

REPORTS OF REFERENCE COMMITTEES
2017 ANNUAL MEETING OF THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

REPORT OF REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS

- (1) BOARD OF TRUSTEES REPORT 2 - NEW SPECIALTY ORGANIZATIONS REPRESENTATION IN THE HOUSE OF DELEGATES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 2 adopted and the remainder of the report filed.

Board of Trustees Report 2 recommends that our AMA grant representation in the House of Delegates to the American Society of Hematology, the American Society of Transplant Surgeons, and the International Society of Hair Restoration Surgery. The report outlines guidelines for representation in the House of Delegates pertaining to National Specialty Societies, which includes a description of responsibilities for these organizations, and finds the aforementioned groups have met these criteria.

Limited testimony was offered following the introduction of this report. However, all of those who spoke did so in support of adoption. Therefore, your Reference Committee recommends that Board of Trustees Report 2 be adopted.

- (2) BOARD OF TRUSTEES REPORT 15 - NO COMPROMISE ON ANTI-FEMALE GENITAL MUTILATION POLICY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 15 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 15 adopted and the remainder of the report filed.

Board of Trustees Report 15 recommends that the AMA conform its “Expansion of AMA Policy on Female Genital Mutilation,” including a “nicking” procedure. The report gives a background of a previous resolution for a no-compromise policy, which raised concerns over labiaplasty, gender reassignment surgery, and the respect for strongly held cultural beliefs. The report ends by listing some strategies for addressing Female Genital Mutilation and ultimately reaffirms the position as laid out in Policy H-525.980 (“Expansion of AMA Policy on Female Genital Mutilation.”)

Testimony was unanimously in favor of the adoption of this report. The author of the resolution generating the report noted that it captured the spirit and intent of opposing the controversial subject of female genital mutilation. All agreed with this sentiment. Your Committee recommends that Board of Trustees Report 15 be adopted.

(3) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 2 - SPECIALTY SOCIETY ALLOCATION FOR HOUSE OF DELEGATES REPRESENTATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Constitution and Bylaws Report 2 adopted and the remainder of the report filed.

Council on Constitution and Bylaws Report 2 recommends that a variety of amendments to the AMA Bylaws be adopted in relation to delegate representation for specialty societies. The report proposes apportionment of one AMA delegate for each one thousand specialty society members who are also AMA members, and adjusting the total number of delegates apportioned to national medical specialty societies to be equal to the total number of delegates apportioned to constituent societies.

There was considerable testimony about how the recommendations in the report would function, with some confusion as to how AMA members in specialty societies will be counted and how representation in the House of Delegates is to be determined. Some speakers noted that the report would result in parity within the House. In addition, some testimony focused on Bylaw 2.2.2 and the problems unified membership may create for parity. Although the Reference Committee is receptive to the concerns regarding Bylaw 2.2.2, it believes amendment or deletion of Bylaw 2.2.2 are beyond the scope of this report and could be more effectively accomplished through the resolution process. Therefore, your Reference Committee recommends that Council on Constitution and Bylaws Report 2 be adopted.

(4) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 1 - AMENDMENT TO E-2.3.2, "PROFESSIONALISM IN SOCIAL MEDIA"

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Ethical and Judicial Affairs Report 1 adopted and the remainder of the report filed.

Council on Ethical and Judicial Affairs Report 1 recommends that E-2.3.2 "Professionalism in The Use of Social Media" be amended. Since the opinion's writing in 2010, other uses of social media have appeared and there is now potential for improving patient education and supporting professional advocacy with ethically appropriate social media use. The report outlines a guideline for physicians maintaining an online presence. The testimony on this report was mixed. Those speaking in favor of the amendment proffered in the report stated that it adequately addresses an ongoing problem of inappropriate social media use, particularly in plastic surgery. Some, however, took issue with terminology in the existing opinion. Because the words deemed ambiguous by some were not a part of the amended language presented in the report, and because the amended language presented as business was universally supported, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 1 be adopted.

(5) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 4 - CEJA'S SUNSET REVIEW OF 2007 HOUSE POLICIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Council on Ethical and Judicial Affairs Report 4 be adopted as amended by CEJA to read as follows:

The Council on Ethical and Judicial Affairs recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated, with the exception of Policy D-250.990, which should be retained, and the remainder of this report be filed.

HOD ACTION: Council on Ethical and Judicial Affairs Report 4 adopted as amended by CEJA and the remainder of the report filed.

Council on Ethical and Judicial Affairs Report 4 presents the annual sunset report of House policies. This report reviewed House polices from 2007. This report recommends that the House of Delegates policies that are listed in the Appendix to this report be sunset.

Testimony was heard regarding the importance of specifically supporting Israel's membership in the World Medical Association. No other testimony was heard, and your Reference Committee agrees that Israel is a valued member of the World Medical Association. The Council on Ethical and Judicial Affairs concurred with this change. Your Reference Committee recommends that CEJA Report 4 be adopted with this one policy retained.

(6) COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT 1 - DELEGATE ALLOCATION FOR SPECIALTY SOCIETIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Council on Long Range Planning and Development Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Long Range Planning and Development Report 1 adopted and the remainder of the report filed.

Council on Long Range Planning and Development Report 1 recommends that Policy G-600.027, "Designation of Specialty Societies for Representation in the House of Delegates" be amended. If adopted, the current specialty society delegation allocation system will be discontinued and the specialty delegate allocation in the House of Delegates will be determined based on the guidelines presented in the report.

Testimony about this report was limited, with most of the discussion focused on offering clarification about when membership numbers are counted and finalized for representation within the House of Delegates by AMA membership staff. A member of the Council on Long Range Planning and Development clarified that the report does not change that process. Your Reference Committee recommends that Council on Long Range Planning and Development Report 1 be adopted.

(7) RESOLUTION 6 - INCREASING ACCESS TO HEALTHCARE INSURANCE FOR REFUGEE POPULATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 6 be adopted.

HOD ACTION: Resolution 6 adopted.

Resolution 6 addresses the need for greater availability and access to health care insurance within the refugee populations, as these groups are typically at a higher risk for chronic and psychiatric conditions. Further, these populations are more likely to have other barriers to accessing health care including, but not limited to, linguistic and cultural challenges and unfamiliarity with health programs and the application process. This resolution asks that our AMA support a variety of programs that help promote education about available low-cost health-care plans and to remove existing language barriers in order to minimize gaps in health-care for the refugee population.

Testimony for Resolution 6 was mixed. While some discussed at length the health care challenges faced by refugee populations, others raised concerns about the unforeseen burdens that may be placed on rural communities where health care infrastructure may be precarious. However, your Reference Committee believes that the resolution as worded only asks that our AMA support existing programs and thus does not place an additional burden on any particular community. Thus, your Reference Committee recommends that Resolution 6 be adopted.

(8) RESOLUTION 9 - COMMERCIAL EXPLOITATION AND HUMAN TRAFFICKING OF MINORS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 9 be adopted.

HOD ACTION: Resolution 9 adopted.

Resolution 9 examines commercial sexual exploitation and sex trafficking of minors, recognizing the role that physicians can play in mitigating this issue. The resolution requests that our AMA advocate for the development of laws and policies that utilize a public health framework to address the commercial sexual exploitation and sex trafficking of minors by promoting care and services for victims instead of arrest and prosecution.

Testimony was in unanimous support of the resolution. Some spoke of their professional experience in working with survivors of human trafficking, and relayed the trauma experienced by these survivors. Others discussed the need to address human trafficking as an important goal of public health. Your Reference Committee recommends that Resolution 9 be adopted.

(9) RESOLUTION 10 - ACCESS TO BASIC HUMAN SERVICES FOR TRANSGENDER INDIVIDUALS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 10 be adopted.

HOD ACTION: Resolution 10 adopted.

Resolution 10 asks that our AMA oppose policies preventing transgender individuals from accessing basic human services and public facilities in line with one's gender identity, including, but not limited to, the use of restrooms. In addition, the resolution requests that the AMA advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one's gender identity.

Testimony on this resolution was limited but unanimous in support of adoption. Those speaking in favor of the resolution noted the tremendous levels of discrimination faced by the transgender community, and that concerted efforts must be launched to protect this population's access to basic human services such as housing, employment, and public restroom access. Your Reference Committee recommends that Resolution 10 be adopted.

(10) RESOLUTION 13 - GENDER IDENTITY INCLUSION AND ACCOUNTABILITY IN REMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 13 be adopted.

HOD ACTION: Resolution 13 adopted.

Resolution 13 addresses the categorization of participants in Risk Evaluation and Mitigation Strategies (REMS) programs, which are designed to prevent fetal exposure to highly teratogenic drugs. Currently, the categorization model effectively prohibits some transgendered individuals from registering in REMS programs by linking the labels of female and child-bearing potential, as individuals who identify as male but retain child-bearing potential are unable to participate in such programs. The lack of gender-neutral categorization in programs where only child-bearing potential matters in a clinical sense creates a barrier to care and promotes cultural insensitivity. The resolution asks that our AMA work with the United States Food and Drug Administration to develop a gender-neutral patient categorization model in Risk Evaluation and Mitigation Strategies programs, focusing exclusively on child-bearing potential rather than gender identity.

Testimony in support of this resolution was unanimous. Testimony focused on the point of determining the reproductive potential of patients in REMS regardless of their gender identity. Testimony explained that the resolution supported the activities that will help in achieving this goal. Further, focusing only on child-bearing potential (while eliminating gender categorization) reduces administrative burdens. Your Reference Committee recommends that Resolution 13 be adopted.

(11) RESOLUTION 16 - CONSIDERATION OF THE HEALTH AND WELFARE OF U.S. MINOR CHILDREN IN DEPORTATION PROCEEDINGS AGAINST THEIR UNDOCUMENTED PARENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 16 be adopted.

HOD ACTION: Resolution 16 adopted.

Resolution 16 asks our AMA to support the mental and physical health and welfare of U.S. minor children in deportation proceedings against their undocumented parents, recognizing the negative effects that the risk of deportation and detention of parents has on their citizen children. The resolution also requests that our AMA work with state and local medical societies in providing care for this population.

The support for Resolution 16 was strong. As with other resolutions that tapped into the personal experiences of physicians working with immigrant patients, this resolution prompted moving accounts of children whose parents have been removed from the country because of their immigration status. Your Reference Committee recommends that Resolution 16 be adopted.

(12) RESOLUTION 18 - PATIENT AND PHYSICIAN RIGHTS REGARDING IMMIGRATION STATUS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 18 be adopted.

HOD ACTION: Resolution 18 adopted.

Resolution 18 asks that our AMA support protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.

Testimony for this resolution was unanimous in its support. Several speakers offered personal accounts of the continuing challenges immigration enforcement actions pose for physicians and their patients, and called for continued opposition to any practices that could place the safety and well-being of immigrant patients in jeopardy. Your Reference Committee recommends that Resolution 18 be adopted.

(13) RESOLUTION 19 - WHO OWNS OUR PATIENTS' DATA?

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 19 be adopted.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the title be changed to read as follows:

OWNERSHIP OF PATIENT DATA

HOD ACTION: Resolution 19 adopted and title changed.

Resolution 19 asks our AMA undertake a study of the use and misuse of patient information by hospitals, corporations, insurance companies, or big pharma, including the impact on patient safety, quality of care and access to care when a patient's data is withheld from his or her physician. The resolution asks for report back at the 2018 Annual Meeting.

The testimony on this resolution was unanimously in favor of adoption. Those who spoke discussed the many challenges posed to accessing patient data and medical records by physicians, and agreed that a study is needed to better identify these obstacles and begin exploring solutions to the use and misuse of patient information. Your Reference Committee recommends that Resolution 19 be adopted with a change in title.

(14) BOARD OF TRUSTEES REPORT 19 - CEJA AND HOUSE OF DELEGATES COLLABORATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 2 in Board of Trustees Report 19 be amended by substitution to read as follows:

2. That, consistent with Bylaw 2.13.1.1, the Speakers consider convening additional sessions of the Reference Committee on Amendments to Constitution and Bylaws when appropriate and feasible to accommodate CEJA business.
(New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 19 be adopted as amended.

HOD ACTION: Board of Trustees Report 19 adopted as amended.

Board of Trustees Report 19 recommends that the Council on Ethical and Judicial Affairs is supported in carrying forward proposals to increase transparency and opportunity for input. It is also recommended that Speakers are

encouraged to convene a separate reference committee for recommendations of the Council on Ethical and Judicial Affairs when appropriate, and formalizing the candidate nomination process prior to the House confirming the candidate. The report details the review of the *Code of Medical Ethics* and CEJA's collaboration with the House of Delegates concerning the *Code of Medical Ethics*, including issues concerning oversight and independence of Ethics from the political climate.

The Council on Constitution and Bylaws testified that existing Recommendation 2 conflicts with Bylaw 2.13.1.1 which provides that all matters pertaining to the Principles of Medical Ethics be referred to the Reference Committee on Amendments to Constitution and Bylaws. Furthermore, another Bylaw (2.13.1.2, Additional Reference Committees) speaks to the need to refer all business on a particular subject to the same reference committee. To avoid the need for a bylaw change, the Council proposed substitute language to accommodate a large volume of CEJA business but obviate the need for an additional reference committee that would require additional reference committee members and staff. Your Reference Committee agrees with this change and heard no testimony to the contrary, and thus recommends that the recommendations of Board of Trustees Report 19 be adopted as amended.

(15) BOARD OF TRUSTEES REPORT 25 – SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES – FIVE-YEAR REVIEW

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 in Board of Trustees Report 25 be amended by addition to read as follows:

~~1. That the American Association of Hip and Knee Surgeons, American Society for Reproductive Medicine, American Society of Neuroimaging, American Thoracic Society, College of American Pathologists, Congress of Neurological Surgeons, Contact Lens Association of Ophthalmologists, Inc., International College of Surgeons – US Section, Society for Cardiovascular Angiography and Interventions, Society for Investigative Dermatology, Inc., Society of Interventional Radiology, and United States and Canadian Academy of Pathology retain representation in the American Medical Association House of Delegates. (Directive to Take Action)~~

1. That the American Society for Reproductive Medicine, American Thoracic Society, College of American Pathologists, Congress of Neurological Surgeons, Contact Lens Association of Ophthalmologists, Inc., International College of Surgeons – US Section, Society for Cardiovascular Angiography and Interventions, Society for Investigative Dermatology, Inc., Society of Interventional Radiology, and United States and Canadian Academy of Pathology retain representation in the American Medical Association House of Delegates. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendation 3 of Board of Trustees Report 25 be amended by deletion to read as follows:

~~2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5 after a year's grace period to increase membership, the American Association of Hip and Knee Surgeons and American Society of Neuroimaging not retain representation in the House of Delegates. (Directive to Take Action)~~

2. **Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5 after a year's**

grace period to increase membership, the American Association of Hip and Knee Surgeons and American Society of Neuroimaging ~~not retain representation in the House of Delegates~~ be allowed only one additional year to meet these requirements. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 25 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 25 adopted (as proposed) and the remainder of the report filed.

Board of Trustees Report 25 recommends that the American Society for Reproductive Medicine, American Thoracic Society, College of American Pathologists, Congress of Neurological Surgeons, Contact Lens Association of Ophthalmologists, Inc., International College of Surgeons – US Section, Society for Cardiovascular Angiography and Interventions, Society for Investigative Dermatology, Inc., Society of Interventional Radiology, and United States and Canadian Academy of Pathology retain representation in the AMA House of Delegates. It also recommends that since the Academy of Physicians in Clinical Research and the American Society of General Surgeons failed to meet the requirements for continued representation in the AMA HOD, they be placed on probation and be given one year to increase their AMA membership. Finally, the report recommends that since the American Association of Hip and Knee Surgeons and American Society of Neuroimaging failed to meet the requirements for continued representation after a year's grace period to increase membership, that they not retain representation in the House of Delegates.

Testimony supported maintaining the inclusion of the American Society of Neuroimaging and the American Association of Hip and Knee Surgeons in the House of Delegates. Testimony regarding both groups lauded their growth in membership and their participation within the AMA, and held that the loss of these societies would be detrimental to the AMA. Both societies presented materials to the Reference Committee outlining their considerable efforts to increase membership. Therefore, your Reference Committee recommends that the American Society of Neuroimaging and the American Association of Hip and Knee Surgeons retain representation in the American Medical Association House of Delegates, and that Board of Trustees Report 25 be adopted as amended.

(16) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 1 - UPDATED
BYLAWS - EMERGENCY BUSINESS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Recommendation 1 in Council on Constitution and Bylaws Report 1 be amended by addition and deletion to read as follows:

1. That the following amendments to the AMA Bylaws be adopted:

- 1.11.3.1.4 Emergency Resolutions. Resolutions of an emergency nature may be presented by a delegate any time after the opening session of the House of Delegates is recessed. Emergency resolutions will be accepted as business only upon a three-fourths vote of delegates present and voting, and if accepted shall be presented to the House of Delegates without consideration by a reference committee. A ~~two-thirds~~ simple majority vote of the delegates present and voting shall be required for adoption.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Constitution and Bylaws Report 1 adopted as amended and the remainder of the report filed.

Council on Constitution and Bylaws Report 1 recommends that several amendments to the AMA Bylaws be adopted. These include restricting the regular business hours to no later than the House of Delegates' opening session, implementing a requirement for a two-thirds vote of delegates present as required for adoption of emergency resolutions and clarifying that "emergency business" are items of business presented after the recess of opening session.

While testimony largely spoke in favor of the report as a whole, considerable disagreement arose over the thresholds for the acceptance and adoption of emergency items of business within the House of Delegates. In particular, testimony focused on the voting threshold for the adoption of emergency resolutions. Many desired establishing a high bar for the acceptance of emergency items as business, but noted that an additional high bar for adoption would be unwarranted. While maintaining a three-fourths vote of present and voting delegates for the acceptance of emergency resolutions as business of the House is suitable, your Reference Committee believes that emergency resolutions should be adopted by a simple majority vote. Based on the testimony heard, your Reference Committee recommends that Council on Constitution and Bylaws Report 1 be adopted as amended.

(17) RESOLUTION 1 - PARTICIPATION OF PHYSICIANS ON HEALTHCARE ORGANIZATION BOARDS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolve of Resolution 1 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association advocate for and promote the membership of ~~actively practicing~~ physicians on the boards of healthcare organizations including, but not limited to, acute care providers; insurance entities; medical device manufacturers; and health technology service organizations (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third resolve of Resolution 1 be amended by addition and deletion to read as follows:

~~RESOLVED, That our AMA provide existing healthcare boards with resources that increase their awareness of the value of physician participation in governance matters. (Directive to Take Action)~~

RESOLVED, That our AMA provide physicians, the public, and health care organizations information on the positive impact of physician leadership. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 1 be adopted as amended.

HOD ACTION: Resolution 1 adopted as amended.

Resolution 1 addresses involvement and participation of physicians on healthcare organization boards, recognizing that involvement in these organizations can improve the quality of physician-hospital relationships and ultimately physician-patient relationships. The resolution requests that our AMA promote the membership of actively participating physicians on healthcare organization boards, and promote educational programs that allow physicians to effectively serve on health organization boards. The resolution also asks that our AMA allow existing healthcare boards to increase their awareness of physician participation by providing resources that would allow them to do so.

The testimony on this resolution was unanimous in its support. Two recommendations for amending the resolves were proffered. First, that “actively practicing” be stricken from the first Resolve in order to encompass a larger population of physicians. Second, that the third Resolve be revised to promote in a clearer way the positive impact of physician leadership on healthcare organization boards. Therefore, your Reference Committee recommends that Resolution 1 be adopted as amended.

(18) RESOLUTION 2 - CARE OF WOMEN AND CHILDREN IN FAMILY IMMIGRATION DETENTION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 2 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association recognize the negative health consequences of ~~oppose~~ the detention of families seeking safe haven (New HOD Policy); and be it further

RESOLVED, That due to the negative health consequences of detention, our AMA oppose the expansion of family immigration detention in the United States (New HOD Policy); and be it further

RESOLVED, That our AMA oppose the separation of parents from their children who are detained while seeking safe haven (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for access to ~~comprehensive~~ health care for women and children in immigration detention. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 2 be adopted as amended.

HOD ACTION: Resolution 2 adopted as amended.

Resolution 2 examines the lack of healthcare access for women and children in family immigration detention centers in the United States and the psychological impacts of separating parent and child during detention. The resolution asks that our AMA oppose the detention of families seeking safe haven, the further expansion and development of these centers, and the separation of parents and children who are seeking safe haven. Further, the resolution asks that our AMA advocate for comprehensive health care access for women and children in immigration detention.

The testimony on Resolution 2 was passionately divided. While several speakers argued that the resolution be supported as written, others found the first two resolves of the resolution to be overtly political and outside the scope of the AMA’s purview. Additional changes to the existing resolves suggested “comprehensive” be stricken from the fourth Resolve and that “women and children” be changed to “individuals” in that same resolve. Arguing against any changes to the resolution’s language, supporters of the resolution spoke about the unique health needs of this vulnerable population, and the importance of focusing on their treatment within detention centers. The Reference Committee found each side of the debate to have valid points worth incorporating into its recommendation for the

final language of the resolution. Therefore, your Reference Committee recommends that Resolution 2 be adopted as amended.

(19) RESOLUTION 3 - MEDICAL SPECTRUM OF GENDER

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 3 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~partner work~~ with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity ~~as a complex interplay of gene expressions and biologic development.~~ (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 3 be adopted as amended.

