p><b>Resolution 203:</b> Right to Privately Contract (AL, AR, DE, DC, FL, GA, Guam, KS, LA, NJ, NC, OK, SC, TN, TX, VA, WV, Triological Society, AmAcadFacial Plastic&amp;ReconSurg)</p>	<p>RESOLVED, That our AMA Board of Trustees immediately make as its highest priority:</p> <ol style="list-style-type: none"> <li>1. The enactment of federal legislation that ensures and protects the fundamental right of physicians to privately contract with patients, without penalties for doing so and regardless of payer within the framework of free market principles with the goal of accomplishing this by 2010; and</li> <li>2. The restoration of fairness to the current health care marketplace through changes in statutes and regulations so that physicians are able to negotiate (individually and as defined groups) fair contracts with private sector and public sector health plans. (Directive to take Action)</li> </ol> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$4,580.</p>	<p>RECOMMENDED FOR REAFFIRMATION CONSENT CALENDAR</p> <p>Support</p>	<p>Adopted as amended; see <a href="http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-b-annotated.pdf">http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-b-annotated.pdf</a> for exact language</p>

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<b>Resolution 204:</b> Criminalization of PLI (Int'l Coll Surg-US Div)	RESOLVED, That our American Medical Association oppose the criminalization of professional liability concerns and lawsuits. (New HOD Policy) Fiscal Note: Staff cost estimated at less than \$500 to implement.	RECOMMENDED FOR REAFFIRMATION CONSENT CALENDAR Monitor/Support	Reaffirmed
<b>Resolution 205:</b> Electronic Prescribing of Class 3 Substances (IL)	RESOLVED, That our American Medical Association work through appropriate channels to permit secure electronic prescriptions of controlled substances. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$9,294.	RECOMMENDED FOR REAFFIRMATION CONSENT CALENDAR  Support	Reaffirmed
<b>Resolution 206:</b> Interpretive Services (IL)	RESOLVED, That our American Medical Association initiate legislation or regulation that physicians be reimbursed for the cost of providing interpretive services. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$9,294.	RECOMMENDED FOR REAFFIRMATION CONSENT CALENDAR  Support	Reaffirmed
<b>Resolution 207:</b> Physician Profiling / Grading and Report Cards MOVED TO REF COM 728 SUPPORT	RESOLVED, That our American Medical Association reaffirm its "Guidelines for Pay-for-Performance Programs," which augment the AMA's "Principles for Pay-for-Performance Programs" (Reaffirm HOD Policy); and be it further  RESOLVED, That our AMA further evaluate this issue and create and support legislation as appropriate so that insurance company grading/rating systems do not encourage deselecting of high-risk patients so as to bolster their profiles and thus contribute to inaccessibility to care for these patients, and not encourage deselecting of physicians. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$9,294.	Support	Moved to ref com G (728)
<b>Resolution 208:</b> Protection to Practice (IL)	RESOLVED, That our American Medical Association adopt policy that government involvement in the practice of medicine must not force the participation of physicians, allowing their participation to remain voluntary (New HOD Policy); and be it further  RESOLVED, That our AMA take action to officially reject any future attempt by individual state and/or federal legislative bodies to require acceptance of any private or government third party payments or contracts as a condition of licensure. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$12,000.	RECOMMENDED FOR REAFFIRMATION CONSENT CALENDAR  Support	Reaffirmed