HOD ACTION: Resolution 3 adopted as amended.

Resolution 3 explains that an individual's genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other. Because the AMA has many policies supporting LGBT issues and recognizes the health care disparities that this population faces, this resolution urges the AMA to help eliminate these disparities by partnering with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity as a complex interplay of gene expressions and biologic development.

Testimony on this resolution was resoundingly in favor of adoption with amendments. Those offering amendments suggested that "partner with" be changed to "work with," and that the language following "gender identity" be stricken entirely. Based on these recommendations, your Reference Committee recommends that Resolution 3 be adopted as amended.

(20) RESOLUTION 12 - PROMOTING THE AMA MODEL MEDICAL STAFF CODE OF CONDUCT AND ITS APPLICATION TO EMPLOYED PHYSICIANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 12 be amended by addition and deletion to read as follows:

~~RESOLVED, That our AMA advocate that, as participating members of their medical staffs, "employed physicians" be afforded the same right of review as non-employed physicians as regards an accusation that their conduct has been characterized as "disruptive, intimidating or inappropriate. (New HOD Policy)~~

RESOLVED, That our AMA advocate for the separation between the terms of employment contracts and medical staff privileges. This separation includes an ongoing right of review for all physicians regardless of employment status with the organization. This right of review may include a physician's good faith conduct that has been characterized as "disruptive, intimidating, or inappropriate." (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 12 be adopted as amended.

HOD ACTION: Resolution 12 adopted as amended.

Resolution 12 requests that our AMA actively educate state and specialty medical societies about the AMA Medical Staff Code of Conduct and promote its use. In addition, the resolution requests that the AMA advocate for employed physicians to be afforded the same right of review as non-employed physicians in accusations where conduct is characterized as “disruptive, intimidating or inappropriate.”

The resolution received unanimous support. Testimony focused on the distinction between employed and non-employed physicians, and how the rights of both categories of physicians should be treated equally with respect to medical staff privileges. The Reference Committee heard lengthy testimony about the distinction between contract rights and medical privilege credentialing, and how the credentialing of medical staff should remain separate from the rights employed physicians obtain/lose through employment contracts. Your Reference Committee recommends that Resolution 12 be adopted as amended.

(21) RESOLUTION 17 - IMPROVING MEDICAL CARE IN IMMIGRANT DETENTION CENTERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 17 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to 1) revise its medical standards governing the conditions of confinement at detention facilities to meet ~~or exceed~~ those set by the National Commission on Correctional Health Care, 2) take necessary steps to achieve full compliance with these standards, and 3) ~~create a system to track complaints related to substandard healthcare quality. filed by detainees~~ (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 17 be amended by the addition of a third Resolve to read as follows:

RESOLVED, That our AMA advocate for access to health care for individuals in immigration detention. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 17 be adopted as amended.

HOD ACTION: Resolution 17 adopted as amended.

Resolution 17 asks that our AMA examine the medical care in immigration detention centers, recognizing that immigrant and refugee populations often have specialized healthcare needs that are not met in these facilities. This resolution requests that our AMA make a public statement that urges U.S. Immigration and customs to increase the quality of healthcare provided to detainees. The resolution also asks that U.S. Customs refrains from partnership with private organizations for immigration detention centers.

Testimony was unanimously in favor of this resolution. Several personal accounts of the deplorable conditions found in immigrant detention centers highlighted the importance of improving care in these facilities. The resolve clauses of the resolution were largely supported, though some commented that the words “or exceeds” be removed from the second Resolve. Based on the testimony heard, the Reference Committee also felt that an additional resolve should be added to offer greater inclusivity over the populations this and other resolutions address. Your Reference Committee recommends that Resolution 17 be adopted as amended.

(22) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 2 -
COMPETENCE, SELF-ASSESSMENT AND SELF-AWARENESS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 2 be referred.

HOD ACTION: Council on Ethical and Judicial Affairs Report 2 referred.

Council on Ethical and Judicial Affairs Report 2 examines what the commitment to competence means for an individual physician in day-to-day practice in order to develop ethics guidance for physicians. The ethical responsibility of competence encompasses more than medical knowledge and skill. Each phase of a medical career carries its own implications of what physicians should know and be able to do to practice safely. Physicians need to be able to recognize when they are and when they are not able to provide appropriate care for their patients. Therefore, CEJA recommends that the ethical responsibility of competence guidelines be adopted for physicians and physicians in training.

Testimony on CEJA Report 2 predominately called for referral. The reasoning for referral stemmed mostly from concerns about language within the report’s recommendations that might have unforeseen legal consequences. The word “promises” was considered too strong and may create legal obligations. The word “accountable” was deemed to be unclear. Your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 2 be referred.

(23) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 3 - ETHICAL
PHYSICIAN CONDUCT IN THE MEDIA

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 3 be referred.

HOD ACTION: Council on Ethical and Judicial Affairs Report 3 referred.

Council on Ethical and Judicial Affairs Report 3 addresses professional ethical obligations of physicians in the media. In an increasing media marketplace, physicians must carefully delineate who they are and how they want to be perceived. It is important that the role of a physician be distinct from a journalist, commentator, or media personality.

CEJA Report 3 received mixed testimony, largely favoring referral. Those in support of the report praised its clarity on the topic of physicians in the media. Concerns about the report remained, however. Some found recommendation (e) to be particularly onerous, which would prevent physicians from speaking on any number of topics that may not be their primary area of expertise but on which they may have applicable insight. Based on the testimony heard, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 3 be referred.

(24) RESOLUTION 7 - HEALTHCARE AS A HUMAN RIGHT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 7 be referred.

HOD ACTION: Resolution 7 referred.

Resolution 7 addresses the need for the universal right of basic standard of living including a basic level of health care. In accordance with the World Health Organization, the United Nations, and the World Medical Association, the resolution examines the need of continued participation of these groups in order to further the development of easily accessible health care. The resolution asks that our AMA recognize that a basic level of health-care is an essential human right. Further, the resolution asks that our AMA support the United Nations' Universal Declaration of Human Rights and its encompassing International Bill of Rights. Finally, it asks that our AMA support the United Nations' Universal Declaration of Human rights and advocate for the United States to remain in the United Nations.

Testimony on this resolution was ideologically rich but robustly divided. The testimony addressed constitutional rights, civil liberties, and the fundamental human rights underpinning health care access. Although important points were made on a variety of related issues, the Reference Committee feels that this is an important and complex topic that requires careful thought and conversation beyond the confines of the hearing and this meeting. Your Reference Committee looks forward to the ongoing conversation initiated by this resolution, and recommends that Resolution 7 be referred.

(25) RESOLUTION 14 - THE NEED TO DISTINGUISH BETWEEN PHYSICIAN ASSISTED SUICIDE AND AID IN DYING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 14 be referred.

HOD ACTION: Resolution 14 referred.

Resolution 14 requests that our AMA when referring to what it currently defines as '*Physician Assisted Suicide*' avoid any replacement with the phrase '*Aid in Dying*' when describing what has been understood as '*Physician Assisted Suicide*.' In addition, the resolution asks that our AMA develop definitions and a clear distinction between what is meant when the AMA uses the phrase '*Physician Assisted Suicide*' and the phrase '*Aid in Dying*.' Further, our AMA requests that these definitions and distinction be fully utilized by our AMA in organizational policy, discussions, and position statements regarding both '*Physician Assisted Suicide*' and '*Aid in Dying*.'

Testimony on this resolution was mixed, with much of the discussion focusing on the complex topic of physician aid in dying. A considerable amount of testimony attempted to distinguish the meaning of "suicide" and argued that its usage is inappropriate in the contemporary debate about aid in dying. Others pointed to the fact that the Council on Ethical and Judicial Affairs is currently reexamining the AMA's current stance on physician aid in dying, and that the definitional challenges noted in the resolution should be discussed upon the presentation of that report. Your Reference Committee recommends that Resolution 14 be referred.

(26) RESOLUTION 15 - APPROPRIATE PLACEMENT OF TRANSGENDER PRISONERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 15 be referred.

HOD ACTION: Resolution 15 referred.

Resolution 15 discusses the fact that transgender individuals sentenced to jail or prison are often placed in facilities based on birth gender, unless they have undergone complete surgical transition. According to statistics, this practice has led to higher levels of violence and abuse. This resolution requests that our AMA establish policy supporting the ability of transgender prisoners to be placed in facilities that are reflective of their affirmed gender status regardless of surgical status, if they so choose.

Support for this resolution was evenly divided. While those in favor of adoption discussed the few protections in place for transgender prisoners, others recognized the complexities of this issue and agreed that more information and research on the subject are necessary. Your Reference Committee agrees that this issue requires more study, and recommends that Resolution 15 be referred.

(27) RESOLUTION 20 - RECOGNITION OF PHYSICIAN ORDERS FOR LIFE SUSTAINING TREATMENT (POLST) FORMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 20 be referred.

HOD ACTION: Resolution 20 referred.

Resolution 20 asks that our AMA advocate with appropriate government, legislative and regulatory bodies to recognize Physician Orders for Life Sustaining Treatment forms completed in one state as valid and enforceable in other states. In addition, the resolution asks that our AMA create a universal Physician Order for Life Sustaining Treatment form that would be valid and enforceable in all states.

Testimony on this resolution was unanimous in support of the intent of this resolution. Those speaking highlighted the challenge of respecting the medical care orders of patients when they cross the jurisdictional boundaries of states. However, because POLST is one of many frameworks in use in the United States, some speakers noted problems with the second Resolve. Your Reference Committee also discussed the myriad problems with a universal POLST form, specifically noting that several issues, including hierarchy of decision making systems, vary from state to state. These differences in legislation, along with other issues, make adoption of this resolution untenable. However, your Reference Committee does recognize that reciprocity of physician orders regarding medical care between state lines is an important issue, and recommends that model state legislation be crafted in order for this to be accomplished in a way that can realistically be implemented. Therefore, your Reference Committee recommends that Resolution 20 be referred.

(28) RESOLUTION 11 - REVISION OF RESEARCHER CERTIFICATION AND INSTITUTIONAL REVIEW BOARD PROTOCOLS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 11 be not adopted.

HOD ACTION: Resolution 11 referred.

Resolution 11 asks our AMA to study existing Collaborative Institutional Training Initiative Standards, Institutional Review Board Protocols and create recommendations that would simultaneously protect patients and permit physicians to easily participate in the dissemination of medical knowledge. The resolution requests that the AMA report back to the House of Delegates at the 2017 Interim Meeting.

No testimony was offered regarding this resolution outside of its introduction. Despite the absence of testimony, the Reference Committee discussed at length the critically important topic of ethics training and certification for physicians in this area, as well as the evolving regulatory environment of human subject research protections in the

United States, including the upcoming changes to IRB oversight protocols. From this discussion, your Reference Committee recommends that Resolution 11 not be adopted.

(29) RESOLUTION 8 - PROMOTING THE USE OF APPROPRIATE LGBTQIA LANGUAGE IN MEDICAL DOCUMENTATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-315.967 be reaffirmed in lieu of Resolution 8.

HOD ACTION: Policy H-315.967 reaffirmed in lieu of Resolution 8.

Resolution 8 explores the proper use of LGBTQIA language, specifically in medical documentation, as information beyond the binary “male” or “female” options can have implications for further health-care. The resolution requests that our AMA support inclusion of a variety of identifiers including biological sex, gender identity, preferred gender pronouns, and sexual orientation. The resolution also asks that this is provided in a culturally sensitive manner.

Testimony was in favor of this resolution and recognized many reasons for having these identifiers in the medical record. However, the resolve of this resolution is covered almost verbatim in Policy H-315.967 “Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation,” which states that our AMA (1) supports the voluntary inclusion of a patient’s biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s) in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; and (2) will advocate for collection of patient data that is inclusive of sexual orientation/gender identity for the purposes of research into patient health. Therefore, your Reference Committee recommends that Policy H-315.967 be reaffirmed in lieu of Resolution 8.

(30) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OPINION 1 - COLLABORATIVE CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Council on Ethical and Judicial Affairs Opinion 1 be filed.

HOD ACTION: Council on Ethical and Judicial Affairs Opinion 1 filed.

Council on Ethical and Judicial Affairs Opinion 1 files the opinion on Collaborative Care, which was adopted at the 2016 Interim Meeting of the House of Delegates.

Only testimony by the delegate who extracted this item was heard. Concern was raised that the opinion doesn’t make clear that the physician should be the clinical leader in a collaborative environment. However, your Reference Committee believes that the second paragraph of this opinion clearly describes the physician as a clinical leader. Furthermore, this opinion was adopted by the HOD at the 2016 Interim Meeting. Therefore, your Reference Committee recommends that Council on Ethical and Judicial Affairs Opinion 1 be filed.

REPORT OF REFERENCE COMMITTEE A

- (1) COUNCIL ON MEDICAL SERVICE REPORT 1 - COUNCIL ON MEDICAL SERVICE SUNSET REVIEW OF 2007 AMA HOUSE POLICIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendation in Council on Medical Service Report 1 adopted and the remainder of the report filed.

Council on Medical Service Report 1 contains recommendations to retain or rescind 2007 AMA socioeconomic policies.

Testimony on Council on Medical Service Report 1 was limited to a member of the Council on Medical Service. Accordingly, your Reference Committee recommends that the recommendation of Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

- (2) RESOLUTION 112 - CMS MUST PUBLISH ALL VALUES FOR NON-COVERED AND BUNDLED SERVICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 112 be adopted.

HOD ACTION: Resolution 112 adopted.

Resolution 112 asks that our AMA advocate that the Centers for Medicare and Medicaid Services must publish the RUC recommended values for all services, including non-covered and bundled services.

Your Reference Committee heard limited yet supportive testimony on Resolution 112. A member of the AMA/Specialty RVS Update Committee (RUC) testified that the RUC submitted a comment letter to the Centers for Medicare and Medicaid Services in 2015 in support of publishing the non-covered/bundled Medicare services in which the RUC had made a recommendation in the Medicare Physician Payment Schedule. As of May 2017, there are approximately 20 services in which CMS has determined a Medicare status of “Bundled”, “Not valid for Medicare purposes”, “Non-covered” or “Statutory exclusion” but did not publish the RUC recommended value. Your Reference Committee believes that it is imperative that CMS publish the work, practice expense and professional liability insurance relative values for these services because the resource-based relative value scale (RBRVS) is used by Medicaid and many private payers. Your Reference Committee notes that there is a long-standing precedent established by the preventive medicine services codes, which are Medicare status indicator “N” (non-covered), yet have had RUC recommended values published on the Medicare Physician Payment Schedule Appendix B since their inception. Your Reference Committee believes that as CMS established this precedent, it should continue to follow it. Physicians have reported problems seeking payment for these services by other payers because CMS has not published RVUs for these services.

An amendment was proffered to include “technical components;” however, the RUC recommended values are comprised of three components: work, practice expense, and professional liability, so this is already addressed in the original resolution language. Your Reference Committee concurs with testimony and the content of the comment letter and recommends that Resolution 112 be adopted.

(3) RESOLUTION 119 - SUPPORT EFFORTS TO IMPROVE ACCESS TO DIABETES SELF-MANAGEMENT TRAINING SERVICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 119 be adopted.

HOD ACTION: Resolution 119 adopted.

Resolution 119 asks that our AMA actively support regulatory and legislative actions that will mitigate barriers to Diabetes Self-Management Training (DSMT) utilization; and support outreach efforts to foster increased reliance on DSMT by physician practices in order to improve quality of diabetes care.

Your Reference Committee heard generally supportive testimony on Resolution 119. As the resolution is consistent with Policy H-160.938, which seeks to have physician-directed benefits of evidence-based self-management training be provided to the beneficiaries of Medicare, Medicaid and other payers, your Reference Committee recommends that Resolution 119 be adopted.

(4) RESOLUTION 120 - NATIONAL PRESSURE ULCER ADVISORY PANEL RECOMMENDATION FOR PRESSURE ULCER NOMENCLATURE CHANGE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 120 be adopted.

HOD ACTION: Resolution 120 adopted.

Resolution 120 asks that our AMA formally oppose a change in nomenclature from “pressure ulcer” to “pressure injury” in the ICD-10 and other diagnostic catalogues and classification systems.

Though limited, testimony on Resolution 120 was unanimously supportive. Concerns were expressed about use of the term “injury,” which could have legal ramifications. Your Reference Committee discussed the potential for a “slippery slope” of requests to comment on specific nomenclature changes; however, we believe this resolution warrants attention. For these reasons, your Reference Committee recommends that Resolution 120 be adopted.

(5) RESOLUTION 128 - PROTECTING PATIENTS’ ACCESS TO EMERGENCY SERVICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 128 be adopted.

HOD ACTION: Resolution 128 adopted.

Resolution 128 asks that our work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the “prudent layperson” standard of determining when to seek emergency care.

Your Reference Committee heard supportive testimony on Resolution 128. As your Reference Committee believes that the resolution strongly responds to an emerging issue for patients seeking emergency care, your Reference Committee recommends that Resolution 128 be adopted.

(6) COUNCIL ON MEDICAL SERVICE REPORT 3 - ENSURING CONTINUITY OF CARE PROTECTIONS DURING ACTIVE COURSES OF TREATMENT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 6 in Council on Medical Service Report 3 be amended by deletion to read as follows:

6. That our AMA support patients in an active course of treatment who switch to a new health plan having the opportunity to receive continued transitional care from their treating out-of-network physicians and hospitals at in-network cost-sharing levels. Transitional care should be provided at the physicians' and hospitals' discretion, ~~after having agreed to payment terms with the health plan.~~ (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 3 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 3 recommends that our AMA reaffirm Policies H-285.911, H-285.908 and H-285.952; modify Policies H-385.936 and H-285.924[4]; support patients in an active course of treatment who switch to a new health plan having the opportunity to receive continued transitional care from their treating out-of-network physicians and hospitals at in-network cost-sharing levels; and continue to provide assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure continuity of care protections for patients in an active course of treatment.

Your Reference Committee heard generally supportive testimony on Council on Medical Service Report 3. A member of the Council on Medical Service introduced the report, noting that additional measures are needed to prevent disruptions in care for patients in an active course of treatment, both for new enrollees in a health plan, and existing enrollees receiving care from providers whose provider leaves or is removed from a plan's network without cause. An amendment was offered to the sixth recommendation of the report to remove language stating that transitional care should be provided after a physician or hospital agrees to payment terms with the patient's health plan. Speakers noted that it is of utmost importance for transitional care to be provided at physician and hospital discretion. The Council on Medical Service accepted the amendment as friendly. As such, your Reference Committee recommends that the recommendations of Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

(7) COUNCIL ON MEDICAL SERVICE REPORT 6 - EXPANSION OF US VETERANS' HEALTH CARE CHOICES
RESOLUTION 117 - EXPANSION OF U.S. VETERANS' HEALTHCARE CHOICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Council on Medical Service Report 6 be amended by addition of a new Recommendation to read as follows:

That our AMA encourage the acceleration of interoperability of electronic personal and medical health records in order to ensure seamless, timely, secure

and accurate exchange of information between VA and non-VA providers and encourage both the VA and physicians caring for veterans outside of the VA to exchange medical records in a timely manner to ensure efficient care. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 6 be adopted as amended in lieu of Resolution 117 and the remainder of the report be filed.

That our AMA encourage the VA to engage with physicians providing care in the VA system to explore and develop solutions on improving the health care choices of veterans.

That our AMA advocate for new funding to support expansion of the Veterans Choice Program.

HOD ACTION: Recommendations in Council on Medical Service Report 6 adopted as amended in lieu of Resolution 117 and the remainder of the report filed.

Council on Medical Service Report 6 recommends that our AMA continue to work with the Veterans Administration (VA) to provide quality care to veterans; continue to support efforts to improve the Veterans Choice Program (VCP) and make it a permanent program; reaffirm Policy H-510.985; encourage the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care, and that the VA develop criteria by which individual veterans may request alternative pathways; support consolidation of all the VA community care programs; encourage the VA to use external assessments as necessary to identify and address systemic barriers to care; support interventions to mitigate barriers to the VA from being able to achieve its mission; and advocate that clean claims submitted electronically to the VA should be paid within 14 days and that clean paper claims should be paid within 30 days.

Resolution 117 asks that our AMA adopt as policy that the Veterans Health Administration expand all eligible veterans' health care choices by permitting them to use funds currently spent on them through the VA system, through mechanisms such as premium support, to purchase private health care coverage, and for veterans over age 65 to use these funds to defray the costs of Medicare premiums and supplemental coverage; and actively support federal legislation to achieve this expansion of healthcare choices for Veterans Administration eligible veterans.

Testimony was supportive on Council on Medical Service Report 6, and mixed on Resolution 117. An amendment was offered to ask our AMA to encourage both the VA and the physicians participating in the Veterans Choice Program VA to exchange medical records in a timely manner to ensure efficient care. A member of the Council on Medical Service accepted the amendment as friendly. As such, your Reference Committee has proposed the addition of a new recommendation to CMS Report 6.