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<b>Resolution 209:</b> Health System and Litigation Reform (IL)	<p>RESOLVED, That our American Medical Association press vigorously and creatively for inclusion of effective medical litigation reforms as part of the comprehensive federal health system/insurance reform debate now underway in Washington, DC (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA consider and, as necessary, negotiate with federal policymakers on a wide range of litigation reform policy options to gain inclusion of a remedy in the health system reform package. These options might include traditional tort reforms, recovery limitations similar to those of the Veterans Administration (VA) system, demonstration/pilot programs on alternate dispute resolution systems such as the VA model and health courts, and/or other effective options to preserve patient access to care. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$12,000.</p>	<p>RECOMMENDED FOR REAFFIRMATION CONSENT CALENDAR</p> <p>ONLY IF PULLED OFF REAFFIRMATION CONSENT CALENDAR – SUPPORT/ACTIVE SUPPORT</p>	Adopted
<b>Resolution 210:</b> Geographic Devaluation of Medicare Payments for PQRI (IA)	<p>RESOLVED, That our American Medical Association reaffirm the concept of equal pay for equal work (Reaffirm HOD Policy D-400.989); and be it further</p> <p>RESOLVED, That the American Medical Association affirm the concept of equal pay for equal quality (New HOD Policy); and be it further</p> <p>RESOLVED, That our AMA lobby Congress and the Centers for Medicare &amp; Medicaid Services to prohibit geographic adjustments from being applied to Physician Quality Reporting Initiative payments. (Reaffirm HOD Policy D-400.985).</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$4,580.</p>	<p>RECOMMENDED FOR REAFFIRMATION CONSENT CALENDAR</p> <p>Support</p>	Reaffirmed
<b>Resolution 211:</b> Geographic Devaluation of E- Prescribing Payments (IA)	<p>RESOLVED, That our American Medical Association lobby Congress and the Centers for Medicare &amp; Medicaid Services to prohibit geographic adjustments for E-prescribing payments. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$4,580.</p>	<p>RECOMMENDED FOR REAFFIRMATION CONSENT CALENDAR</p> <p>Support</p>	Reaffirmed
<b>Resolution 212:</b> Geographic Practice Code Index (GPCI) Adjustment to Technical Component Fees for Imaging Procedures (IA)	<p>RESOLVED, That our American Medical Association advocate Congress to immediately eliminate the inaccurate Geographic Practice Cost Index (GPCI) adjustment for the technical component of imaging studies (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA advocate Congress to bring about a 1.0 floor for all Geographic Practice Cost Index (GPCI) practice expense adjustments. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$9,294.</p>	<p>RECOMMENDED FOR REAFFIRMATION CONSENT CALENDAR</p> <p>Support</p>	Referred

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<b>Resolution 213:</b> Stricter Fines for Violating Direct-to-Consumer Advertisements (MI)	RESOLVED, That our American Medical Association lobby the US Food and Drug Administration for stricter sanctions and monetary fines against pharmaceutical companies for flouting the guidelines regarding direct-to-consumer advertisements. (Directive to Take Action)  Fiscal Note: Staff cost estimated at less than \$500 to implement.	RECOMMENDED FOR REAFFIRMATION CONSENT CALENDAR  Support	Reaffirmed
<b>Resolution 214:</b> Policies on Physician Rating MOVED TO REF COM G 729	RESOLVED, That our American Medical Association formulate policies on physician rating and urge insurance companies, third-party agencies, private companies, and Web sites to publish the methods of rating and specifically mention how much of such rating is dependent on the cost incurred by a particular doctor (Directive to Take Action) ; and be it further  RESOLVED, That our AMA work to ensure transparency to the whole process of rating physicians with proper steps built in to address the grievances of the physicians involved. (Directive to Take Action)  Fiscal Note: Implement accordingly at estimated staff cost of \$4,969.	Support	Moved to ref com G (Res. 729)
<b>Resolution 215:</b> Insurance Companies Use of Contractors to Recover Payments (MO)	RESOLVED, That our AMA seek legislation to limit insurance companies, their agents, or any contractors from requesting payment back on paid claims to no more than 90 days after payment is made (Directive to Take Action); and be it further  RESOLVED, That such legislation require insurance companies, their agents, or any contractors to have a defined and acceptable process for physicians to dispute these maneuvers to get payment back on claims already processed, verified, and paid (Directive to Take Action); and be it further  RESOLVED, That such legislation ban insurance companies, their agents or contractors from using re-pricers and re-reviewers and to adhere to their own pricing and reviewing guidelines as agreed upon in their contracts with physicians (Directive to Take Action); and be it further  RESOLVED, That our AMA pursue legislation to end ERISA preemption of state laws to regulate self-insured plans in this regard and apply the same rules to Medicare and other federal plans. (Directive to take Action)  Fiscal Note: Implement accordingly at estimated staff cost of \$3,047.	RECOMMENDED FOR REAFFIRMATION CONSENT CALENDAR  Support	Adopted as amended; see <a href="http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-b-annotated.pdf">http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-b-annotated.pdf</a> for exact language