Your Reference Committee notes that Council on Medical Service Report 6 responded to referred Resolution 229-A-16, "Expansion of US Veterans' Health Care Choices," the intent of which is consistent with that of Resolution 117. Your Reference Committee believes that Council on Medical Service Report 6 appropriately responds to the recommendation of both resolutions to permit veterans to use funds currently spent on them through the VA to purchase private health care coverage. In particular, the report explains the difficulty of providing premium support to veterans. A member of the Council on Medical Service emphasized that suggesting premium support for veterans to purchase health care in the private sector is not a new concept. Importantly, the Council member underscored that the Veterans Health Administration is not a health insurance plan with a defined amount of money to give veterans to purchase private health care. Rather, it is the largest integrated health care system in the US and provides highly specialized and comprehensive care that is not available to the same extent in the private sector. Your Reference Committee agrees, and notes that the VHA provides unique, highly specialized care for many medical conditions, such as spinal cord and traumatic brain injuries, which are not available to the same extent outside of the VHA.

Your Reference Committee believes that the recommendations of Council on Medical Service Report 6 emphasize the need for our AMA to advocate for further improvements to the care the VA provides to veterans, including supporting efforts to improve the Veterans Choice Program and make it a permanent program, and encouraging the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care. As such, your Reference Committee recommends that the recommendations of Council on Medical Service Report 6 be adopted as amended in lieu of Resolution 117, and that the remainder of the report be filed.

(8) COUNCIL ON MEDICAL SERVICE REPORT 9 - CAPPING FEDERAL MEDICAID FUNDING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Council on Medical Service Report 9 be amended by addition of a new Recommendation to read as follows:

That our American Medical Association (AMA) oppose caps on federal Medicaid funding. (New HOD Policy)

HOD ACTION: Recommendation A adopted as new HOD policy.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Recommendation 1 in Council on Medical Service Report 9 be amended by addition and deletion as follows:

HOD ACTION: Recommendation 1 in Council on Medical Service Report 9 referred.

~~That our American Medical Association (AMA) advocate for the following principles of safeguards if federal Medicaid funding is capped:~~

- a. Individuals, including children and adolescents, who are currently eligible for Medicaid should not lose their coverage, and federal funding for the amount, duration, and scope of currently covered benefits should not be reduced;
- b. The amount of federal funding available to states must be sufficient to ensure adequate access to all statutorily required services;
- c. Cost savings mechanisms should not decrease patient access to quality care or physician payment;
- d. The methodology for calculating the federal funding amount should take into consideration the state's ability to pay for health care services, rate of unemployment, concentration of low income individuals, population growth, and overall medical costs;
- e. The federal funding amount should be based on the actual cost of health care services for each state;
- f. The federal funding amount should continue to fund the Affordable Care Act (ACA) Medicaid expansion populations in states that have expanded Medicaid and provide non-expansion states with the option to expand Medicaid with additional funding to cover their expansion populations;
- g. The federal funding ~~amount should be indexed to accurately reflect~~ should be responsive to changes in actual health care costs or state-specific trend rates, not fixed on a preset growth index (e.g., consumer price index);
- h. Maximum cost-sharing requirements should not exceed five percent of family income; and

i. The federal government should continuously monitor the impact of ~~capping~~ federal Medicaid funding to ensure ~~that~~ robust patient access to care, adequate physician payment and the sustainability ~~ability~~ of states ~~to sustain their~~ programs ~~has not been compromised~~. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Recommendation 2 in Council on Medical Service Report 9 be amended by addition and deletion to read as follows:

That our AMA advocate that Congress and the Department of Health and Human Services seek and take into consideration ~~the concerns and~~ input of ~~from~~ our ~~the~~ AMA and interested state medical associations, national medical specialty societies, governors, Medicaid directors, mayors, and other stakeholders during the process of developing federal legislation, regulations, and guidelines on ~~modifications to~~ Medicaid funding. (New HOD Policy)

HOD ACTION: Recommendation C adopted as new HOD policy.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 9 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations A and C adopted as new HOD Policy, with the adopted title change applicable to the categorization and inclusion of these policies in PolicyFinder.

Recommendation 1 in Council on Medical Service Report 9 referred.

The body of Council on Medical Service Report 9 referred.

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that the title of Council on Medical Service Report 9 be changed to read as follows:

FEDERAL MEDICAID FUNDING

Council on Medical Service Report 9 recommends that our AMA advocate for a series of safeguards if federal Medicaid funding is capped; and advocate that Congress and the Department of Health and Human Services take into consideration the concerns and input of the AMA and interested state medical associations, national medical specialty societies, governors, Medicaid directors, mayors and other stakeholders during the process of developing federal legislation, regulations, and guidelines on modifications to Medicaid funding.

Testimony unanimously opposed per capita caps on federal Medicaid funding. However, testimony was mixed about whether AMA should adopt policy on safeguards in the event that Congress establishes per capita caps. Many speakers raised concerns that the policy would be misinterpreted as tacit support for per capita caps and instead recommended reaffirmation of Policy D-290.985, which calls for payment levels based on costs of care and utilization and payment arrangements that do not expose practitioners to excessive financial risk, in lieu of the recommendations in the report. Others testified in support of amendment to explicitly state our AMA's opposition to per capita capped funding and in support of the recommendations that would provide AMA with tools to oppose harmful federal reform proposals. Another amendment was offered to remove all references to capped funding and instead apply the safeguards to any changes to the Medicaid funding scheme.

Your Reference Committee agrees with testimony calling for opposition to capping federal Medicaid funding. However, your Reference Committee also believes that the first recommendation of the report should be retained as general principles for federal Medicaid funding. To accurately reflect these changes, your Reference Committee also recommends a title change. In summary, your Reference Committee recommends that Council on Medical Service Report 9 be adopted as amended and the remainder of the report be filed.

(9) JOINT REPORT OF THE COUNCIL ON MEDICAL SERVICE AND THE COUNCIL ON SCIENCE AND PUBLIC HEALTH - VALUE OF PREVENTIVE SERVICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 4 of the Joint Report of the Council on Medical Service and the Council on Science and Public Health be amended by addition and deletion to read as follows:

That our AMA encourage committees that make preventive services recommendations to:

- a. Follow processes that promote transparency; and clarity ~~and uniformity~~ among their methods;
- b. Develop evidence reviews and recommendations with enough specificity to inform cost-effectiveness analyses;
- c. Rely on the very best evidence available, with consideration of expert consensus only when other evidence is not available;
- d. Work together to identify preventive services that are not supported by evidence or are not cost-effective, with the goal of prioritizing preventive services; and
- e. Consider the development of recommendations on both primary and secondary prevention. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendation 7 of the Joint Report of the Council on Medical Service and the Council on Science and Public Health be amended by addition and deletion as follows:

That our AMA encourage public and private payers to cover ~~prioritize coverage~~ of preventive services for which consensus has emerged in the recommendations of multiple guidelines-making groups. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the recommendations of the Joint Report of the Council on Medical Service and the Council on Science and Public Health be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Joint Report of the Council on Medical Service and the Council on Science and Public Health adopted as amended and the remainder of the report filed.

The Joint Report of the Council on Medical Service and the Council on Science and Public Health recommends that our AMA reaffirm Policies H-185.939, H-110.986 and H-410.953; encourages committees that make preventive services recommendations to follow processes that promote transparency, clarity and uniformity among their methods, develop evidence reviews and recommendations with enough specificity to inform cost-effectiveness analyses, rely on the very best evidence available, with consideration of expert consensus only when other evidence

is not available, work together to identify preventive services that are not supported by evidence or are not cost-effective, with the goal of prioritizing preventive services, and consider the development of recommendations on both primary and secondary prevention; encourage relevant national medical specialty societies to provide input during the preventive services recommendation development process; encourage comparative-effectiveness research on secondary prevention to provide data that could support evidence-based decision making; and encourage public and private payers to prioritize coverage of preventive services for which consensus has emerged in the recommendations of multiple guidelines-making groups.

Testimony on the Joint Report of the Council on Medical Service and the Council on Science and Public Health was supportive. Testimony particularly emphasized the value of preventive services and the need for value-based insurance design that accounts for the cost effectiveness of preventive care. Testimony emphasized that physicians, rather than payers, prioritize preventive services; payers merely cover services. Accordingly, an amendment was offered to the seventh recommendation directing our AMA to encourage payers to cover preventive services. Another amendment was offered to strike language calling for uniformity among methods of the guidelines-making committees because those committees have different objectives and differing methods may be appropriate. Your Reference Committee agrees and recommends that the Joint Report of the Council on Medical Service and the Council on Science and Public Health be adopted as amended and the remainder of the report be filed. Your Reference Committee also notes that an error in the report referring to the “Women’s Preventive Services Institute” will be corrected to read “Women’s Preventive Services Initiative.”

(10) RESOLUTION 101 - ELIMINATING FINANCIAL BARRIERS FOR EVIDENCE-BASED HIV PRE-EXPOSURE PROPHYLAXIS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 101 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association amend Policy H-20.895 by addition to read as follows: H-20.895, Pre-Exposure Prophylaxis (PrEP) for HIV 1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines. 2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances. 3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant. ~~34. Our AMA advocates that individuals not be denied any various financial products, including disability insurance, on the basis of HIV pre-exposure prophylaxis (PrEP) use.~~ (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 101 be adopted as amended.

HOD ACTION: Resolution 101 adopted as amended with a change in title.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 101 be changed to read as follows:

ELIMINATING BARRIERS FOR EVIDENCE-BASED HIV PRE-EXPOSURE PROPHYLAXIS

Resolution 101 asks that our AMA amend Policy H-20.895 by addition to advocate that individuals not be denied various financial products, including disability insurance, on the basis of HIV pre-exposure prophylaxis (PrEP) use.

Testimony was supportive of Resolution 101. Speakers emphasized that insurance denials levied against those who make efforts to protect themselves against contracting HIV are excessively discriminatory. Your Reference Committee agrees and also believes that the language should be amended to apply to insurance products generally, as limitation to financial products is ambiguous. An amendment was offered to broaden the scope of Resolution 101 to include removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant. Your Reference Committee agrees with this amendment, and has amended the resolution accordingly. Your Reference Committee recommends that Resolution 101 be adopted as amended with a change in title.

(11) RESOLUTION 107 - REPEAL AND REPLACE OUR OUTDATED REFUNDABLE ADVANCEABLE TAX CREDIT POLICY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 107.

HOD ACTION: The following resolution adopted in lieu of Resolution 107.

~~IMPROVING HEALTH INSURANCE MARKETPLACE AFFORDABILITY, COMPETITION AND STABILIZATION~~

STUDYING MECHANISMS INCLUDING A PUBLIC OPTION TO IMPROVE HEALTH INSURANCE MARKETPLACE AFFORDABILITY, COMPETITION AND STABILIZATION

That our AMA study mechanisms to improve affordability, competition and stability in the individual health insurance marketplace. (Directive to Take Action)

RESOLVED, that our AMA study the feasibility of a public option insurance plan as a model as a part of a pluralistic health care system to improve access to care.

Resolution 107 asks that our AMA study whether our current advanceable refundable tax credit policy is feasible given the worsening health care market failure that has occurred since this policy was developed; and study the feasibility of a Medicare public option model as a model to improve access to care, considering options for modifications to benefits package and cost sharing.

There was mixed testimony on Resolution 107. A member of the Council on Legislation noted that premium tax credits contribute to market stability, rather than instability as suggested in Resolution 107. For example, the Congressional Budget Office (CBO) in May 2017 concluded that the subsidies to purchase coverage provided for under the ACA, combined with the effects of the individual mandate, are anticipated to cause sufficient demand for insurance by enough people, including people with low health care expenditures, for the market to be stable in most areas. The CBO also has found that the ACA's Medicaid expansion has positively impacted health insurance coverage rates. Of note, our AMA already has policy in support of the Medicaid expansion – Policies H-290.997 and D-290.979.

Importantly, a member of the Council on Medical Service testified that the Council is preparing a report for the 2017 Interim Meeting that will address health insurance marketplace stability. Addressing the intent of Resolution 107, your Reference Committee believes a study is warranted of mechanisms to improve affordability, competition and stability in the individual health insurance marketplace. As such, your Reference Committee believes that that the recommended alternate language be adopted in lieu of Resolution 107.

- (12) RESOLUTION 108 - OUT-OF-NETWORK INSURANCE BENEFIT AVAILABILITY IN INDIVIDUAL INSURANCE MARKET AND SELF-FUNDED PLANS
 RESOLUTION 115 - OUT-OF-NETWORK CARE
 RESOLUTION 118 - THIRD PARTY PATIENT REIMBURSEMENT FOR OUT-OF-NETWORK PHYSICIANS
 RESOLUTION 127 - BALANCE BILLING STATE REGULATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolutions 108, 115, 118 and 127.

HOD ACTION: The following resolution adopted in lieu of Resolutions 108, 115, 118 and 127.

OUT-OF-NETWORK CARE

RESOLVED, That our AMA reaffirm Policies H-165.839, H-373.998, H-285.911 and H-285.908 (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA adopt the following principles related to ~~unexpected unanticipated~~ out-of-network care:

1. Patients must not be financially penalized for receiving ~~unexpected unanticipated~~ care from an out-of-network provider.
2. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
3. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
4. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
5. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
6. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
7. ~~In lieu of balance billing of patients in these circumstances, a m~~Minimum coverage standards for ~~unexpected unanticipated~~ out-of-network services should be identified. ~~The m~~Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary being based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
8. ~~Physician-triggered m~~Mediation should be permitted in those instances where ~~their~~ a physician's unique background or skills (~~i.e.~~ e.g. the Gould Criteria) are not accounted for within a minimum coverage standard. (New HOD Policy); and be it further

RESOLVED, That our AMA develop model state legislation addressing the coverage of and payment for ~~unexpected~~ unanticipated out-of-network care.
(Directive to Take Action)

Resolution 108 asks that our AMA seek the availability of out-of-network benefits for all federally sponsored health insurance plans, federal exchange, and/or self-funded plans including plans utilizing usual, customary and reasonable (UCR) payment methodology.

Resolution 115 asks that our AMA adopt a series of principles related to unexpected out-of-network care; and reaffirm Policies H-185.939, H-450.941 and D-285.972.

Resolution 118 asks that our AMA policy seek to require insurers and third-party payers to properly reimburse patients and/or out-of-network physicians their usual charges, and that there be no increase in deductibles or co-payments for those patients requiring care from out-of-network physicians because of urgent and emergent treatment needed in emergency rooms and hospitals and/or seek federal legislation addressing these issues.

Resolution 127 asks that our AMA report on the status of the various current efforts across the country, including the many state legislative efforts, to limit non-Medicare balance billing; develop model state legislation to assist its component members in their advocacy efforts against current efforts to regulate balance billing; and report back to the House of Delegates at the 2017 Interim Meeting according to AMA Policy D-380.996.

Your Reference Committee heard generally supportive testimony on Resolution 115 and the recommendation of Resolution 127 calling for model state legislation, and mixed testimony regarding Resolutions 108 and 118. Your Reference Committee believes that existing AMA policy, as well as the alternate language proposed by the Reference Committee based on Resolution 115, addresses the issues highlighted in Resolutions 108 and 118. As such, your Reference Committee is recommending the reaffirmation of Policies H-165.839, H-373.998, H-285.911 and H-285.908. An eighth principle also has been added, which states that physician-triggered mediation should be permitted in those instances where their unique background or skills (i.e. the Gould Criteria) are not accounted for within a minimum coverage standard. The Gould criteria are used to determine the reasonable and customary value of non-contracted services, and consider a provider's training, qualification and length of practice.

Concerning Resolution 115, on which the proposed alternate language is based, a member of the Council on Legislation noted that with more than 20 bills this year in the states, most using problematic payment standards that would undermine fair contracting efforts and cap physician payment below market rates, the AMA was not able, due to existing policy, to fully support proactive solutions or develop our own proposals. In addition, many state medical societies worked with national and state medical specialty societies on proposals to equitably and fairly solve the issue of so-called "surprise billing," and many of those proposals reflected the goal of Resolution 115 – establishing a fair payment standard in lieu of being able to send that surprise bill. Your Reference Committee appreciates the amendment proffered to the seventh principle of Resolution 115, and added language to ensure that the intent of Resolution 115 was not lost, and that the intent of the seventh principle of Resolution 115 would not be scaled back to merely a reaffirmation of existing policy.

Overall, your Reference Committee believes that the intent of Resolution 115 provides the AMA with a strong pathway forward on out-of-network care, "surprise billing," and balance billing. Your Reference Committee agrees with testimony that suggested that this issue is due to an insurance market failure, and that the proposed policy in Resolution 115 is a fair solution that protects patients from financially burdensome "surprise" balance bills, while also ensuring that incentives for insurers to offer fair contracts to hospital-based physicians are in place. Your Reference Committee believes that it is incredibly important and noteworthy that impacted national medical specialty societies, as well as several states with experience dealing with this legislative issue, have come together to support new policy that allows for proactive advocacy. Your Reference Committee also agrees with testimony that stated that Resolution 115 offers a much-needed unified message for medicine and allows the AMA to be proactive in these debates at the state level. Your Reference Committee understands testimony that emphasized that without stronger and more unified advocacy, troubling policies will likely be enacted.

At the same time, your Reference Committee heard mixed testimony on the AMA having policy that could support a bar on balance billing in the hospital setting. But, your Reference Committee believes that the seventh principle of Resolution 115, as incorporated into the proposed alternate language, would allow the AMA to support proactive

solutions in the states that benefit both patients and physicians. Also, of note, nothing in the alternate language would permit the AMA to come into and offer this policy in a state, for example, where the medical societies believe they can maintain the right to balance bill or where they do not want to engage in this manner. Your Reference Committee believes that alternate language that incorporates the intent of Resolutions 108, 115, 118 and 127 would provide the AMA with additional strong and proactive policy on the issues of out-of-network care, “surprise billing,” and balance billing, and believes that such alternate language should be adopted in lieu of the resolutions.

H-165.839 Health Insurance Exchange Authority and Operation

1. Our American Medical Association adopts the following principles for the operation of health insurance exchanges: A) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features. B) Any benefits standards implemented for plans participating in the exchange and/or to determine minimum creditable coverage for an individual mandate should be designed with input from patients and actively practicing physicians. C) Physician and patient decisions should drive the treatment of individual patients. D) Actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options. E) Regulations addressing physician participation in public, private or non-profit health insurance options in the exchange that impact physician practice should ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process. F) Any necessary federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices. 2. Our AMA: (A) supports using the open marketplace model for any health insurance exchange, with strong patient and physician protections in place, to increase competition and maximize patient choice of health plans, (B) will advocate for the inclusion of actively practicing physicians and patients in health insurance exchange governing structures and against the categorical exclusion of physicians based on conflict of interest provisions; (C) supports the involvement of state medical associations in the legislative and regulatory processes concerning state health insurance exchanges; and (D) will advocate that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information. (CMS Rep. 3, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 105, A-10; Appended: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 812, I-13; Reaffirmed: Sub. Res. 813, I-13)

H-373.998 Patient Information and Choice

Our AMA supports the following principles: 1. Greater reliance on market forces, with patients empowered with understandable fee/price information and incentives to make prudent choices, and with the medical profession empowered to enforce ethical and clinical standards which continue to place patients' interests first, is clearly a more effective and preferable approach to cost containment than is a government-run, budget-driven, centrally controlled health care system. 2. Individuals should have freedom of choice of physician and/or system of health care delivery. Where the system of care places restrictions on patient choice, such restrictions must be clearly identified to the individual prior to their selection of that system. 3. In order to facilitate cost-conscious, informed market-based decision-making in health care, physicians, hospitals, pharmacies, durable medical equipment suppliers, and other health care providers should be required to make information readily available to consumers on fees/prices charged for frequently provided services, procedures, and products, prior to the provision of such services, procedures, and products. There should be a similar requirement that insurers make available in a standard format to enrollees and prospective enrollees information on the amount of payment provided toward each type of service identified as a covered benefit. 4. Federal and/or state legislation should authorize medical societies to operate programs for the review of patient complaints about fees, services, etc. Such programs would be specifically authorized to arbitrate a fee or portion thereof as appropriate and to mediate voluntary agreements, and could include the input of the state medical society and the AMA Council on Ethical and Judicial Affairs. 5. Physicians are the patient advocates in the current health system reform debate. Efforts should continue to seek development of a plan that will effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients' freedom to select physicians and/or health plans of their choice. 6. Efforts should

continue to vigorously pursue with Congress and the Administration the strengthening of our health care system for the benefit of all patients and physicians by advocating policies that put patients, and the patient/physician relationships, at the forefront. (BOT Rep. QQ, I-91; Reaffirmed: BOT Rep. TT, I-92; Reaffirmed: Ref. Cmte. A, A-93; Reaffirmed: BOT Rep. UU, A-93; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: CMS Rep. G, A-93; Reaffirmed: Sub. Res. 701, A-93; Sub. Res. 125, A-93; Reaffirmation A-93; Reaffirmed: BOT Rep. 25, I-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: CMS Rep. 5, I-93; Reaffirmed: CMS Rep. 10, I-93; Reaffirmed: Sub. Res. 107, I-93; Reaffirmed: BOT Rep. 46, A-94; Reaffirmed: Sub. Res. 127, A-94; Reaffirmed: Sub. Res. 132, A-94; Reaffirmed: BOT Rep. 16, I-94; BOT Rep. 36 - I-94; Reaffirmed: CMS Rep. 8, A-95; Reaffirmed: Sub. Res. 109, A-95; Reaffirmed: Sub. Res. 125, A-95; Reaffirmed by Sub. Res. 107, I-95; Reaffirmed: Sub. Res. 109, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmation A-96; Reaffirmation I-96; Reaffirmation A-97; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMS Rep. 3, I-97; Reaffirmation I-98; Reaffirmed: CMS Rep. 9, A-98; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-04; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 4, A-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmation I-14; Reaffirmed: CMS Rep. 4, A-15)

H-285.911 Health Insurance Safeguards

Our AMA will advocate that health insurance provider networks should be sufficient to provide meaningful access to subscribers, for all medically necessary and emergency care, at the preferred, in-network benefit level on a timely and geographically accessible basis. (CMS Rep. 8, A-10; Reaffirmed in lieu of Res. 815, I-13; Reaffirmation I-15)

H-285.908 Network Adequacy

1. Our AMA supports state regulators as the primary enforcer of network adequacy requirements.
2. Our AMA supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. Physicians may be added to the network at any time.
3. Our AMA supports requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy, including the number and type of providers that have joined or left the network; the number and type of specialists and subspecialists that have left or joined the network; the number and types of providers who have filed an in-network claim within the calendar year; total number of claims by provider type made on an out-of-network basis; data that indicate the provision of Essential Health Benefits; and consumer complaints received.
4. Our AMA supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
5. Our AMA advocates for regulation and legislation to require that out-of-network expenses count toward a participant's annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies.
6. Our AMA supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
7. Our AMA supports health insurers paying out-of-network physicians fairly and equitably for emergency and out-of-network bills in a hospital. AMA policy is that any legislation which addresses this issue should assure that insurer payment for such care be based upon a number of factors, including the physicians' usual charge, the usual and customary charge for such service, the circumstances of the care and the expertise of the particular physician.
8. Our AMA provides assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure physicians and patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks.
9. Our AMA supports the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities.
10. Our AMA advocates for legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited.
11. Our AMA advocates that health plans should be required to document to regulators that they have met requisite standards of network adequacy including hospital-based physician specialties (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible. (CMS Rep. 4, I-14; Reaffirmation I-15; Reaffirmed in lieu of Res. 808, I-15; Modified: Sub. Res. 811, I-15)

(13) RESOLUTION 111 - VA TECHNOLOGY-BASED EYE CARE SERVICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 111 be amended by addition of a new Resolve to read as follows:

That our AMA reaffirm Policy H-480.946. (Reaffirm HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 111 be adopted as amended.

HOD ACTION: Resolution 111 adopted as amended.

Resolution 111 asks that our AMA encourage the Department of Veterans Affairs to continue to explore telemedicine approaches that increase access to quality health care to U.S. Veterans, including the Technology-Based Eye Care Services (TECS) program; and work with Congress to ensure that U.S. Veterans can access eye care through the Technology-Based Eye Care Services (TECS) program.

There was generally supportive testimony on Resolution 111. A speaker underscored that VA telehealth services must provide appropriate care; in response, your Reference Committee is recommending the reaffirmation of Policy H-480.946, which outlines principles to guide the coverage of and payment for telemedicine. In particular, the principles state that the standards and scope of telemedicine services should be consistent with related in-person services, and that the delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes. Your Reference Committee recommends that Resolution 111 be adopted as amended.

H-480.946 Coverage of and Payment for Telemedicine

1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles: a) A valid patient-physician relationship must be established before the provision of telemedicine services, through: - A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or - A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or - Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology. Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services. b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services. c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board. d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services. e) The delivery of telemedicine services must be consistent with state scope of practice laws. f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit. g) The standards and scope of telemedicine services should be consistent with related in-person services. h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes. i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine. j) The patient's medical history must be collected as part of the provision of any telemedicine service. k) The

provision of telemedicine services must be properly documented and should include providing a visit summary to the patient. l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record. m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services. 2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information. 3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine. 4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine. 5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models. 6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service. 7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines. (CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed in lieu of Res. 815, I-15; Reaffirmed: CME Rep. 06, A-16; Reaffirmed: CMS Rep. 06, I-16)

(14) RESOLUTION 114 - COVERAGE FOR PREVENTIVE CARE AND IMMUNIZATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 114 be adopted as amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate that all public and private payers be required to provide first dollar coverage of ~~identify as policy that~~ routine preventive pediatric care, as recommended by the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP), and immunizations, as recommended by the Centers for Disease Control and Prevention, with approval of the AAP and AAFP ~~American Academy of Family Physicians, be a required benefit of any public or private health insurance product and that it has first dollar coverage, without copays or deductibles.~~ (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 114 be adopted as amended.

HOD ACTION: Resolution 114 adopted as amended.

Resolution 114 asks that our AMA identify as policy that routine preventive pediatric care, as recommended by the American Academy of Pediatrics (AAP), and immunizations, as recommended by the Centers for Disease Control and Prevention with approval of the AAP and American Academy of Family Physicians, be a required benefit of any public or private health insurance product and that it has first dollar coverage, without copays or deductibles.

There was positive testimony on Resolution 114. Speakers emphasized the need to remove all financial barriers to pediatric preventive care. Some recommended that all routine preventive care should receive first dollar coverage; however, others cautioned against expanding the scope of the resolution to include preventive care for adults because doing so could make health insurance premiums unaffordable. Your Reference Committee agrees that the resolution should remain specific to pediatric care and notes that several existing policies address this subject: Policy H-165.846 advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children; Policy H-185.969 urges insurance coverage for

immunization with no co-pays or deductibles; Policy H-440.992 states that there should be no financial barrier to immunization of children; and Policy H-290.972 advocates for first-dollar coverage of preventive services for Medicaid beneficiaries. Your Reference Committee also recommends amendment to provide greater clarity.

(15) RESOLUTION 116 - MEDICARE ADVANTAGE PAYMENT POLICIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 116 be amended by addition of a new Resolve to read as follows:

RESOLVED, That our AMA reaffirm Policy D-330.923, which encourages the Centers for Medicare & Medicaid Services to award Medicare Advantage Programs to those health plans where physician payment rates are no less than Medicare Fee for Service rates. (Reaffirm HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 116 be amended by addition and deletion to read as follows:

~~RESOLVED, That our American Medical Association urge the Centers for Medicare and Medicaid Services (CMS) to require support that Medicare Advantage plans must provide enrollees with coverage for, at a minimum, all Part A and Part B original Medicare services, if the enrollee is entitled to benefits under both parts, to abide by all traditional Medicare Fee for Service payment and medical policies when reimbursing physicians on a fee for service basis to ensure uniformity in Medicare benefits and to reduce physician burdens. This policy is not intended to impact capitation rates that are agreed to between a Medicare Advantage plan and a physician or physician organization. (New HOD Policy)~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 116 be adopted as amended.

HOD ACTION: Resolution 116 adopted as amended with a change in title.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the title of Resolution 116 be changed to read as follows:

MEDICARE ADVANTAGE POLICIES

Resolution 116 asks that our AMA urge the Centers for Medicare and Medicaid Services (CMS) to require Medicare Advantage plans to abide by all traditional Medicare Fee-for-Service payment and medical policies when reimbursing physicians on a fee-for-service basis to ensure uniformity in Medicare benefits and to reduce physician burdens. The resolution stipulates that this policy is not intended to impact capitation rates that are agreed to between a Medicare Advantage plan and a physician or physician organization.

Your Reference Committee heard limited, mixed testimony on Resolution 116. The resolution asks the AMA to urge the CMS to require Medicare Advantage plans to abide by all traditional Medicare fee-for-service payment and medical policies when reimbursing physicians on a fee-for-service basis. However, your Reference Committee notes that this is already clearly stated in the Medicare Managed Care Manual (Chapter 4):

10.2 – Basic Rule (Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16) A Medicare Advantage Organization (MAO) offering a Medicare Advantage (MA) plan must provide enrollees in that plan with all Part A and Part B original Medicare services, if the enrollee is entitled to benefits under both parts, and Part B services if the enrollee is a grandfathered “Part B only” enrollee. The MAO fulfills its obligation of providing original Medicare benefits by furnishing the benefits directly, through arrangements, or by paying for the benefits on behalf of enrollees.

Your Reference Committee agrees that adopting a broad policy statement that would support this existing Medicare payment policy would be prudent. Testimony attested that following the Medicare services guidelines should be a floor not a ceiling in regard to services and payment. Your Reference Committee believes that Policy D-330.923 addresses the payment issues raised in this resolution by stating that MA programs should be awarded only to those health plans where “physician payment rates are no less than Medicare Fee for Service rates.” For these reasons, your Reference Committee recommends that Resolution 116 be adopted as amended.

D-330.923 Medicare Advantage Plans

Our AMA encourages the Centers for Medicare & Medicaid Services to award Medicare Advantage Programs only to those health plans that meet all of the following criteria: (1) an 85% or higher medical loss ratio; (2) physician payment rates are no less than Medicare Fee for Service rates; and (3) use enforceable contracts that prohibit unilateral changes in physician payment rates. (Res. 837, I-08)

- (16) RESOLUTION 123 - IMPROVING THE PREVENTION OF COLON CANCER BY INSURING THE WAIVER OF THE CO-PAYMENT IN ALL CASES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 123 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA reaffirm Policies H-165.840, H-185.954, H-185.960, H-425.987 and H-425.992 (Reaffirm HOD Policy); and be it further

~~RESOLVED, That our American Medical Association strongly advocate that all approved preventive services be included in all health plans (New HOD Policy); and be it further~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 123 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support requiring Medicare to waive the coinsurance for colorectal screening tests, including therapeutic intervention(s) required during the procedure strongly urge members of the Congress and the President to support legislation to correct the oversight in the original legislation providing the benefit of colonoscopy screening with the inducement that the copay would not be required when a polyp or other lesion is found as part of the screening process. (New HOD Policy Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 123 be adopted as amended.

HOD ACTION: Resolution 123 adopted as amended.

Resolution 123 asks that our AMA strongly advocate that all approved preventive services be included in all health plans; and strongly urge members of the Congress and the President to support legislation to correct the oversight in the original legislation providing the benefit of colonoscopy screening with the inducement that the copay would not be required when a polyp or other lesion is found as part of the screening process.

There was generally supportive testimony on Resolution 123. Members of the Council on Medical Service cited policies on preventive service coverage, and raised concerns with the wording of the first Resolve. Your Reference Committee agrees that existing policy addresses the intent of the first Resolve, and as such recommends the reaffirmation of Policies H-165.840, H-185.954, H-185.960, H-425.987 and H-425.992 in lieu of the first Resolve. In addition, your Reference Committee amended the second Resolve to align with AMA advocacy efforts to date. AMA advocacy efforts have called for requiring Medicare to waive the coinsurance for colorectal screening tests, regardless of whether therapeutic intervention is required during the procedure. For example, as noted in testimony, the AMA submitted letters to sponsors of relevant legislation in both the House of Representatives and the Senate.

H-165.840 Preventive Medical Care Coverage for All

Our AMA advocates for (1) health care reform that includes evidence-based prevention insurance coverage for all; (2) evidence-based prevention in all appropriate venues, such as primary care practices, specialty practices, workplaces and the community. (Res. 827, I-08; Reaffirmed in lieu of Res. 107, A-12)

H-185.954 Coverage for Certain Types of Well Care Examinations by Health Insurers

Our AMA: (1) will continue to facilitate the education of the American public and physicians as to the benefits of clinical preventive services, such as mammography screening and periodic physical examinations; (2) will continue to evaluate on a regular basis the benefits and cost-effectiveness of clinical preventive services guidelines; and (3) urges all health insurers to make available for purchase a wide variety of group and individual health insurance policies that provide coverage for a range of clinical preventive services. (Sub. Res. 108, A-97; Modified: CMS Rep. 7, A-00; Reaffirmed: CMS Rep. 3, A-02; Renumbered: CMS Rep. 7, I-05; Reaffirmed in lieu of Res. 107, A-12)

H-185.960 Support for the Inclusion of the Benefit for Screening for Colorectal Cancer in All Health Plans
Our AMA supports health plan coverage for the full range of colorectal cancer screening tests. (Res. 726, I-04; Reaffirmation I-07)

H-425.987 Preventive Medicine Services

1. Our AMA supports (A) continuing to work with the appropriate national medical specialty societies in evaluating and coordinating the development of practice parameters, including those for preventive services; (B) continuing to actively encourage the insurance industry to offer products that include coverage for general preventive services; and (C) appropriate reimbursement and coding for established preventive services. 2. Our AMA will seek legislation or regulation so that evidence-based screenings are paid for separately when provided as part of a comprehensive well-patient examination/review. (CMS Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-07; Reaffirmed and Appended: Res. 804, I-11; Reaffirmed in lieu of Res. 107, A-12)

H-425.992 Coverage of Preventive Medical Services by Medicare

The AMA advocates revision of current Medicare guidelines to include coverage of appropriate preventive medical services. (Res. 85, A-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmation A-99; Reaffirmed in lieu of Res. 104, A-06; Reaffirmation A-07; Reaffirmation I-07)

(17) RESOLUTION 124 - EMERGENCY MEDICAL SERVICES REIMBURSEMENT FOR ON-SITE TREATMENT AND TRANSPORT TO NON-TRADITIONAL DESTINATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 124 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association amend ~~existing AMA~~ Policy H-240.978, "Medicare's Ambulance Service Regulations," by addition and deletion to read as follows:

The AMA supports changes in Medicare regulations governing ambulance service coverage guidelines that would expand the term "appropriate facility" to allow full payment for transport to ~~facilities other than the closest based upon the physician's judgment~~ the most appropriate facility based on the patient's needs and the determination made by physician medical direction; and expand the list of eligible transport locations from the current three sites of care (nearest hospital, critical access hospital, or skilled nursing facility) based upon the on-site evaluation and consulting physician's physician medical direction (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA work with the Centers for Medicare & Medicaid Services (CMS) to ~~reimburse pay~~ emergency medical services providers for the evaluation and transport of patients to the most current appropriate ~~next~~ site of care ~~rather than only~~ not limited to the current CMS defined ~~and limited~~ transport locations.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 124 be adopted as amended.

HOD ACTION: Resolution 124 adopted as amended with a change in title.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 124 be changed to read as follows:

EMERGENCY MEDICAL SERVICES PAYMENT FOR ON-SITE
TREATMENT AND TRANSPORT TO NON-TRADITIONAL
DESTINATIONS

Resolution 124 asks that our AMA amend Policy H-240.978 by addition to support expanding the list of eligible transport locations from the current three sites of care (nearest hospital, critical access hospital, or skilled nursing facility) based upon the on-site evaluation and consulting physician's judgement; and work with the Centers for Medicare and Medicaid Services (CMS) to reimburse emergency medical services providers for the evaluation and transport of patients to the appropriate next site of care rather than only to CMS defined and limited transport locations.

Your Reference Committee heard limited testimony in support of Resolution 124. Testimony asserted that the current limited list of eligible transport locations impedes care. A speaker offered amended language in response to concerns regarding the consulting physician. Your Reference Committee accepts the amendment and further recommends a change from the term "reimbursement" to "payment." For these reasons, your Reference Committee recommends that Resolution 124 be adopted as amended.

(18) RESOLUTION 125 - MEDICAID SUBSTANCE USE DISORDER
COVERAGE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 125 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~work with~~ advocate that the Centers for Medicare and Medicaid Services (CMS) ~~to~~ provide expanded Medicaid payment coverage for the medical management and treatment of all substance use disorders (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 125 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate for ~~work with CMS to establish~~ clear billing and coding processes regarding the medical management and treatment of all substance use disorders. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 125 be amended by addition of a new Resolve to read as follows:

RESOLVED, That our AMA recognize the expertise of addiction specialist physicians and the importance of improving access to management and treatment of addiction services with Medicaid payment for all physician specialties. (New HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 125 be amended by addition of a new Resolve to read as follows:

RESOLVED, That our AMA reaffirm Policy H-320.945, which opposes abuse of prior authorization. (Reaffirm HOD Policy)

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 125 be adopted as amended.

HOD ACTION: Resolution 125 adopted as amended.

Resolution 125 asks that our AMA work with the Centers for Medicare and Medicaid Services (CMS) to provide expanded Medicaid payment coverage for the medical management and treatment of all substance use disorders; and work with CMS to establish clear billing and coding processes regarding the medical management and treatment of all substance use disorders.

There was supportive testimony on Resolution 125. Testimony stressed the need for improved access to and additional providers of substance use disorder treatment and that Medicaid payment policies hinder access to care. An amendment was offered to advocate for the elimination of prior authorization requirements that impede care; however, your Reference Committee believes that existing policy addresses the intent of the amendment. As such, your Reference Committee recommends the reaffirmation of Policy H-320.945, which opposes abuse of prior authorization. An amendment was also offered that would affirm the expertise of addiction medicine specialists and call for payment policies that do not preclude payment on the basis of physician specialty. Your Reference Committee agrees with the intent of the amendment and also recommends additional amendments to clarify the intent of the resolution. In particular, your Reference Committee notes that states and Medicaid managed care plans, in addition to CMS, set billing processes and recommends language to be inclusive of those entities. Accordingly, your Reference Committee recommends Resolution 125 be adopted as amended.

H-320.945 Abuse of Preauthorization Procedures

Our AMA opposes the abuse of preauthorization by advocating the following positions: (1) Preauthorization should not be required where the medication or procedure prescribed is customary and properly indicated, or is a treatment for the clinical indication, as supported by peer-reviewed medical publications or for a patient currently managed with an established treatment regimen. (2) Third parties should be required to make preauthorization statistics available, including the percentages of approval or denial. These statistics should be provided by various categories, e.g., specialty, medication or diagnostic test/procedure, indication offered, and reason for denial. (Sub. Res. 728, A-10; Reaffirmation I-10; Reaffirmation A-11; Reaffirmed: Res. 709, A-12)

(19) RESOLUTION 126 - INSURANCE COVERAGE FOR COMPRESSION STOCKINGS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 126 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support ~~engage all relevant stakeholders in ensuring unconditional~~ Medicare ~~compensation~~ payment for gradient compression stockings as prescribed by a physician under Medicare benefits coverage ~~the durable medical equipment portion of coverage, including for cases of preventative use and for patients without a present venous stasis ulcer.~~ (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 126 be adopted as amended.

HOD ACTION: Resolution 126 adopted as amended.

Resolution 126 asks that our AMA engage all relevant stakeholders in ensuring unconditional Medicare compensation for gradient compression stockings as prescribed by a physician under the durable medical equipment portion of coverage, including for cases of preventative use and for patients without a present venous stasis ulcer.

There was generally supportive testimony on Resolution 126. An amendment was offered to specify that Medicare pay for gradient compression stockings under Medicare benefits coverage. Your Reference Committee agrees with the amendment, and as such recommends that Resolution 126 be adopted as amended.

(20) RESOLUTION 110 - OVER-THE-COUNTER CONTRACEPTIVE DRUG ACCESS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 110 be referred.

HOD ACTION: Resolution 110 referred.

Resolution 110 asks that our AMA condemn age-based, cost-based, and other non-medical barriers to contraceptive drug access; adopt policy supporting equitable access to over-the-counter (OTC) contraception, including those forms of contraception recommended for OTC sale, patient risk assessment screening tools, and prescribing by non-physicians; support policy solutions that prohibit cost-sharing obstacles to OTC contraceptive drug access, and full coverage of all contraception without regard to prescription or OTC utilization, since all contraception is essential preventive health care; and advocate for the legislative and/or regulatory mechanisms needed to achieve improvements for OTC contraceptive drug access and quality.

Testimony on Resolution 110 was mixed. Testimony was supportive of the general intent to increase access to contraception and many speakers emphasized that contraception is safe and effective and that increased access to contraceptives would benefit patients, especially disadvantaged patient populations. Testimony was in favor of language in support of first dollar coverage of contraception. However, testimony also raised several concerns. Some emphasized that because there are no contraceptives currently available OTC, the resolution may be premature. Other concerns were raised that some age-based barriers to contraception drug access are appropriate. Other testimony emphasized that patients should not self-screen for contraception and physician judgement is needed to prescribe the appropriate form of contraception. Amendment was offered to remove language to advocate for access to OTC contraception prescribed by non-physicians.

Your Reference Committee believes that while increasing access to contraception in all forms is important, complex issues were raised that deserve further study. Accordingly, your Reference Committee recommends that Resolution 110 be referred.

(21) RESOLUTION 103 - BENEFIT PAYMENT SCHEDULE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-385.987 be reaffirmed in lieu of Resolution 103.

HOD ACTION: Policy H-385.987 reaffirmed in lieu of Resolution 103.

Resolution 103 asks that our AMA adopt as policy a definition of “Benefit Payment Schedule plan,” and support the inclusion of Benefit Payment Schedule plans as one option in a pluralistic system of health care financing.

There was mixed testimony on Resolution 103, including a call for reaffirmation. Your Reference Committee notes that the definition of “Benefit Payment Schedule plan” outlined in Resolution 103 is consistent with that of an indemnity payment system, to which there is already AMA policy directly applicable. In addition, your Reference Committee notes that the term “indemnity payment system” is used and widely understood by health care and other stakeholders outside of our AMA. Your Reference Committee agrees with testimony that stated that existing AMA policy appropriately responds to the issues raised in Resolution 103, and as such recommends that Policy H-385.987 be reaffirmed in lieu of Resolution 103.

H-385.987 Support for Indemnity Payment System

The AMA reaffirms its support for the validity of the indemnity payment system as one of a pluralistic approach to payment methods, and supports implementation of the indemnity payment system as a preferred policy at the national level as is appropriate and feasible. (Res. 65, A-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: Res. 105, A-99; Reaffirmed: CMS Rep. 5, A-09)

(22) RESOLUTION 106 - MEDICAL LOSS RATIO

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-155.959, D-155.993 and H-320.968 be reaffirmed in lieu of Resolution 106.