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<b>Resolution 216:</b> Electronic Submission of Schedule II-V Narcotic Prescriptions (William C. Sternfeld, MD, Delegate, Ohio)	RESOLVED, That our American Medical Association work with the US Drug Enforcement Agency to allow the electronic submission of prescriptions for Schedule II thru V medications. (Directive to Take Action)  Fiscal Note: Implement accordingly at estimated staff cost of \$867.	RECOMMENDED FOR REAFFIRMATION CONSENT CALENDAR Support	Reaffirmed
<b>Resolution 217:</b> Health Systems' Practices of Reclassification of Place of Service, Opting Not to Bill Medicare for Hospital and Aggressive Denial of Hospital Days in Reaction to Recovery Audits (PA)	RESOLVED, That our American Medical Association work with Centers for Medicare & Medicaid Services (CMS) to remove the requirement of linkage of Part A and Part B place of service, both for physicians' reimbursements and also as a requirement of Recovery Audits Contractors, and report back at the 2009 Interim Meeting (Directive to Take Action); and be it further  RESOLVED, That our AMA study and work with CMS to establish policy and/or regulations preventing hospital systems from the practice of possibly illegally attempting to avoid adverse outcomes from RACs by opting to not bill for inpatient Medicare services, and report back at the 2009 Interim Meeting (Directive to Take Action); and be it further  RESOLVED, That our AMA work with CMS to protect patients from adverse outcomes such as unanticipated co-pays resulting from hospital systems' reclassification of patients from inpatient to observation or outpatient status, and also to protect patients and their families from unanticipated skilled nursing home charges that may result from hospital systems' aggressive denial of inpatient hospital days in order to avoid adverse outcomes from RACs. (Directive to Take Action)  Fiscal Note: Implement accordingly at estimated staff cost of \$3,056.	RECOMMENDED FOR REAFFIRMATION CONSENT CALENDAR Support	Referred
<b>Resolution 218:</b> Open Source Code Electronic Medical Records (PA)	RESOLVED, That our American Medical Association support law and public policy that would make available to providers at nominal cost, an EMR system based on open source code, that would meet the certification and "meaningful use" requirements of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5), with technical support and upgrade governance by a public-private consortium that meaningfully represents and implements the interests of physicians and their patients. (New HOD Policy)  Fiscal Note: Staff cost estimated at less than \$500 to implement.	RECOMMENDED FOR REAFFIRMATION CONSENT CALENDAR Support	Adopted as amended; see <a href="http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-b-annotated.pdf">http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-b-annotated.pdf</a> for exact language
<b>Resolution 219:</b> Out of Network Payments (TX)	RESOLVED, That our American Medical Association support state and federal legislation and regulation mandating clear and transparent health insurance company language so that prudent lay persons know their financial responsibility when receiving care out of network (Directive to Take Action); and be it further  RESOLVED, That our AMA seek legislation and regulation necessary to assure clear and transparent language describing patient financial responsibility for patients covered by self-	RECOMMENDED FOR REAFFIRMATION CONSENT CALENDAR Support	Reaffirmed

## AMA-YPS Handbook Review: HOD Reference Committee B (legislation)

Full text at <http://www.ama-assn.org/ama1/pub/upload/mm/475/refcomb.pdf>. Recommendations are preliminary until ratified by the AMA-YPS Assembly on June 12, 2009. Recommended AMA-YPS Positions: Support, Active Support, Oppose, Active Oppose, Monitor

RESOLUTION/Report	ACTION REQUESTED	YPS POSITION	FINAL HOD ACTION
	<p>funded ERISA plans subjecting such plans to stricter regulation by the US Department of Labor, Internal Revenue Service (IRS), and US Attorney General. (Directive to Take Action).</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$18,688.</p>		
<p><b>Resolution 220:</b> Follow-on Biologic Medications (UT)</p>	<p>RESOLVED, That pharmaceutical companies should be allowed to make follow-on biologic medications available to physicians and their patients in a reasonable period of time with a reasonably predictable pathway to bring them to market (New HOD Policy); and be it further</p> <p>RESOLVED, That our American Medical Association advocate for enactment of federal law that would establish a pathway for follow-on biologic medications to be allowed on the market, with two guiding principles: 1) a reasonable time frame for US Food and Drug Administration exclusivity and patent expiration with a straightforward regulatory process for follow-on biologic competitors to be brought to market, and 2) the protection of patient safety in both the original branded products and all follow-on products that are brought to market. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$4,580.</p>	Monitor/Support	Adopted
<p><b>Resolution 221:</b> MIPPA Electronic Prescribing Provisions (VA)</p>	<p>RESOLVED, That our American Medical Association support the concept of electronic prescribing, as well as the offering of financial and other incentives for its adoption, but strongly discourage a funding structure that financially penalizes physicians that have not adopted such technology. (New HOD Policy)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$1,859.</p>	Support	Substitute Resolution 202 adopted in lieu of Resolutions 202, 221 and 223; see <a href="http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-b-annotated.pdf">http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-b-annotated.pdf</a> for exact language
<p><b>Resolution 222:</b> Recognition of the "Nurse as Agent" of the Prescriber in Long Term Care Settings (Am Med Directors Assoc)</p>	<p>RESOLVED, That our American Medical Association urge the US Drug Enforcement Agency to amend its regulations to recognize nursing facility staff as agents of the prescriber/physician in long term care facilities. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$1,188.</p>	Support	Adopted as amended; see <a href="http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-b-annotated.pdf">http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-b-annotated.pdf</a> for exact language
<p><b>Resolution 223:</b> Timeline and Penalties for Physicians Not Adopting EHR and E-</p>	<p>RESOLVED, That current American Medical Association Policy H-478.993 be revised to add "and that public and private insurers should not be allowed to assess a penalty for not adopting EHR"; (Modify Current HOD Policy) and be it further</p>	Support	Substitute Resolution 202 adopted in lieu of Resolutions 202, 221 and 223; see

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RESOLUTION/Report	ACTION REQUESTED	YPS POSITION	FINAL HOD ACTION
Prescribing (Maryland)	RESOLVED, That our AMA work with the Centers for Medicare & Medicaid Services to eliminate or delay the penalty in the current stimulus package for not adopting EHR and E-prescribing. (Directive to Take Action)  Fiscal Note: Implement accordingly at estimated staff cost of \$2,400.		<a href="http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-b-annotated.pdf">http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-b-annotated.pdf</a> for exact language
<b>Resolution 224:</b> Expanding Patients' Legal Rights When Insurance Companies Deny Care (NJ)	RESOLVED, That our American Medical Association lobby for the passage of legislation that would permit legal causes-of-action by the insured against their healthcare insurers and their agents for: a. damages caused when diagnostic tests and/or treatments are denied as "not medically necessary," when the denial of such tests and/or treatments result in harm to the insured; and for b. damages caused when diagnostic tests and/or treatments are denied as "not covered," when such tests and/or treatments are, in fact, covered, and the denial of such tests and/or treatments results in harm to the insured. (Directive to Take Action)  Fiscal Note: Implement accordingly at estimated staff cost of \$2,000.	Support	Reaffirmed
<b>Resolution 225:</b> Request that CMS Lower the Minimum Threshold for E-Prescribing Rebate from 50% to 25% for 2009 (NM)	RESOLVED, That in order for physicians to be able to receive the 2% Medicare rebate for electronic prescribing, our American Medical Association request that the Centers for Medicare & Medicaid Services lower the required threshold percentage of visits with eligible prescriptions sent to pharmacies electronically in calendar year 2009, from 50% to 25%, thereby allowing a later start of E-prescribing during 2009 without physicians being penalized for the considerable backlog in E-prescribing certification. (Directive to Take Action)  Fiscal Note: Implement accordingly at estimated staff cost of \$2,000.	Support	Adopted
<b>Resolution 226:</b> Revision of Federal Tort Claims Act (NY)	RESOLVED, That our American Medical Association act on the proposal that all patients whose care is funded in all or in part by federal funds, and/or whose care is delivered in facilities funded in all or in part by federal funds, such as those patients covered by Medicare, Medicaid, railroad retirement benefits, S-Chip, insurance purchased with pre-tax dollars, treated in not-forprofit facilities, etc., be brought under the jurisdiction of the Federal Tort Claims Act. (Directive to Take Action)  Fiscal Note: Implement accordingly at estimated staff cost of \$1,000.	Support	Referred
<b>Resolution 227:</b> Information Technology and Stimulus Money (NY)	RESOLVED, That our American Medical Association caution health care policy makers that the Health Care Information Technology stimulus money, as outlined in the American Reinvestment and Recovering Act, will cause a sudden rise in the demand for health care IT products and services which may result in inflated prices for physicians (Directive to Take	Support	Adopted