HOD ACTION: Policies H-155.959, D-155.993 and H-320.968 reaffirmed in lieu of Resolution 106.

Resolution 106 asks that our AMA encourage medical insurance companies to change the term “Medical Loss Ratio” to “Medical Benefit Ratio” and that insurance companies define the elements comprising the “Medical Benefit Ratio;” and advocate that in the interest of full transparency, health financing plans, including insurance, prepaid care and value based payment models, should be required to publish their Medical Benefit Ratios.

There was mixed testimony on Resolution 106. Testimony noted that our AMA already has a strong policy foundation addressing medical loss ratios. As a result, the AMA has been engaged in federal advocacy on this issue,

as well as at the National Association of Insurance Commission (NAIC), with our AMA continuing to be part of a medical loss ratio workgroup at NAIC. In addition, testimony noted that the term “medical loss ratio” is defined at the federal and state levels in numerous statutes and regulations – insurers cannot change the name of the requirement. Your Reference Committee also believes that Resolution 106 may have unintended consequences, as advocating for the use of the term “medical benefit ratio” may undermine AMA advocacy on this issue. Overall, your Reference Committee believes that existing AMA policy appropriately responds to the issues raised in Resolution 106. In particular, AMA policy prioritizes health plans clearly and concisely disclosing their medical loss ratios to prospective enrollees, consistent with the intent of Resolution 106 to make medical loss ratios more patient-centric. As such, your Reference Committee recommends that Policies H-155.959, Policy D-155.993 and H-320.968 be reaffirmed in lieu of the resolution.

H-155.959 Legislation to Reduce Administrative Waste in Health Insurance by Accurate Reporting of Medical Expense Ratios

AMA policy is that private health plans should be required to report data related to administrative costs, expenses and rate setting to appropriate state regulatory bodies to allow for the calculation of medical expense ratios to be consistent on the state level. (Res. 727, A-08)

D-155.993 Legislation to Reduce Administrative Waste in Health Insurance by Accurate Reporting of Medical Expense Ratios

Our AMA: (1) will develop model state legislation and regulations that would require that all private health plans make publicly available annually, and publish separately, their medical care costs and their administrative costs, using the format called for in AMA Policy H 155.963; (2) supports state legislation to require that all private health plans make publicly available annually, and publish separately, their medical care costs and their administrative costs; and (3) supports the development and implementation of a uniform, national accounting and reporting system to report administrative expenses and medical expense ratios as part of greater, national uniformity of market regulation. (Res. 727, A-08)

H-320.968 Approaches to Increase Payer Accountability

Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability. (1) Disclosure Requirements. Our AMA supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on (a) coverage provisions, benefits, and exclusions; (b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient; (d) medical expense ratios; and (e) cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97) (2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review; (c) Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior

authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay. (3) Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above. (BOT Rep. M, I-90; Reaffirmed by Res. 716, A-95; Reaffirmed by CMS Rep. 4, A-95; Reaffirmation I-96; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMS Rep. 13, I-98; Reaffirmation I-98; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-00; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation A-09; Reaffirmed: Sub. Res. 728, A-10; Modified: CMS Rep. 4, I-10; Reaffirmation A-11; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 07, A-16)

(23) RESOLUTION 109 - SIMPLIFY MEDICARE FACE TO FACE REQUIREMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy D-330.914 be reaffirmed in lieu of Resolution 109.

HOD ACTION: Policy D-330.914 reaffirmed in lieu of Resolution 109.

Resolution 109 asks that our AMA advocate to simplify the Medicare requirements for a “Face to Face” visit with a patient by a physician as a precondition for Medicare home health coverage, including advocating for alternatives for such “Face to Face” visit such as by telehealth.

Mixed testimony was heard on Resolution 109. Testimony from the Council on Medical Service recognized that CMS Report 3-I-12, “Face-to-Face Encounter Rule,” addressed this topic. While several speakers raised concerns about telehealth issues and requested referral, the author testified that this was not intended to be a telehealth issue. Your Reference Committee believes that existing AMA policy appropriately responds to the issues raised in Resolution 109, and as such recommends that Policy D-330.914 be reaffirmed in lieu of Resolution 109.

D-330.914 Face-to-Face Encounter Rule

1. Our AMA will: (A) work with the Centers for Medicare & Medicaid Services (CMS) and appropriate national medical specialty societies to ensure that physicians understand the alternative means of compliance with and payment policies associated with Medicare's face-to-face encounter policies, including those required for home health, hospice and durable medical equipment; (B) work with CMS to continue to educate home health agencies on the face-to-face documentation required as part of the certification of eligibility for Medicare home health services to ensure that the certification process is streamlined and minimizes paperwork burdens for practicing physicians; and (C) continue to monitor legislative and regulatory proposals to modify Medicare's face-to-face encounter policies and work to prevent any new unfunded mandatory administrative paperwork burdens for practicing physicians. 2. Our AMA will work with CMS to enable the use of HIPAA-compliant telemedicine and video monitoring services to satisfy the face-to-face requirement in certifying eligibility for Medicare home health services. (CMS Rep. 3, I-12; Appended Res. 120, A-14)

(24) RESOLUTION 121 - ADVANCED CARE PLANNING CODES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-70.919, H-85.956 and H-140.845 be reaffirmed in lieu of Resolution 121.

HOD ACTION: Policies H-70.919, H-85.956 and H-140.845 reaffirmed in lieu of Resolution 121.

Resolution 121 asks that our AMA assess the degree of use of CPT Codes 99497 and 99498 since they were established; study the barriers to discussion about advanced care planning by physicians and patients; and advocate for the expanded use of CPT Codes 99497 and 99498 when sufficient time and effort is spent in face-to-face contact with patients and families and when spread out over multiple clinical visits in order to satisfy the time requirements, due to the complexity of the subject matter.

Your Reference Committee heard limited testimony in support of Resolution 121. Testimony attested to the value of the advance care planning CPT codes and to the AMA/Specialty Society RVS Update Committee (RUC) support of the creation and payment of these codes in 2014-15. It was noted that the request in the first Resolve has been accomplished in that Medicare utilization data is available for CPT codes 99497 and 99498. In 2016, the codes were reported 619,658 and 11,982 times, respectively. The third Resolve asks the AMA to advocate for expanded use of these codes. Your Reference Committee stresses that any changes to code definitions would have to be requested through a code change proposal using the established CPT process that is outlined in Policy H-70.919. Interpretations of current CPT code definitions should also be obtained through the CPT process.

Finally, while testimony supported the spirit of the resolution, your Reference Committee concurs that there is extensive AMA policy to support and encourage the use of advance directives. Most recently, BOT Report 5-I-16 addressed this issue in the context of the IOM “Dying in America” report. Therefore, the report that is requested in the second resolve clause has been accomplished. As such, your Reference Committee recommends that Policies H-70.919, H-140.845 and H-85.956 be reaffirmed in lieu of Resolution 121.

H-70.919 Use of CPT Editorial Panel Process

Our AMA reinforces that the CPT Editorial Panel is the proper forum for addressing CPT code set maintenance issues and all interested stakeholders should avail themselves of the well-established and documented CPT Editorial Panel process for the development of new and revised CPT codes, descriptors, guidelines, parenthetical statements and modifiers.

H-140.845 Encouraging the Use of Advance Directives and Health Care Powers of Attorney

Our AMA will: (1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies; (2) encourage nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility; (3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD); (4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas; (7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license; (8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives; (9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (11) advocate for the implementation of secure electronic advance health care directives. (CCB/CLRPD Rep. 3, A-14; Reaffirmed: BOT Rep. 9, I-15; Reaffirmed: Res. 517, A-16; Reaffirmed: BOT Rep. 05, I-16)

H-85.956 Educating Physicians About Advance Care Planning

Our AMA: (1) will continue efforts to better educate physicians in the skills necessary to increase the prevalence and quality of meaningful advance care planning, including the use of advance directives, and to improve recognition of and adherence to a patient's advance care decisions; (2) supports development of materials to educate physicians about the requirements and implications of the Patient Self-Determination Act, and supports the development of materials (including, but not necessarily limited to, fact sheets and/or brochures) which physicians can use to educate their patients about advance directives and requirements of the Patient Self-Determination Act; (3) encourages residency training programs, regardless of or in addition to current specialty specific ACGME requirements, to promote and develop a high level of knowledge of and ethical standards for the use of such documents as living wills, durable powers of attorney for health care, and ordering DNR status, which should include medical, legal, and ethical principles guiding such physician decisions. This knowledge should include aspects of medical case management in which decisions are made to limit the duration and intensity of treatment; (4) will work with medical schools, graduate medical education programs and other interested groups to increase the awareness and the creation of personal advance directives for all medical students and physicians; and (5) encourages development of a model educational module for the teaching of advance directives and advance care planning. (CCB/CLRPD Rep. 3, A-14; Appended: Res. 307, A-14; Reaffirmed: BOT Rep. 05, I-16)

REPORT OF REFERENCE COMMITTEE B

- (1) BOARD OF TRUSTEES REPORT 13 – CLOSING GAPS IN PRESCRIPTION DRUG MONITORING PROGRAMS (RESOLUTION 209-A-16)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 13 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 13 adopted and the remainder of the report filed.

The Board of Trustees recommends that the following be adopted in lieu of Resolution 232-A-16, and that the remainder of the report be filed. 1. That our AMA conduct a literature review of available data showing the outcomes of PDMPs on opioid-related mortality and other harms; improved pain care; and other measures to be determined in consultation with our AMA Task Force to Reduce Opioid Abuse. (Directive to Take Action) 2. That our AMA advocate that U.S. Department of Veterans Affairs pharmacies report prescription information required by the state into the state PDMP. (Directive to Take Action) 3. That our AMA advocate for physicians and other health care professionals employed by the VA to be eligible to register for and use the state PDMP in which they are practicing even if the physician or other health care professional is not licensed in the state. (Directive to Take Action) 4. That our AMA seek clarification from SAMHSA on whether opioid treatment programs and other substance use disorder treatment programs may share dispensing information with state-based PDMPs. (Directive to Take Action)

Your Reference Committee heard overwhelmingly supportive testimony on Board of Trustees Report 13 and for Prescription Drug Monitoring Programs (PDMPs) to have a public health focus, include real-time data, be integrated into physicians' workflow, and continue to have a state-based focus. Your Reference Committee heard testimony that our AMA should support the ability of state PDMPs to have the capability for physicians to know when their patients have received a prescription for controlled substances from multiple prescribers or multiple pharmacies in a short period of time. Your Reference Committee also heard testimony that our AMA should support the interoperability of state PDMPs with electronic health records and with a public health focus, which has been extensively outlined in AMA policy and advocacy efforts. For all of the reasons articulated in a thorough and extensive Board Report, your Reference Committee recommends adoption.

- (2) BOARD OF TRUSTEES REPORT 14 – MEDICARE PART B DOUBLE DIPPING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 14 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 14 adopted and the remainder of the report filed.

The Board of Trustees recommends that Resolution 209-A-16 not be adopted and the remainder of the report be filed.

Your Reference Committee heard limited but supportive testimony on Board Report 14. Your Reference Committee commends our Board of Trustees for its thorough and comprehensive report and agrees that paycheck deductions go to fund the Part A trust fund, not a beneficiary's share of the Part B premium. Therefore, your Reference Committee recommends adoption of Board Report 14.

(3) RESOLUTION 203 – AMA TO SUPPORT PHARMACEUTICAL PRICING NEGOTIATION IN US

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 203 be adopted.

HOD ACTION: Resolution 203 adopted.

Resolution 203 asks that our American Medical Association prioritize its support for the Centers for Medicare & Medicaid Services (CMS) to negotiate pharmaceutical pricing for all applicable medications covered by CMS. (New HOD Policy)

Your Reference Committee agrees with the unanimous but limited testimony in support of Resolution 203, and therefore recommends adoption.

(4) RESOLUTION 210 – VIOLATION OF HIPAA ELECTRONIC TRANSACTION STANDARDS BY INSURER

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 210 be adopted.

HOD ACTION: Resolution 210 adopted.

Resolution 210 asks that our American Medical Association present information on ICD-10 improper claim denials to the Centers for Medicare and Medicaid Services (CMS) and its Office of E-Health Standards & Services, to determine whether the insurers' failure to properly update their claims processing systems has constituted a violation of the HIPAA Electronic Transaction Standards and should trigger disciplinary or corrective actions to prevent these occurrences in the future. (Directive to Take Action)

Your Reference Committee heard limited but supportive testimony on Resolution 210. Notably, your Reference Committee heard testimony that our AMA worked for multiple years to delay and then ease the transition to the ICD-10 code set and specifically, that our AMA secured an ICD-10 Ombudsman to receive and triage physician problems as the code set was implemented. Your Reference Committee also heard that our AMA is continuing to investigate and working to resolve problems that may have occurred during the transition to ICD-10. Accordingly, your Reference Committee recommends adoption of Resolution 210.

(5) RESOLUTION 220 – ACCOUNTABILITY OF 911 EMERGENCY SERVICES FUNDING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 220 be adopted.

HOD ACTION: Resolution 220 adopted.

Resolution 220 asks that our American Medical Association encourage federal guidelines and state legislation that protects against reallocation of 911 funding to unrelated services. (Directive to Take Action)

Your Reference Committee heard limited but supportive testimony on Resolution 220 and therefore recommends adoption.

- (6) RESOLUTION 226 – DIRECT AMERICAN MEDICAL ASSOCIATION TO ASK CMS AND HHS TO REMOVE PRACTICE EXPENSE AND MALPRACTICE EXPENSE FROM PUBLICLY REPORTED PAYMENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 226 be adopted.

HOD ACTION: Resolution 226 adopted.

Resolution 226 asks that our American Medical Association petition the Centers for Medicare & Medicaid Services and the Office of Health & Human Services to remove practice expense and malpractice expense from reimbursements reported to the public. (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 226. Those testifying noted that CMS' publication of physician data includes information that could be misconstrued by the general public, including practice and medical liability expenses. Your Reference Committee also heard testimony that acknowledged past AMA advocacy efforts on this issue, and confirmed the need for continued advocacy specifically on the inclusion of practice and medical liability expenses in publicly reported Medicare data. Therefore, your Reference Committee recommends adoption of Resolution 226.

- (7) RESOLUTION 233 – REGULATION OF PHYSICIAN ASSISTANTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 233 be adopted.

HOD ACTION: Resolution 233 adopted. Amendment B-3 referred for decision.

Amendment B-3: RESOLVED, That the AMA will adopt policy that APRNs are subject to the jurisdiction of state medical licensing and regulatory boards for the regulation and discipline of APRNs in their performance of medical acts, and that the AMA will develop model state legislation in support of states to accomplish this policy.

Resolution 233 asks that our American Medical Association advocate in support of maintaining the authority of medical licensing and regulatory boards to regulate the practice of medicine through oversight of physicians, physician assistants and related medical personnel (New HOD Policy); and be it further, that our AMA oppose legislative efforts to establish autonomous regulatory boards meant to license, regulate, and discipline physician assistants outside of the existing state medical licensing and regulatory bodies' authority and purview. (New HOD Policy)

Your Reference Committee heard testimony in support of Resolution 233. Testimony suggested that the resolution be amended to incorporate regulation of advanced practice registered nurses (APRNs). Your Reference Committee notes that while in most states Physician Assistants (PAs) are under the authority of the state medical board, every state places the authority to regulate APRNs under the state nursing board—a structure that is unlikely to change. Your Reference Committee heard testimony commenting on the timeliness of this resolution, noting anticipated legislation to move PAs into a more autonomous role. Your Reference Committee agrees, and as such, recommends that Resolution 233 be adopted.

(8) RESOLUTION 236 – RETAIL PRICE OF DRUGS DISPLAYED IN DIRECT-TO-CONSUMER PHARMACEUTICAL ADVERTISING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 236 be adopted.

HOD ACTION: Resolution 236 adopted.

Resolution 236 asks that our American Medical Association advocate to the applicable Federal agencies (including the Food and Drug Administration, the Federal Trade Commission, and the Federal Communications Commission) which regulate or influence direct-to-consumer advertising of prescription drugs that such advertising should be required to state the manufacturer's suggested retail price of those drugs. (Directive to Take Action)

Your Reference Committee heard overwhelmingly supportive testimony on Resolution 236. Your Reference Committee strongly believes that transparency of prescription drug prices is important and needed along a continuum of stakeholders. Your Reference Committee also believes disclosing the suggested retail price will help facilitate and promote transparency in pricing and costs and, therefore, recommends adoption of Resolution 236.

(9) BOARD OF TRUSTEES REPORT 11 - PHYSICIAN-PATIENT TEXT MESSAGING AND NON-HIPAA COMPLIANT ELECTRONIC MESSAGING
RESOLUTION 239 – AMA SUPPORT FOR TEXTING AS APPROVED HIPAA COMMUNICATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Recommendation of Board of Trustees Report 11 be amended by addition of a new Recommendation to read as follows:

That our American Medical Association work with the Office of Civil Rights to develop guidance on text messaging to facilitate the appropriate and safe use of this technology when communicating patient information.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Recommendation of Board of Trustees Report 11 be amended to read as follows:

The Board of Trustees recommends that AMA Policy H-478.997 be amended by addition to read as follows, and that the remainder of the report be filed:

Policy H-478.997, "Guidelines for Patient-Physician Electronic Mail and Text Messaging"

New communication technologies must never replace the crucial interpersonal contacts that are the very basis of the patient-physician relationship. Rather, electronic mail and other forms of Internet communication should be used to enhance such contacts. Furthermore, before using electronic mail or other electronic communication tools, physicians should consider Health Information Portability and Accountability Act (HIPAA) and other privacy requirements, as well as related AMA policy on privacy and confidentiality, including Policies H-315.978 and H-315.989. Patient-physician electronic mail is defined as computer-based communication between physicians and patients within a

professional relationship, in which the physician has taken on an explicit measure of responsibility for the patient's care. These guidelines do not address communication between physicians and consumers in which no ongoing professional relationship exists, as in an online discussion group or a public support forum.

(1) For those physicians who choose to utilize e-mail for selected patient and medical practice communications, the following guidelines be adopted.

Communication Guidelines:

- (a) Establish turnaround time for messages. Exercise caution when using e-mail for urgent matters.
- (b) Inform patient about privacy issues.
- (c) Patients should know who besides addressee processes messages during addressee's usual business hours and during addressee's vacation or illness.
- (d) Whenever possible and appropriate, physicians should retain electronic and/or paper copies of e-mail communications with patients.
- (e) Establish types of transactions (prescription refill, appointment scheduling, etc.) and sensitivity of subject matter (HIV, mental health, etc.) permitted over e-mail.
- (f) Instruct patients to put the category of transaction in the subject line of the message for filtering: prescription, appointment, medical advice, billing question.
- (g) Request that patients put their name and patient identification number in the body of the message.
- (h) Configure automatic reply to acknowledge receipt of messages.
- (i) Send a new message to inform patient of completion of request.
- (j) Request that patients use autoreply feature to acknowledge reading clinicians message.
- (k) Develop archival and retrieval mechanisms.
- (l) Maintain a mailing list of patients, but do not send group mailings where recipients are visible to each other. Use blind copy feature in software.
- (m) Avoid anger, sarcasm, harsh criticism, and libelous references to third parties in messages.
- (n) Append a standard block of text to the end of e-mail messages to patients, which contains the physician's full name, contact information, and reminders about security and the importance of alternative forms of communication for emergencies.
- (o) Explain to patients that their messages should be concise.
- (p) When e-mail messages become too lengthy or the correspondence is prolonged, notify patients to come in to discuss or call them.
- (q) Remind patients when they do not adhere to the guidelines.
- (r) For patients who repeatedly do not adhere to the guidelines, it is acceptable to terminate the e-mail relationship.

Medicolegal and Administrative Guidelines:

- (a) Develop a patient-clinician agreement for the informed consent for the use of e-mail. This should be discussed with and signed by the patient and documented in the medical record. Provide patients with a copy of the agreement. Agreement should contain the following:
 - (b) Terms in communication guidelines (stated above).
 - (c) Provide instructions for when and how to convert to phone calls and office visits.
 - (d) Describe security mechanisms in place.
 - (e) Hold harmless the health care institution for information loss due to technical failures.

- (f) Waive encryption requirement, if any, at patient's insistence.
 - (g) Describe security mechanisms in place including:
 - (h) Using a password-protected screen saver for all desktop workstations in the office, hospital, and at home.
 - (i) Never forwarding patient-identifiable information to a third party without the patient's express permission.
 - (j) Never using patient's e-mail address in a marketing scheme.
 - (k) Not sharing professional e-mail accounts with family members.
 - (l) Not using unencrypted wireless communications with patient-identifiable information.
 - (m) Double-checking all "To" fields prior to sending messages.
 - (n) Perform at least weekly backups of e-mail onto long-term storage. Define long-term as the term applicable to paper records.
 - (o) Commit policy decisions to writing and electronic form.
- (2) The policies and procedures for e-mail be communicated to all patients who desire to communicate electronically.
- (3) The policies and procedures for e-mail be applied to facsimile communications, where appropriate.
- (4) The policies and procedures for e-mail be applied to text and electronic messaging using a secure communication platform, where appropriate.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the recommendations of Board of Trustees Report 11 be adopted as amended in lieu of Resolution 239 and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 11 adopted as amended in lieu of Resolution 239 and that the remainder of the report filed.