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RESOLUTION/Report	ACTION REQUESTED	YPS POSITION	FINAL HOD ACTION
	<p>Action); and be it further RESOLVED, That our AMA advise physicians and health care policy makers that the ongoing maintenance of health care IT can be costly, and that this ongoing expense will fall to physicians long after the stimulus money is exhausted. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$1,188</p>		
<p><b>Resolution 228:</b> Inappropriate Incentives for Recommending Generic Drugs Over Brand Name Drugs and Greater Transparency with Primary Benefit Management Plans (NY)</p>	<p>RESOLVED, That our American Medical Association call upon the Centers for Medicare &amp; Medicaid Services to abolish the provision of providing incentives for pharmacists to “push” generic drugs over brand name drugs (Directive to Take Action); and be it further RESOLVED, That our AMA urge the Centers for Medicare &amp; Medicaid Services to assure that there be greater transparency between the use of generics vs. brand name medications so as to enable patients to make informed and intelligent decision (Directive to Take Action); and be it further RESOLVED, That our AMA seek passage of legislation similar to that passed in Maine in 2003 and, subsequently, in other states, that would allow for the regulation of Pharmacy Benefit Management plans by imposing contract transparency and conflict of interest requirements and would require that savings based on drug volume discounts be passed on to client health plans and consumers. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$6,000.</p>	Support	Reaffirmed
<p><b>Resolution 229:</b> Medical Marijuana (NY)</p>	<p>RESOLVED, That our American Medical Association offer assistance in seeking clear, indisputable confirmation from the federal government that physicians who follow the proposed New York State legislation if passed and regulation when subsequently developed will not be prosecuted for allegedly failing to follow the Presidential order still in place making it illegal for a physician to prescribe or even advise a patient to use marijuana for medical purposes (Directive to Take Action); and be it further RESOLVED, That our AMA seek a reversal of the Executive Order itself that makes it illegal for a physician to prescribe or advise medical marijuana. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$1,000.</p> <p>Note: This topic is currently under study by the CSAPH.</p>	Monitor	Referred
<p><b>Resolution 230:</b> Mandated Unnecessary Care for Group Home Residents (PA)</p>	<p>RESOLVED, That our American Medical Association advocate for our patients, who are unable to communicate or advocate for themselves, by working with appropriate regulatory and legislative bodies to effect changes in legislative and regulatory codes at local, state and federal levels to ensure that only nationally recognized, necessary and indicated medical care be mandated for group home residents. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$1,100.</p>	Support	Referred

## AMA-YPS Handbook Review: HOD Reference Committee B (legislation)

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RESOLUTION/Report	ACTION REQUESTED	YPS POSITION	FINAL HOD ACTION
<p><b>Resolution 231:</b> Radiology Benefits Managers: Practicing Medicine Without the Patient (AmCollCard and AmCollRad)</p>	<p>RESOLVED, That our American Medical Association address the intrusion of radiology benefit managers (RBMs) into the doctor-patient interaction (e.g., denying one diagnostic test in favor of another) by a) studying the prevalence of forced test substitution and denial of requested imaging services by RBMs contracted by third-party payers; b) advocating against such practices; c) supporting the use of appropriate use criteria (AUC) developed by medical societies and expert physicians as an alternative to RBMs; and d) reporting back progress on this issue at the 2009 Interim Meeting. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$12,000.</p>	<p>Support</p>	<p>Adopted as amended; see <a href="http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-b-annotated.pdf">http://www.ama-assn.org/ama1/pub/upload/mm/475/a-09-ref-comm-b-annotated.pdf</a> for exact language</p>