The Board of Trustees recommends that: AMA Policy H-478.997 be amended by addition to read as follows, and that the remainder of the report be filed. Policy H-478.997, "Guidelines for Patient-Physician Electronic Mail" New communication technologies must never replace the crucial interpersonal contacts that are the very basis of the patient-physician relationship. Rather, electronic mail and other forms of Internet communication should be used to enhance such contacts. Furthermore, before using electronic mail or other electronic communication tools, physicians should consider Health Information Portability and Accountability Act (HIPAA) requirements as well as related AMA policy on privacy and confidentiality, including Policies H-315.978 and H-315.989. Patient-physician electronic mail is defined as computer-based communication between physicians and patients within a professional relationship, in which the physician has taken on an explicit measure of responsibility for the patient's care. These guidelines do not address communication between physicians and consumers in which no ongoing professional relationship exists, as in an online discussion group or a public support forum. (1) For those physicians who choose to utilize e-mail for selected patient and medical practice communications, the following guidelines be adopted.

Communication Guidelines:

- (a) Establish turnaround time for messages. Exercise caution when using e-mail for urgent matters.
- (b) Inform patient about privacy issues.
- (c) Patients should know who besides addressee processes messages during addressee's usual business hours and during addressee's vacation or illness.
- (d) Whenever possible and appropriate, physicians should retain electronic and/or paper copies of e-mail communications with patients.
- (e) Establish types of transactions (prescription refill, appointment scheduling, etc.) and sensitivity of subject matter (HIV, mental health, etc.) permitted over e-mail.

- (f) Instruct patients to put the category of transaction in the subject line of the message for filtering: prescription, appointment, medical advice, billing question.
- (g) Request that patients put their name and patient identification number in the body of the message.
- (h) Configure automatic reply to acknowledge receipt of messages.
- (i) Send a new message to inform patient of completion of request.
- (j) Request that patients use autoreply feature to acknowledge reading clinicians message.
- (k) Develop archival and retrieval mechanisms.
- (l) Maintain a mailing list of patients, but do not send group mailings where recipients are visible to each other. Use blind copy feature in software.
- (m) Avoid anger, sarcasm, harsh criticism, and libelous references to third parties in messages.
- (n) Append a standard block of text to the end of e-mail messages to patients, which contains the physician's full name, contact information, and reminders about security and the importance of alternative forms of communication for emergencies.
- (o) Explain to patients that their messages should be concise.
- (p) When e-mail messages become too lengthy or the correspondence is prolonged, notify patients to come in to discuss or call them.
- (q) Remind patients when they do not adhere to the guidelines.
- (r) For patients who repeatedly do not adhere to the guidelines, it is acceptable to terminate the e-mail relationship.

Medicolegal and Administrative Guidelines:

- (a) Develop a patient-clinician agreement for the informed consent for the use of e-mail. This should be discussed with and signed by the patient and documented in the medical record. Provide patients with a copy of the agreement. Agreement should contain the following:
 - (b) Terms in communication guidelines (stated above).
 - (c) Provide instructions for when and how to convert to phone calls and office visits.
 - (d) Describe security mechanisms in place.
 - (e) Hold harmless the health care institution for information loss due to technical failures.
 - (f) Waive encryption requirement, if any, at patient's insistence.
 - (g) Describe security mechanisms in place including:
 - (h) Using a password-protected screen saver for all desktop workstations in the office, hospital, and at home.
 - (i) Never forwarding patient-identifiable information to a third party without the patient's express permission.
 - (j) Never using patient's e-mail address in a marketing scheme.
 - (k) Not sharing professional e-mail accounts with family members.
 - (l) Not using unencrypted wireless communications with patient-identifiable information.
 - (m) Double-checking all "To" fields prior to sending messages.
 - (n) Perform at least weekly backups of e-mail onto long-term storage. Define long-term as the term applicable to paper records.
 - (o) Commit policy decisions to writing and electronic form.
- (2) The policies and procedures for e-mail be communicated to all patients who desire to communicate electronically.
- (3) The policies and procedures for e-mail be applied to facsimile communications, where appropriate.
- (4) The policies and procedures for e-mail be applied to text and electronic messaging using a secure communication platform, where appropriate.

Resolution 239 asks that our American Medical Association collaborate with medical technology companies and the federal government to improve texting platforms so that more commercially available devices comply with HIPAA without having to utilize expensive and complex encryption technology (Directive to Take Action); and be it further, that our AMA advocate for the relaxation of HIPAA rules regulating the use of commercially available devices to transfer protected health information. (New HOD Policy)

Your Reference Committee heard supportive testimony on Board of Trustees Report 11. Those testifying noted the potential benefits of using text messaging to communicate with colleagues and patients but expressed confusion about when it is appropriate to use this technology to convey health information. Your Reference Committee recognizes this lack of clarity and appreciates the guidance provided in Board of Trustees Report 11. Specifically,

the Report includes examples of when physicians can utilize texting and also outlines considerations that should be addressed before sending electronic messages. Your Reference Committee believes that the recommendations to the Board of Trustees Report 11 should reference text messaging in the title of the policy that is being amended to further support the intent behind the Report. Furthermore, the Board of Trustees Report 11 recommendations should recognize the higher level of confidentiality for substance abuse disorders. Your Reference Committee therefore recommends that the phrase “and other privacy requirements” be added to the amended language.

Your Reference Committee heard mixed testimony on Resolution 239. Testimony noted that our AMA is actively engaged in working towards these goals and that there are new and affordable technologies being made available to facilitate such communication. To recognize this ongoing advocacy, your Reference Committee recommends that Board of Trustees Report 11 be amended by addition to include another recommendation that states that our AMA work with the Office of Civil Rights to develop guidance on text messaging to facilitate the appropriate and safe use of this technology when communicating patient information.

(10) BOARD OF TRUSTEES REPORT 22 – COUNCIL ON LEGISLATION
SUNSET REVIEW OF 2007 HOUSE POLICIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Recommendation of Board of Trustees Report 22 be amended by addition to read as follows:

The Board of Trustees recommends that the House of Delegates policies listed in Appendix 1 to this report be acted upon in the manner indicated, except for H-330.929 and clause one of Policy H-450.962, which should be retained, and the remainder of this report be filed.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Recommendation of Board of Trustees Report 22 be adopted as amended and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 22 adopted as amended and that the remainder of the report filed.

The Board of Trustees recommends that the House of Delegates policies listed in Appendix 1 to this report be acted upon in the manner indicated and the remainder of this report be filed.

Your Reference Committee heard and agreed with testimony urging that H-330.929 and clause one of Policy H-450.962 be retained. Therefore, your Reference Committee recommends that the recommendation of Board of Trustees Report 22 be adopted as amended and that the remainder of the report be filed.

(11) RESOLUTION 201 – IMPROVING DRUG AFFORDABILITY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 201 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support drug price transparency legislation ~~that requires pharmaceutical manufacturers to disclose, in a timely fashion, the basis for the prices of all prescription drugs, including but not limited to: (1) research and development costs paid by both the manufacturer and any other entity; (2) manufacturing costs; (3) advertising and marketing costs; (4) total revenues and direct and indirect sales; (5) unit price;~~

~~(6) financial assistance provided for each drug including any discounts, rebates and/or prescription drug assistance; (7) any offshoring of either jobs or profits; (8) any reverse payment settlements; (9) payments to third parties—such as wholesalers, group purchasing organizations (GPOs), managed care organizations (MCOs), and pharmacy benefit management companies (PBMs) (New HOD Policy); and be it RESOLVED, That our AMA support legislation that requires pharmaceutical manufacturers to provide public notice before increasing the wholesale price of any brand or specialty drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase (New HOD Policy); and be it further~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 201 be amended by deletion to read as follows:

~~RESOLVED, That our AMA support legislation that requires pharmaceutical manufacturers to provide public notice before increasing the wholesale price of any brand or specialty drug by 10% or more each year or per course of treatment (New HOD Policy); and be it further~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 201 be adopted as amended.

HOD ACTION: Resolution 201 adopted as amended.

Resolution 201 asks that our American Medical Association support drug price transparency legislation that requires pharmaceutical manufacturers to disclose, in a timely fashion, the basis for the prices of all prescription drugs, including but not limited to: (1) research and development costs paid by both the manufacturer and any other entity; (2) manufacturing costs; (3) advertising and marketing costs; (4) total revenues and direct and indirect sales; (5) unit price; (6) financial assistance provided for each drug including any discounts, rebates and/or prescription drug assistance; (7) any offshoring of either jobs or profits; (8) any reverse payment settlements; (9) payments to third parties--such as wholesalers, group purchasing organizations (GPOs), managed care organizations (MCOs), and pharmacy benefit management companies (PBMs) (New HOD Policy); and be it further that our AMA support legislation that requires pharmaceutical manufacturers to provide public notice before increasing the wholesale price of any brand or specialty drug by 10% or more each year or per course of treatment (New HOD Policy); and be it further that our AMA support legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients (New HOD Policy); and be it further that our AMA support the expedited review of generic drug applications and prioritize review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment. (New HOD Policy)

Your Reference Committee heard overwhelmingly supportive testimony on Resolution 201, but that urged modification to simplify and combine the first and second Resolves and adopt Resolves 3 and 4. Your Reference Committee strongly believes there is a need to address price gouging and anti-competitive behaviors by pharmaceutical companies. Your Reference Committee supports added transparency as well as new authorities to expedite competition through the regulatory process as well as to expand authorities for federal agencies to address monopoly behaviors. Your Reference Committee also heard testimony that transparency is essential but should be targeted and meaningful. Your Reference Committee also heard testimony that Resolve 1 may be too prescriptive and inhibits innovation, and that a more flexible approach will be more effective by focusing generally on the issues related to price gouging. Therefore, your Reference Committee recommends adoption of Resolution 201 with amendments combining Resolves 1 and 2, striking original Resolve 2, and adopting Resolves 3 and 4.

- (12) RESOLUTION 206 – MACRA AND THE INDEPENDENT PRACTICE OF MEDICINE
 RESOLUTION 209 – REDUCE PHYSICIAN PRACTICE ADMINISTRATIVE BURDEN
 RESOLUTION 222 – RESPONSE TO BURDENSOME GOVERNMENTAL MANDATE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends adoption of the following resolution in lieu of Resolutions 206, 209, and 222:

HOD ACTION: The following resolution adopted in lieu of Resolutions 206, 209, and 222:

RESOLVED, That our AMA, in the interest of patients and physicians, encourage the Centers for Medicare and Medicaid Services and Congress to revise the Merit-Based Incentive Payment System to a simplified quality and payment system with significant input from practicing physicians, that focuses on easing regulatory burden on physicians, allowing physicians to focus on quality patient care; and be it further

RESOLVED, That our AMA advocate for appropriate scoring adjustments for physicians treating high-risk beneficiaries in the MACRA program; and be it further

RESOLVED, That our AMA urge CMS to continue studying whether MACRA creates a disincentive for physicians to provide care to sicker Medicare patients.

Resolution 206 asks that our American Medical Association advocate for appropriate scoring adjustments for physicians treating high-risk beneficiaries in the MACRA program (New HOD Policy); and be it further that our AMA study if MACRA creates a disincentive for physicians to provide care to sicker Medicare patients. (Directive to Take Action)

Resolution 209 asks that our American Medical Association advocate to repeal the law that conditions a portion of a physician's Medicare payment on compliance with the Medicare Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APM) programs (New HOD Policy); and be it further, that, should full repeal not be achievable, our AMA advocate for legislation and/or regulation to significantly reduce the administrative burdens and penalties associated with compliance with the MIPS and APM programs. (New HOD Policy)

Resolution 222 asks that our American Medical Association, in the interest of patients and physicians, encourage the Centers for Medicare and Medicaid Services, Congress and the Trump Administration to revise the Merit Based Incentive Payment System to a simplified quality and payment system, with significant input from practicing physicians, that focuses on easing regulatory burden on physicians, allowing physicians to focus on quality patient care. (New HOD Policy)

Your Reference Committee heard supportive testimony on Resolutions 206 and 222. Your Reference Committee heard testimony that our AMA should continue to advocate for the Centers for Medicare and Medicaid Services to develop appropriate scoring methodologies in the Quality Payment Program (QPP) that accurately adjusts for high risk beneficiaries. Your Reference Committee also heard supportive testimony on Resolution 222. Your Reference Committee heard testimony that our AMA should continue to ensure that the Merit-Based Incentive Payment System (MIPS) focuses on easing the regulatory burden on physicians and allows physicians to focus on quality care. Your Reference Committee heard supportive testimony of a new resolution that adopts the intent of Resolutions 206 and 222.

Your Reference Committee heard limited testimony on Resolution 209, which cited the continued burden of the QPP reporting programs. However, the majority of the testimony was focused on improving the QPP rather than

repealing the Medicare Access and CHIP Reauthorization Act (MACRA). Most testimony supported our AMA's continued advocacy to reduce the administrative burden for physicians under QPP. Your Reference Committee also heard testimony that the second resolve in Resolution 209 is similar to Resolution 222. Therefore, your Reference Committee recommends that a new resolution be adopted in lieu of Resolutions 206, 209, and 222.

(13) RESOLUTION 208 – HOUSING PROVISION AND SOCIAL SUPPORT TO IMMEDIATELY ALLEVIATE CHRONIC HOMELESSNESS IN THE UNITED STATES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 208 be amended by deletion to read as follows:

RESOLVED, That our AMA amend Policy H-160.903 by addition to read as follows:

H-160.903, Eradicating Homelessness

Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) will work with state medical societies to advocate for legislation implementing stable, affordable housing and appropriate voluntary social services as a first priority in the treatment of chronically-homeless individuals, without mandated therapy or services compliance; and (3) supports the appropriate organizations in developing an effective national plan to eradicate homelessness. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 208 be adopted as amended.

HOD ACTION: Resolution 208 referred.

Resolution 208 asks that our AMA amend Policy H-160.903 by addition to read as follows: H-160.903, Eradicating Homelessness Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) will work with state medical societies to advocate for legislation implementing stable, affordable housing and appropriate voluntary social services as a first priority in the treatment of chronically-homeless individuals, without mandated therapy or services compliance; and (3) supports the appropriate organizations in developing an effective national plan to eradicate homelessness. (Modify Current HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 208. Your Reference Committee heard testimony that directing our AMA to support legislation to implement stable, affordable housing for the homeless is consistent with existing policy that supports stable and affordable housing as an effective approach to eradicating homelessness. However, your Reference Committee agreed with testimony presented suggesting that housing should be a priority but not necessarily the first priority. Your Reference Committee therefore recommends adoption of Resolution 208 as amended.

- (14) RESOLUTION 211 – SALE OF HEALTH INSURANCE ACROSS STATE LINES
RESOLUTION 240 – MINIMUM FEDERAL STANDARDS FOR INTERSTATE SALE OF HEALTH INSURANCE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that adoption of the following resolution in lieu of Resolutions 211 and 240:

HOD ACTION: The following resolution adopted as amended by deletion in lieu of Resolutions 211 and 240:

SALE OF HEALTH INSURANCE ACROSS STATE LINES

RESOLVED, In examining proposals to sell health insurance across state lines, our AMA supports the following principles:

- (1) Federal or state legislation allowing the selling of health insurance across state lines, including multi-state compacts, should ensure that patient and provider protection laws are consistent with ~~National Association of Insurance Commissioners' standards~~ and enforceable under the laws of the state in which the patient resides. These protections include not weakening any state's laws or regulations involving: (a) network adequacy and transparency; (b) fair contracting and claims handling; (c) prompt pay for physicians; (d) regulation of unfair health insurance market products and activities; (e) rating and underwriting rules; (f) grievance and appeals procedures; and (g) fraud; and
(2) Patients purchasing an out-of-state policy should retain the right to bring a claim in a state court in the state in which the patient resides.

Resolution 211 asks that our American Medical Association oppose federal and state legislative proposals that would permit the sale of health insurance products in a state that does not comply with that state's law and regulations. (New HOD Policy)

Resolution 240 asks that our American Medical Association advocate for the establishment of minimum federal standards on the interstate sale of health insurance, consistent with existing AMA policy (New HOD Policy); and be it further, that our AMA advocate that minimum federal standards should not weaken any states' requirements on network adequacy, tort, financial protections, and other relevant insurance plan regulations. (New HOD Policy).

Your Reference Committee heard generally supportive testimony on the intent of Resolutions 211 and 240. Your Reference Committee heard testimony that our AMA should support federal or state legislation allowing the selling of health insurance across state lines only if it ensures that patient consumer protection laws and provider protection laws are consistent with National Association of Insurance Commissioners' standards. Your Reference Committee agrees with testimony that a substitute resolution is needed given the increased Congressional interest in exploring this topic and that having a clear statement would further demonstrates AMA's viewpoint to interested stakeholders. Your Reference Committee also agrees that it is important to stress that patients purchasing an out-of-state policy should retain the right to bring a claim in a state court in the state in which the patient resides. Therefore, your Reference Committee recommends adoption of a new resolution in lieu of Resolutions 211 and 240.

- (15) RESOLUTION 224 – MEDICARE PREPAYMENT AND RAC AUDIT REFORM

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy H-330.921 be amended by addition as follows:

Medicare Prepayment and Postpayment Audits H-330.921.

1. AMA policy is that with respect to prepayment and postpayment audits by the Medicare program, the following principles guide AMA advocacy efforts:

- (a) The confidential medical record should be preserved as an instrument of clinical care, with strong confidentiality protections and, we oppose its use as an accounting document;
- (b) CMS should discontinue random prepayment audits of E&M services;
- (c) In lieu of prepayment audits, CMS should use focused medical review of outliers based on reviews of patterns of services, using an independent medical peer review process, where physicians practicing in the same specialty, review their peers;
- (d) No financial or legal penalties should be assessed based on one level of disagreement in E&M code assignment; and
- (e) CMS must stop the practice of requiring physicians to repay alleged Medicare overpayments before an actual appeal is rejected or a final administrative decision or a court order is rendered. Legislative relief will be sought if advocacy with CMS is not successful in this regard.

2. Our AMA advocates that all government recovery programs contain complete physician access to any data mining criteria and programs, that there is same-specialty/same-subspecialty physician review prior to denial of claims, and that any denial of claims be based on medical necessity review as determined by that same-specialty/same-subspecialty physician reviewer, and will explore options for increased reimbursement of physician costs related to government audits, including remedies available through the Equal Access to Justice Act.

3. Our AMA supports the enactment of federal legislation or regulation that requires fairness in the practice of conducting physicians' post-payment audits as contained in paragraph 1 above, and which would include the following:

- (a) The requirement for such audits to be reviewed by a physician board certified within the same specialty prior to any requirement for repayment by the audited physician
- (b) The requirement for the repayment to be placed in escrow until the appeals process is complete
- (c) The removal of any incentives that are based upon a percentage of recovery for contracted government auditors
- (d) The establishment of a mechanism for recovery of a practice's legal fees incurred for unsuccessful audits
- (e) The full disclosure of contract terms with audit contractors
- (f) The elimination or improvement of the extrapolation formula
- (g) The payment for costly documentation requests
- (h) Imposition of penalties on auditors for inaccurate findings, and
- (i) Incentivizing the auditors to perform more physician education.

4. Our AMA formally request that Medicare employ rules for prepayment and postpayment audits that are at least as protective as the Recovery Audit Contractor (RAC) rules for physicians, and that our AMA continue to advocate for reforms to the audit process, including giving great weight to the treating physician's determination of medical necessity.

5. Our AMA propose to Medicare that there be a mechanism by which prepayment and postpayment audit denials can be resolved via the telephone or other electronic communications.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-330.921 be adopted as amended in lieu of Resolution 224.

HOD ACTION: Policy H-330.921 adopted as amended in lieu of Resolution 224.

Resolution 224 asks that our American Medical Association formally request that Medicare employ rules for prepayment audits that are at least as protective as the Random Audit Contractor (RAC) rules for physicians, and that our AMA continue to advocate for reforms to the audit process, including giving great weight to the treating physician's determination of medical necessity (Directive to Take Action); and be it further, that our AMA propose to Medicare that there be a mechanism by which prepayment audit denials can be resolved via the telephone or other electronic communications (Directive to Take Action); and be it further, that our AMA continue its current legislative and regulatory efforts to reform the Medicare RAC and Prepayment Audit process for physicians by eliminating or improving the extrapolation formula, requiring physician reviewers within the same subspecialty, providing payment for costly documentation requests, prohibiting recoupment of physician payment until the appeals process is final, imposing penalties on auditors for inaccurate findings, and incentivizing the auditors to perform more physician education. (Directive to Take Action)

Your Reference Committee heard limited but supportive testimony on Resolution 224. Your Reference Committee agrees that Medicare pre- and post-payment reviews are deeply flawed and have negatively impacted individual physician practices. Our AMA is well-positioned to provide information on lessons learned and shared strategies for addressing these reviews and providing regulatory relief to physicians. Your Reference Committee heard testimony that existing policy can be amended by incorporating the resolves of Resolution 224 into already existing policy and by expanding the resolution to include all post-payment reviews. For these reasons, your Reference Committee recommends that AMA Policy H-330.921 be amended and adopted in lieu of Resolution 224.

(16) RESOLUTION 227 – IMPROVING CLINICAL UTILITY OF MEDICAL DOCUMENTATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 227 be amended by addition to read as follows:

That our American Medical Association advocate for implementation of the 21st Century Cures provision to ensure appropriate, effective, and less burdensome documentation requirements in the use of electronic health records. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 227 be adopted as amended.

HOD ACTION: Resolution 227 adopted as amended.

Resolution 227 asks that our American Medical Association advocate for appropriate, effective, and less burdensome requirements in the use of electronic health records. (Directive to Take Action)

Your Reference Committee heard limited but favorable testimony in support of Resolution 227, with strong comments about the excessive documentation burdens associated with EHRs. Testimony highlighted that our AMA has worked to address this issue by securing a provision in the 21st Century Cures Act that seeks to reduce EHR documentation requirements on physicians. Your Reference Committee notes that our AMA is actively working to implement this new law. Therefore, your Reference Committee recommends that Resolution 227 be amended to include reference to these ongoing advocacy efforts and tailor the request to addressing documentation requirements.

(17) RESOLUTION 228 – FREE SPEECH APPLIES TO SCIENTIFIC KNOWLEDGE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 228 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~work with members of the U.S. Congress and the Trump Administration to assure~~ advocate that scientific knowledge, data, and research will continue to be protected and freely disseminated in accordance with the U.S. First Amendment (Directive to Take Action); ~~and be it further~~

~~RESOLVED, That our AMA oppose any federal policies, orders, laws, or directives that alter or prevent the free dissemination of scientific and technological information and research that is by right and law the property of the American people and support legal proceedings in opposition to violations of scientific integrity policies.~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 228 be adopted as amended.

HOD ACTION: Resolution 228 adopted as amended.

Resolution 228 asks that our American Medical Association work with members of the U.S. Congress and the Trump Administration to assure that scientific knowledge, data, and research will continue to be protected and freely disseminated in accordance with the U.S. First Amendment (Directive to Take Action); and be it further, that our AMA oppose any federal policies, orders, laws, or directives that alter or prevent the free dissemination of scientific and technological information and research that is by right and law the property of the American people and support legal proceedings in opposition to violations of scientific integrity policies. (New HOD Policy)

Your Reference Committee heard conflicting testimony on Resolution 228. Testimony was presented that supports the underlying issues raised by Resolution 228, including the importance of protecting scientific integrity and the dissemination of scientific knowledge. Testimony was also presented that these are important issues but that the resolves are too broad, such as calling on our AMA to support legal proceedings in opposition to violations of scientific integrity policies. Your Reference Committee agrees that the underlying issues raised by Resolution 228, such as protecting scientific integrity and the dissemination of scientific knowledge, are important and that protecting them is consistent with existing AMA policy; however, your Reference Committee agrees with testimony that the language of the second resolve is too broad. Your Reference Committee also heard testimony that the reference to a specific administration within Resolution 228 should be eliminated. Accordingly, your Reference Committee recommends that Resolution 228 be amended by addition and deletion.

(18) RESOLUTION 229 – MEDICARE'S APPROPRIATE USE CRITERIA PROGRAM

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 229 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA continue to advocate to delay the effective date of the Medicare AUC Program until the Centers for Medicare & Medicaid (CMS) can adequately addresses technical and workflow challenges with its implementation and any interaction between ~~can adequately assess how the~~

Quality Payment Program ~~and affects~~ the use of advanced diagnostic imaging appropriate use criteria.

~~RESOLVED, That our AMA call upon Congress and the Administration to revisit the necessity and value of the Medicare AUC Program given the establishment of the Quality Payment Program~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 229 be adopted as amended.

HOD ACTION: Resolution 229 adopted as amended.

Resolution 229 asks that our American Medical Association advocate to delay the effective date of the Medicare AUC Program until the Centers for Medicare & Medicaid can adequately assess how the Quality Payment Program affects the use of advanced diagnostic imaging (Directive to Take Action); and be it further, that our AMA call upon Congress and the Administration to revisit the necessity and value of the Medicare AUC Program given the establishment of the Quality Payment Program. (Directive to Take Action)

Your Reference Committee heard an abundance of testimony on Resolution 229. Generally, the testimony supported the concept of appropriate use criteria but urged for further delay of the program. Your Reference Committee agrees with the general tenor of the testimony and believes that our AMA will continue to advocate for a delay of the Appropriate Use Criteria program to resolve technical and workflow challenges. Specifically, the program needs to address integration of criteria into Electronic Health Records and increase interoperability between ordering and referring providers. Furthermore, your Reference Committee heard testimony that all physicians will have difficulty incorporating AUC at the same time they are grappling with the Quality Payment Program. Your Reference Committee does, however, agree with testimony that seeking a congressional approach is not appropriate at this time and instead that continued advocacy with CMS would be more effective. Accordingly, your Reference Committee agrees with an amendment offered by the Council on Legislation that would delete the second Resolve and amend the first Resolve to reflect specific challenges with current implementation. Therefore, your Reference Committee recommends that Resolution 229 be adopted with amendments.

(19) RESOLUTION 231 – NALOXONE PRICE INCREASE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy H-95.932 be amended by addition and deletion to read as follows:

Our AMA supports legislative, ~~and~~ regulatory, and national advocacy efforts ~~that~~ to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community based organization, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-95.932 be adopted as amended in lieu of Resolution 231.

HOD ACTION: Resolution 231 adopted. Policy H-95.932 amended.

Resolution 231 asks that our American Medical Association amend existing AMA Policy, H-95.932, “Increasing Availability of Naloxone,” by addition and deletion as follows: 1. Our AMA supports legislative, and regulatory, and national advocacy efforts that to increase access to affordable naloxone, including but not limited to

collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery. (Modify Current HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 231. Your Reference Committee heard testimony that some manufacturers of naloxone have dramatically increased their list prices, which has led to reports of reduced access by community-based organizations, first responders, public health agencies, and others. Your Reference Committee also heard that a multi-pronged approach is needed including transparency, right sizing pricing, and increased competition to address sky rocketing prices in various segments of the pharmaceutical market. Therefore, your Reference Committee recommends AMA Policy H-95.932 be adopted as amended in lieu of Resolution 231.

(20) RESOLUTION 238 – LIMITATION ON REPORTS TO THE NATIONAL PRACTITIONER DATA BANK UNRELATED TO PATIENT CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 238 be amended by addition and deletion to read as follows:

RESOLVED that our AMA ~~formally~~ request that the Health Resources and Services Administration (HRSA) clarify that reports of medical staff appointment denial ~~by of physicians~~ be (1) contingent upon competency or conduct issues related to the physicians' provision of or failure to provide healthcare services that adversely affect the health or welfare of a result in patient, harm and (2) only based on a professional review action and not for administrative or eligibility reasons; and be it further

RESOLVED that our AMA advocate that ~~formally petition the Secretary of HHS to direct the HRSA to~~ remove the name of any physician from the NPDB reported for reasons not related to competence or conduct ~~patient care that~~ adversely affected the health or welfare of a resulted in patient harm. (Directive to Take Action).

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 238 be adopted as amended.

HOD ACTION: Resolution 238 adopted as amended.

Resolution 238 asks that our American Medical Association formally request that the Health Resources and Services Administration (HRSA) clarify that reports of medical staff appointment denial by physicians are contingent upon competency issues related to physicians' provision of or failure to provide healthcare services that result in patient harm (Directive to Take Action); and be it further, that our AMA formally petition the Secretary of HHS to direct the HRSA to remove the name of any physician from the National Practitioner Data Bank reported for reasons not related to patient care that resulted in patient harm. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 238. Your Reference Committee has serious concerns about the value of the data gathered by the NPDP in assessing a practitioner's competence. Your Reference Committee also received amendments intended to help clarify what type of actions should be reported to the NPDB. Therefore, Your Reference Committee recommends adoption of Resolution 238 with amendments.

- (21) RESOLUTION 212 – ADVOCACY FOR SEAMLESS INTERFACE BETWEEN PHYSICIAN ELECTRONIC HEALTH RECORDS, PHARMACIES AND PRESCRIPTION DRUG MONITORING PROGRAMS TO BE CREATED AND FINANCED BY THE COMMERCIAL EHR AND DISPENSING PROGRAM PROVIDERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 212 be referred.

HOD ACTION: Resolution 212 referred.

Resolution 218 asks that our American Medical Association join the American College of Legal Medicine to advocate federally-mandated interfaces between provider/dispenser electronic health record systems in the clinical, hospital and pharmacy environments and state prescription drug databases and/or prescription drug management plans (Directive to Take Action); and be it further, that our AMA advocate that the cost of generating these interfaces be borne by the commercial EHR and dispensing program providers (Directive to Take Action); and be it further, that our AMA advocate that the interface should include automatic query of any opioid prescription, from a provider against the state prescription drug database/prescription drug management plan (PDMP) to determine whether such a patient has received such a medication, or another Schedule II drug from any provider in the preceding ninety (90) days (Directive to Take Action); and be it further, that our AMA advocate that the prescriber and the patient's EHR-listed dispensing pharmacy should then be notified of the existence of the referenced patient in the relevant PDMP database, the substance of the previous prescription(s) (including the medication name, number dispensed and prescriber's directions for use) in real time and prior to the patient receiving such medication (Directive to Take Action); and be it further, that our AMA advocate that the electronic record management program at the pharmacy filling the relevant prescription, contemporaneously as it enters the filling of the prescription by the pharmacist, likewise be required to automatically query the state PDMP as a secondary mechanism to prevent inappropriate prescribing, forgery, duplication and/or too great a frequency of use of the involved controlled medication (Directive to Take Action); and be it further, that our AMA work with ACLM and other concerned societies to urge Congress to timely enact and implement such a statutory scheme supported by a workable and concise regulatory framework, chiefly concentrating on the interfacing of all applicable electronic health record and pharmaceutical dispensing systems with every individual state's PDMP, thereafter designating a timeframe wherein all treating providers and dispensing pharmacists would be required to perform such queries, in concert with the routine ordering of and filling of a controlled substance to be used in the treatment of patients (Directive to Take Action); and be it further, that our AMA advocate that oversight of the appropriate prescribing of and filling of prescriptions for controlled substances remain with the involved individual federal and state criminal law enforcement agencies, the involved state departments of health, or similar entities and the involved relevant state provider and/or pharmacy licensure authorities (Directive to Take Action); and be it further, that our AMA advocate that statistics be maintained and reviewed on a periodic basis by state PDMP personnel and relayed to state departments of health or agencies similarly situated so as to identify and possibly treat those patients identified through this screening mechanism as potential drug abusers and/or at risk of addiction. (Directive to Take Action).

Your Reference Committee acknowledges the work of our AMA on ensuring accurate, reliable Prescription Drug Monitoring Programs (PDMPs) that support physicians and their patients. Your Reference Committee appreciates the intent of Resolution 212; however, at the same time, must acknowledge the overwhelming testimony concerned with the language of the resolution, the complexity of the issues it addressed, and the challenges that exist to obtaining what Resolution 212 asks for. In addition, your Reference Committee heard testimony that the resolution raised questions of a federal scheme for PDMP policy, and creating new technology standards that are either in opposition to our AMA policy or already happening within PDMP development. Due to the complexities and uncertainty raised in testimony, your Reference Committee recommends that Resolution 212 be referred.

(22) RESOLUTION 218 – LICENSING OF ELECTRONIC HEALTH RECORDS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 218 be referred.

HOD ACTION: Resolution 218 referred.

Resolution 218 asks that our American Medical Association develop model legislation for licensing electronic health records with a focus on ensuring system interoperability. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 218. Testimony supporting the resolution expressed frustration with a lack of interoperability of EHRs and stressed the need to improve interoperability by establishing standards for EHRs. However, testimony against the resolution warned that state requirements may have the impact of hindering interoperability efforts. Commenters stated that EHRs are certified through a process in which the vendor must meet specific federal criteria in order to be used in the Meaningful Use program and expressed concern that state level criteria could hinder interoperability by creating different standards among the states. Our current AMA efforts are focused on harmonizing standards, as competing standards are a major roadblock to interoperability. And in addition to fracturing of EHR design requirements, state licensing could result in EHR vendors passing additional costs on to physicians. Your Reference Committee that this is a complex issue that warrants further study, and therefore recommends referral.

(23) RESOLUTION 219 – INTEGRATION OF DRUG PRICE INFORMATION INTO ELECTRONIC MEDICAL RECORDS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 219 be referred.

HOD ACTION: Resolution 219 referred.

Resolution 219 asks that American Medical Association support the incorporation of estimated patient out of pocket drug costs into electronic medical records in order to help reduce patient cost burden (New HOD Policy); and be it further, that our AMA collaborate with invested stakeholders, such as physician groups, 9 Electronic Medical Records (EMR) vendors, hospitals, insurers, and governing bodies to integrate estimated out of pocket drug costs into electronic medical records in order to help reduce patient cost burden. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 219. Testimony noted that existing AMA policy recently adopted by our House of Delegates already covers the goals of Resolution 219. Specifically, our House of Delegates adopted new AMA policy on price transparency during the 2015 Annual Meeting that is almost identical to the resolves outlined in Resolution 219. While testimony in opposition to Resolution 219 questioned the feasibility of incorporating accurate information on out-of-pocket drug costs into electronic medical records (EMRs), testimony in support of Resolution 219 stated that real-time benefit checks are already being incorporated into some EMRs. Your Reference Committee believes that this issue would benefit from further study into feasibility and current practices, as well as potential implications on physician practice. Therefore, your Reference Committee recommends that Resolution 219 be referred.

(24) RESOLUTION 230 – CMS REIMBURSEMENT GUIDELINES FOR TEACHING PHYSICIAN SUPERVISION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 230 be referred.

HOD ACTION: Resolution 230 referred.

Resolution 230 asks that our American Medical Association recommend that the Centers for Medicare and Medicaid Services change its policy to allow reimbursement for minor procedures performed by residents as long as the supervising physician is present for the key portions of the minor procedure. (Directive to Take Action).

Your Reference Committee heard mixed testimony on Resolution 230. Supportive testimony noted that the resolution appropriately asks for payment of a service, supervised by a physician, be it a major or a minor procedure, as long as there was supervision. Other testimony discussed the possible danger of having minor procedures based solely on time, with no evaluation of the intensity involved in the procedure. Your Reference Committee also heard testimony on possible ambiguity around the definition of a minor procedure. Due to the complexities and uncertainty raised in testimony, your Reference Committee recommends that Resolution 230 be referred.

(25) RESOLUTION 237 – PROTECTION OF CLINICIAN-PATIENT PRIVILEGE**RECOMMENDATION:**

Madam Speaker, your Reference Committee recommends that Resolution 237 be referred.

HOD ACTION: Resolution 237 referred.

Resolution 237 asks that our American Medical Association advocate to the relevant national bodies for the clinician-patient privilege to be regulated according to the privacy protections in the Health Insurance Portability and Accountability Act of 1996 without regard to where care is received. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 237. Testimony addressed the need for protection of privacy regardless of where the patient seeks care. The Reference Committee also heard testimony that our AMA has not previously looked into the intersection between HIPAA and the Family Education Rights and Privacy Act as it relates to student records. Your Reference Committee heard testimony that our AMA should first engage with relevant stakeholders to better understand the issue and potential policy implications before creating more robust privacy protections for such health information. Therefore, your Reference Committee recommends that Resolution 237 be referred.

(26) RESOLUTION 213 – COPYING AND/OR SCANNING COSTS**RECOMMENDATION:**

Madam Speaker, your Reference Committee recommends that Resolution 213 be not adopted.

HOD ACTION: Resolution 213 not adopted.

Resolution 213 asks that our American Medical Association seek changes to the federal HIPAA regulations so that charges related to providing patient records defer to state law when charges to be imposed for searching, retrieval and other matters are determined. (Directive to Take Action)

Your Reference Committee heard mixed testimony with respect to Resolution 213. Those in favor of the resolution noted the significant expense that could be incurred when trying to search and retrieve medical information and highlighted that state law, if not for the Health Insurance Portability and Accountability Act requirements, would permit physicians to recover some of these expenses. Those opposed to the resolution voiced concerns about creating the impression that our AMA was not supportive of patient access to their information. In addition, others noted that the U.S. Department of Health and Human Services and Congress are strongly supportive of access to medical records and efforts to change the cost requirements could backfire, forcing physicians to bear the entire cost of providing this information. Given these concerns and an environment that heavily favors patient access, your Reference Committee recommends that Resolution 213 not be adopted.

(27) RESOLUTION 214 – MEDICAL LIABILITY COVERAGE THROUGH THE FEDERAL TORT CLAIMS ACT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 214 not be adopted.

HOD ACTION: Resolution 214 referred.

Resolution 214 asks that our American Medical Association seek legislation that would lead to malpractice insurance coverage through the Federal Tort Claims Act for all physicians who participate in Medicare and/or Medicaid and all federal insurance plans. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 214. Testimony in favor of adoption stated that physicians are being required to follow government standards and therefore should be immune from liability under the FTCA. Testimony against adoption of Resolution 214 was presented that there is no evidence that a universal application of the FTCA would reduce the filing of meritless claims and would go against strong AMA policy against supporting federal preemptive legislation that would undermine effective state tort reform efforts. Your Reference Committee also heard testimony on the possible unintended consequences of adoption of Resolution 214. Accordingly, your Reference Committee recommends that Resolution 214 not be adopted.

(28) RESOLUTION 205 – LIMITING MEDICARE PART D ENROLEE COSTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-110.990 be reaffirmed in lieu of Resolution 205.

HOD ACTION: Policy H-110.990 reaffirmed in lieu of Resolution 205.

Resolution 205 asks that our American Medical Association advocate for a Medicare Part D limiting charge for prescription medications (Directive to Take Action); and that our AMA advocate for a Medicare Part D annual out-of-pocket limit. (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 205. Your Reference Committee heard testimony that Resolution 205 ultimately seeks to address the high costs of prescription drugs, which is better addressed through AMA advocacy that advances transparency, right-sizing drug pricing strategies, and combatting anti-competitive behaviors of drug manufactures as laid out in existing AMA policy. Therefore, your Reference Committee recommends that Policy H-110.990 be reaffirmed in lieu of Resolution 205.

Cost Sharing Arrangements for Prescription Drugs H-110.990

Our AMA:

1. believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients;
2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes; and
3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and out-of-pocket costs of individual prescription drugs prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition.

(29) RESOLUTION 207 – SKY ROCKETING DRUG PRICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-110.986, H-110.987, H-110.988, H-110.990, H-110.991, and H-110.997 be reaffirmed in lieu of Resolution 207.

HOD ACTION: Policies H-110.986, H-110.987, H-110.988, H-110.990, H-110.991, and H-110.997 reaffirmed in lieu of Resolution 207.

Resolution 207 asks that our American Medical Association strongly advocate for policies, regulations and legislation that protect patients from sky rocketing exorbitant prices for previously affordable drugs (Directive to Take Action); and be it further, that our AMA advocate for an “out of pocket” maximum dollar amount for total drug costs for our patients not to exceed \$500 per month. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 207. Testimony was heard of our AMA efforts to combat price spikes in previously affordable generic drugs and to reduce the burden of escalating drug prices on our patients. Testimony also noted that our AMA has dedicated a decade to this effort including advancing support to combat anti-competitive pay-for-delay settlement agreements between brand drug companies and generic manufacturers. This includes supporting the development of an approval pathway for biosimilars to interject much needed competition to combat the high cost of biologicals. Our AMA has met with the new Administration to highlight the priorities to advance right-sizing pricing, increased transparency, and addressing industry actions that reduce competition in the drug market. Our AMA has advocated for policies during the congressional negotiations over the U.S. Food and Drug Administration (FDA) user fee reauthorization that would ensure a meaningful pathway for priority review would be available when there was a lack of competition. Your Reference Committee concludes that the first resolve of Resolution 207 is already being addressed based on existing AMA policy. Furthermore, regarding the resolution’s second resolve, your Reference Committee agrees with testimony that it is in direct contravention of long-standing AMA policies related to cost-sharing which, per existing AMA policy, should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes (emphasis added). Moreover, your Reference Committee agrees that the second resolve could have a destabilizing effect on the private insurance market, and be unsustainable to the Medicare Trust Fund, or could require a level of national price controls that likely would negatively impact innovation. Therefore, your Reference Committee recommends that Policies H-110.986, H-110.987, H-110.988, H-110.990, H-110.991, and H-110.997 be reaffirmed in lieu of Resolution 207.

H-110.986 Incorporating Value into Pharmaceutical Pricing

(1) Our AMA supports value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by the following principles: (a) value-based prices of pharmaceuticals should be determined by objective, independent entities; (b) value-based prices of pharmaceuticals should be evidence-based and be the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes; (c) processes to determine value-based prices of pharmaceuticals must be transparent, easily accessible to physicians and patients, and provide practicing physicians and researchers a central and significant role; (d) processes to determine value-based prices of pharmaceuticals should limit administrative burdens on physicians and patients; (e) processes to determine value-based prices of pharmaceuticals should incorporate affordability criteria to help assure patient affordability as well as limit system-wide budgetary impact; and (f) value-based pricing of pharmaceuticals should allow for patient variation and physician discretion. (2) Our AMA supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research. (3) Our AMA supports direct purchasing of pharmaceuticals used to treat or cure diseases that pose unique public health threats, including hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size. CMS Rep. 05, I-16

H-110.987 Pharmaceutical Cost

(1) Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives. (2) Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition. (3) Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry. (4) Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system. (5) Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies. (6) Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation. (7) Our AMA supports legislation to shorten the exclusivity period for biologics. (8) Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens. (9) Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients, and will report back to the House of Delegates regarding the progress of the drug pricing advocacy campaign at the 2016 Interim Meeting. CMS Rep. 2, I-15 Reaffirmed in lieu of: Res. 817, I-16

H-110.988 Controlling the Skyrocketing Costs of Generic Prescription Drugs

(1) Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs. (2) Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients. (3) Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs. (4) Our AMA supports measures that increase price transparency for generic prescription drugs. Sub. Res. 106, A-15 Reaffirmed: CMS 2, I-15 Reaffirmed in lieu of: Res. 817, I-16

H-110.990 Cost Sharing Arrangements for Prescription Drugs

Our AMA: (1) believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients; (2) believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes; and (3) supports the development and use of tools and technology that enable physicians and patients to determine the actual price and out-of-pocket costs of individual prescription drugs prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition. CMS Rep. 1, I-07 Reaffirmation A-08 Reaffirmed: CMS Rep. 1, I-12 Reaffirmed in lieu of Res. 105, A-13

H-110.991 Price of Medicine

Our AMA (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications, and (2) will pursue legislation requiring pharmacies to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication. CMS Rep. 6, A-03 Appended: Res. 107, A-07

H-110.997 Cost of Prescription Drugs

Our AMA (1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing

practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs; (2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices; (3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products; (4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies; (5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies; (6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and (7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients. BOT Rep. O, A-90 Sub. Res. 126 and Sub. Res. 503, A-95 Reaffirmed: Res. 502, A-98 Reaffirmed: Res. 520, A-99 Reaffirmed: CMS Rep. 9, I-99 Reaffirmed: CMS Rep.3, I-00 Reaffirmed: Res. 707, I-02 Reaffirmation A-04 Reaffirmed: CMS Rep. 3, I-04 Reaffirmation A-06 Reaffirmed in lieu of Res. 814, I-09 Reaffirmed in lieu of Res. 201, I-11

(30) RESOLUTION 215 – REVISITING EXEMPTIONS FOR REPORTING PEER-REVIEWED JOURNAL ARTICLES AND MEDICAL TEXTBOOKS PER THE SUNSHINE ACT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy D-140.958 be reaffirmed in lieu of Resolution 215.

HOD ACTION: Policy D-140.958 reaffirmed in lieu of Resolution 215.

Resolution 215 asks that our American Medical Association work again, first, with the Centers for Medicare and Medicaid Services (CMS) to administratively expand the Sunshine Act exception (that covers "...educational materials that directly benefit patients or are intended for patient use") to include peer-reviewed journal articles and medical textbooks when provided to physicians (Directive to Take Action); and be it further, that if no redress is obtained from CMS, that our AMA work again, with the Congress to, once and for all, legislatively expand the exception in ACA section 1128G(e)(10)(B)(iii) to include peer-reviewed journal articles and medical textbooks when provided to physicians. (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 215. Your Reference Committee heard testimony that reprints and textbooks are education materials that directly benefit patients and should be excluded from reporting under the Sunshine Act. Your Reference Committee supports efforts to obtain relief from CMS to revise this regulation or seek congressional action, if necessary. Your Reference Committee agrees with the author that current AMA policy incorporates much of Resolution 215, and that the impetus behind the resolution is to encourage continued AMA activity on this issue. Given the language of existing policy and the recognition that our AMA will continue to engage on this issue, your Reference Committee recommends that Policy D-140.958 be reaffirmed in lieu of Resolution 215.

D-140.958 Medical Textbooks and Peer-Reviewed Journal Reprints per the Sunshine Act

Our AMA will work, first, with the Centers for Medicare & Medicaid Services (CMS) to administratively expand the Sunshine Act exception that covers "...educational materials that directly benefit patients or are intended for patient use" to include medical textbooks and peer-reviewed journal articles provided to physicians; {given that such resources are, in fact, "continuing educational materials" that assist physicians to become better informed about their clinical decision-making and thus "...directly benefit patients..."}; and if no redress is obtained from CMS, our AMA will work with the Congress to legislatively expand the

exception in ACA section 1128G(e)(10)(B)(iii) to include medical textbooks and peer-reviewed journal articles provided to physicians.

(31) RESOLUTION 216 – ELECTRONICALLY PRESCRIBE CONTROLLED SUBSTANCES WITHOUT ADDED PROCESSES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies D-120.956, D-120.958, H-478.991 and H-120.957 be reaffirmed in lieu of Resolution 216.

HOD ACTION: Resolution 216 referred with report back at I-17.

Resolution 216 asks that our American Medical Association advocate for full electronic prescribing of all prescriptions, without additional cumbersome electronic verification, including Schedule 2-5 controlled substances, eliminating the need for “wet signed” paper prescriptions and faxes for specific classes of prescriptions. (New HOD Policy)

Your Reference Committee heard testimony strongly supportive of the intent of Resolution 216. Our AMA supports electronic prescribing of controlled substances as part of the solution to reversing the nation’s opioid epidemic. Your Reference Committee notes that current Drug Enforcement Administration requirements for biometric devices limit user-friendly consumer electronics already found in physicians’ offices, such as fingerprint readers on laptop computers and mobile phones from being used for two-factor authentication in Electronically Prescribed Controlled Substances (EPCS). Your Reference Committee acknowledges the frustration heard in testimony regarding how two-factor authentication and other rules contribute to cumbersome workflows and applications and notes that EPCS uptake is slow precisely due to these barriers. Your Reference Committee also heard testimony that our AMA continues to have discussions with key stakeholders to work toward improving the integration of EPCS and the interoperability of Prescription Drug Monitoring Programs and electronic health records into practice workflows and clinical decision-making. It is important to acknowledge that our AMA has made and continues to make these points at both the federal and state levels. As such, your Reference Committee recommends that Policies D-120.956, D-120.958, H-478.991, and H-120.957 be reaffirmed in lieu of Resolution 216.

D-120.956 Electronic Prescribing and Conflicting Federal Guidelines

Our American Medical Association will address with the Centers for Medicare & Medicaid Services and the Drug Enforcement Administration the contradictory guidance, issued respectively by those two federal agencies, relating to electronic transmission of physicians’ prescriptions to pharmacies--commonly referred to as “e-prescribing”--for Schedules III, IV and V drugs, as those current guidelines add rather than reduce administrative paperwork and defeat the purpose of electronic handling of prescriptions.

D-120.958 Federal Roadblocks to E-Prescribing

(1) Our AMA will initiate discussions with the Centers for Medicare and Medicaid Services and state Medicaid directors to remove barriers to electronic prescribing including removal of the Medicaid requirement that physicians write, in their own hand, “brand medically necessary” on a paper prescription form. (2) Our AMA will initiate discussions with the Drug Enforcement Administration to allow electronic prescribing of Schedule II prescription drugs. (3) It is AMA policy that physician Medicare or Medicaid payments not be reduced for non-adoption of E-prescribing. (4) Our AMA will work with federal and private entities to ensure universal acceptance by pharmacies of electronically transmitted prescriptions. (5) Our AMA will advocate for appropriate financial and other incentives to physicians to facilitate electronic prescribing adoption. (6) Our AMA will: (A) investigate regulatory barriers to electronic prescription of controlled substances so that physicians may successfully submit electronic prescriptions for controlled substances; and (B) work with the Centers for Medicare & Medicaid Services to eliminate from any program (e.g., the Physician Quality Reporting System, meaningful use, and e-Prescribing) the requirement to electronically prescribe controlled substances, until such time that the necessary protocols are in place for electronic prescribing software vendors and pharmacy systems to comply. (7) Our AMA will work with representatives of pharmacies, pharmacy benefits managers, and software vendors to expand the ability to electronically prescribe all medications. (8) Our AMA will petition the Centers for Medicare

& Medicaid Services and the federal government to have all pharmacies, including government pharmacies, accept e-prescriptions or to temporarily halt the e-prescribing requirements of meaningful use until this is accomplished.

H-478.991 Federal EMR and Electronic Prescribing Incentive Program

Our AMA: (1) will 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; (2) supports the concept of electronic prescribing, as well as the offering of financial and other incentives for its adoption, but strongly discourages a funding structure that financially penalizes physicians that have not adopted such technology; and (3) will work with the Centers for Medicaid & Medicare Services and the Department of Defense to oppose programs that unfairly penalize or create disincentives, including e-prescribing limitations for physicians who provide care to military patients, and replace them with meaningful percentage requirements of e-prescriptions or exemptions of military patients in the percentages, where paper prescriptions are required.

H-120.957 Prescription of Schedule II Medications by Fax and Electronic Data Transmission

Our AMA: (1) encourages the Drug Enforcement Administration to rewrite Section 1306 of Title 21 of the Code of Federal Regulations to accommodate encrypted electronic prescriptions for Schedule II controlled substances, as long as sufficient security measures are in place to ensure the confidentiality and integrity of the information. (2) Our AMA supports the concept that public key infrastructure (PKI) systems or other signature technologies designed to accommodate electronic prescriptions should be readily adaptable to current computer systems, and should satisfy the criteria of privacy and confidentiality, authentication, incorruptibility, and nonrepudiation. (3) Because sufficient concerns exist about privacy and confidentiality, authenticity, and other security measures, the AMA does not support the use of "hard copy" facsimile transmissions as the original written prescription for Schedule II controlled substances, except as currently allowed in Section 1306 of Title 21 of the Code of Federal Regulations.

(32) RESOLUTION 217 – INAPPROPRIATE REQUESTS FOR DEA NUMBERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-100.972 and H-100.982 be reaffirmed in lieu of Resolution 217.

HOD ACTION: Policies H-100.972 and H-100.982 reaffirmed in lieu of Resolution 217.

Resolution 217 asks that our American Medical Association create a national registry or database where physicians can report inappropriate uses or requests for their DEA numbers (Directive to Take Action); and be it further, That our AMA educate or seek penalties for those entities requesting or requiring use of DEA numbers outside of the prescribing of controlled substances (Directive to Take Action); and be it further, that our AMA encourage the federal government to monitor and shut down any electronic means, including websites, that collect and distribute providers' DEA numbers, which would serve to protect the public and minimize the "hassle factor" for physicians. (New HOD Policy)

Your Reference Committee heard overwhelming testimony supporting the notion that the DEA should refrain from divulging a physician's DEA number unless there is a valid reason for doing so. Testimony also supported insurance companies and pharmaceutical companies using a physician's state medical license number to identify a physician in the computer files instead of the DEA number when controlled substances are not involved. Furthermore, testimony was clear that our AMA is opposed to DEA using the registration number for any purpose other than for verification to the dispenser that the prescriber is authorized by federal law to prescribe controlled substances. In addition, testimony highlighted that our AMA also developed model state legislation on this issue in 2012 that would address the concerns raised by Resolution 217, but it was not clear whether states have availed themselves of this model state legislation. Your Reference Committee, therefore, not only recommends that states consider the model AMA state legislation, but also that existing policies, H-100.972 and H-100.982, be reaffirmed in lieu of Resolution 217.

H-100.972 Misuse of the DEA License Number

Our AMA: (1) affirms its opposition to use of the Drug Enforcement Administration (DEA) license number for any purpose other than for verification to the dispenser that the prescriber is authorized by federal law to prescribe the substance; and will explore measures to discourage or eliminate the use of physicians' DEA license numbers as numerical identifiers in insurance processing and other data bases, either through legislation, regulation or accommodation with organizations which currently insist on collection of this sensitive data; (2) seeks to have its proposed legislation introduced, which would limit the use of DEA numbers to those federal and state entities that use the number to oversee and enforce the law regarding the manufacture, distribution, and dispensing of controlled substances; and (3) continues to advocate for the adoption of the AMA's Medical Education number as the unique identifier for physicians.

H-100.982 Confidentiality of Drug Enforcement Agency Numbers

Our AMA (1) believes that the Drug Enforcement Agency should refrain from divulging a physician's DEA number unless there is a valid reason for doing so; (2) believes that insurance companies and pharmaceutical companies should use a physician's state medical license number to identify a physician in the computer files instead of the DEA number when controlled substances are not involved; (3) will develop model legislation to restrict the use of the DEA number for monitoring the prescribing of controlled substances only; and (4) supports legislation or regulations to prevent insurance companies and other entities from using DEA registration numbers for identification of physicians.

(33) RESOLUTION 223 – TAX DEDUCTIONS FOR DIRECT-TO-CONSUMER ADVERTISING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-105.988 be reaffirmed in lieu of Resolution 223.

HOD ACTION: Policy H-105.988 reaffirmed in lieu of Resolution 223.

Resolution 223 asks that our American Medical Association support legislation to prohibit costs for direct-to-consumer advertising of prescription medications, medical devices, and controlled drugs to be considered deductible business expenses for tax purposes. (New HOD Policy)

Your Reference Committee heard generally supportive testimony on Resolution 223. Your Reference Committee heard that our AMA has long-standing policy opposing direct to consumer advertising for prescription drugs and implantable devices. Specifically, your Reference Committee notes that AMA policy, H-105.988(11), Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices, provides that our AMA supports eliminating the costs for DTCA of prescription drugs as a deductible business expense for tax purposes. Your Reference Committee also heard testimony that expanding this policy to include medical devices, which would go beyond implantable devices as referenced in current AMA policy, would substantially expand the scope of products covered and could include those that may or may not require a prescription. Testimony noted that there is little evidence suggesting that DTCA of medical devices more broadly create the same difficulties in patient care and patient-physician interactions as DTCA for prescription drugs. While your Reference Committee strongly agrees that DTCA undermines the quality of patient-physician interactions and this also drives costs for prescription drugs, your Reference Committee does not believe expanding this provision to all medical devices is warranted at this time. Your Reference Committee therefore recommends that H-105.988 be reaffirmed in lieu of Resolution 223.

H-105.988 Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices

1. To support a ban on direct-to-consumer advertising for prescription drugs and implantable medical devices.

2. That until such a ban is in place, our AMA opposes product-claim DTCA that does not satisfy the following guidelines:

(a) The advertisement should be indication-specific and enhance consumer education about the drug or implantable medical device, and the disease, disorder, or condition for which the drug or device is used.

(b) In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and

responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug's or device's approval for marketing.

(c) The advertisement should clearly indicate that the product is a prescription drug or implantable medical device to distinguish such advertising from other advertising for non-prescription products.

(d) The advertisement should not encourage self-diagnosis and self-treatment, but should refer patients to their physicians for more information. A statement, such as "Your physician may recommend other appropriate treatments," is recommended.

(e) The advertisement should exhibit fair balance between benefit and risk information when discussing the use of the drug or implantable medical device product for the disease, disorder, or condition. The amount of time or space devoted to benefit and risk information, as well as its cognitive accessibility, should be comparable.

(f) The advertisement should present information about warnings, precautions, and potential adverse reactions associated with the drug or implantable medical device product in a manner (e.g., at a reading grade level) such that it will be understood by a majority of consumers, without distraction of content, and will help facilitate communication between physician and patient.

(g) The advertisement should not make comparative claims for the product versus other prescription drug or implantable medical device products; however, the advertisement should include information about the availability of alternative non-drug or non-operative management options such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition.

(h) In general, product-claim DTCA should not use an actor to portray a health care professional who promotes the drug or implantable medical device product, because this portrayal may be misleading and deceptive. If actors portray health care professionals in DTCA, a disclaimer should be prominently displayed.

(i) The use of actual health care professionals, either practicing or retired, in DTCA to endorse a specific drug or implantable medical device product is discouraged but if utilized, the advertisement must include a clearly visible disclaimer that the health care professional is compensated for the endorsement.

(j) The advertisement should be targeted for placement in print, broadcast, or other electronic media so as to avoid audiences that are not age appropriate for the messages involved.

(k) In addition to the above, the advertisement must comply with all other applicable Food and Drug Administration (FDA) regulations, policies and guidelines.

3. That the FDA review and pre-approve all DTCA for prescription drugs or implantable medical device products before pharmaceutical and medical device manufacturers (sponsors) run the ads, both to ensure compliance with federal regulations and consistency with FDA-approved labeling for the drug or implantable medical device product.

4. That the Congress provide sufficient funding to the FDA, either through direct appropriations or through prescription drug or implantable medical device user fees, to ensure effective regulation of DTCA.

5. That DTCA for newly approved prescription drug or implantable medical device products not be run until sufficient post-marketing experience has been obtained to determine product risks in the general population and until physicians have been appropriately educated about the drug or implantable medical device. The time interval for this moratorium on DTCA for newly approved drugs or implantable medical devices should be determined by the FDA, in negotiations with the drug or medical device product's sponsor, at the time of drug or implantable medical device approval. The length of the moratorium may vary from drug to drug and device to device depending on various factors, such as: the innovative nature of the drug or implantable medical device; the severity of the disease that the drug or implantable medical device is intended to treat; the availability of alternative therapies; and the intensity and timeliness of the education about the drug or implantable medical device for physicians who are most likely to prescribe it.

6. That our AMA opposes any manufacturer (drug or device sponsor) incentive programs for physician prescribing and pharmacist dispensing that are run concurrently with DTCA.

7. That our AMA encourages the FDA, other appropriate federal agencies, and the pharmaceutical and medical device industries to conduct or fund research on the effect of DTCA, focusing on its impact on the patient-physician relationship as well as overall health outcomes and cost benefit analyses; research results should be available to the public.

8. That our AMA supports the concept that when companies engage in DTCA, they assume an increased responsibility for the informational content and an increased duty to warn consumers, and they may lose an element of protection normally accorded under the learned intermediary doctrine.

9. That our AMA encourages physicians to be familiar with the above AMA guidelines for product-claim DTCA and with the Council on Ethical and Judicial Affairs Ethical Opinion E-9.6.7 and to adhere to the ethical guidance provided in that Opinion.

10. That the Congress should request the Agency for Healthcare Research and Quality or other appropriate entity to perform periodic evidence-based reviews of DTCA in the United States to determine the impact of DTCA on health outcomes and the public health. If DTCA is found to have a negative impact on health outcomes and is detrimental to the public health, the Congress should consider enacting legislation to increase DTCA regulation or, if necessary, to prohibit DTCA in some or all media. In such legislation, every effort should be made to not violate protections on commercial speech, as provided by the First Amendment to the U.S. Constitution.

11. That our AMA supports eliminating the costs for DTCA of prescription drugs as a deductible business expense for tax purposes.

12. That our AMA continues to monitor DTCA, including new research findings, and work with the FDA and the pharmaceutical and medical device industries to make policy changes regarding DTCA, as necessary.

13. That our AMA supports "help-seeking" or "disease awareness" □ advertisements (i.e., advertisements that discuss a disease, disorder, or condition and advise consumers to see their physicians, but do not mention a drug or implantable medical device or other medical product and are not regulated by the FDA).

(34) RESOLUTION 225 – TRUTH IN ADVERTISING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-405.969 be reaffirmed in lieu of Resolution 225.

HOD ACTION: Policy H-405.969 reaffirmed in lieu of Resolution 225.

Resolution 225 asks that our American Medical Association support clarity and truth in advertising by requiring physicians to fully disclose board certification status, medical license restrictions as permitted by law, residency and fellowship status, particularly with vulnerable patients such as those treated in confined settings such as locked mental health institutions and correctional settings and encourage restricting the use of the title "doctor" in closed settings to only medical doctors. (New HOD Policy)

Your Reference Committee heard testimony generally in opposition to Resolution 225 and in support of existing AMA policy and advocacy. While our AMA supports truth and transparency in advertising and communication with patients, this policy does not extend to prohibiting use of the term "doctor," and rather, encourages requiring non-physicians health care practitioners presenting themselves as "doctors" disclose the license under which they are practicing. Your Reference Committee heard support for this more balanced approach, as well as the longstanding and successful AMA Truth in Advertising Campaign, which has led to the adoption of laws in 20 states to date. More information on this state legislative campaign, including model legislation, is available at ama-assn.org/truth-advertising.

Your Reference Committee also heard that our AMA policy has long discouraged discrimination against physicians based on board certification status or the fact that a physician's license is or has been restricted by the physician's state medical board. Your Reference Committee heard concerns that this resolution, if adopted, could lead to such discrimination against physicians. In addition, your Reference Committee heard testimony suggesting that disclosure of medical license restrictions would be a particular burden for young physicians in those states that require one or more years of practice before being eligible for board certification. For these reasons, your Reference Committee recommends that AMA Policy H-405.969 be reaffirmed in lieu of Resolution 225.

H-405.969 Definition of a Physician

1. The AMA affirms that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine. 2. AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition above, must

specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree. 3. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign.

(35) RESOLUTION 235 – TOWARDS ELIMINATING ERISA STATE PREEMPTION OF HEALTH PLAN LIABILITY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-285.915, H-285.945, D-385.984, and D-385.973 be reaffirmed in lieu of Resolution 235.

HOD ACTION: Policies H-285.915, H-285.945, D-385.984, and D-385.973 reaffirmed in lieu of Resolution 235.

Resolution 235 our American Medical Association renew active advocacy for Executive and Congressional action to amend the Employee Retirement Income Security Act (ERISA) to eliminate the state preemption clause and provide patients with a less restrictive and/or less burdensome process to seek adequate redress or compensation for damages incurred as a result of coverage decisions made by employer-sponsored health plans (Directive to Take Action); and be it further, that our AMA reaffirm Policies H-285.945, H-285.915, D-385.984 and D-385.973. (Reaffirm HOD Policy)

Your Reference Committee heard very limited but supportive testimony on Resolution 235. Your Reference Committee believes that existing policy calls for the elimination of ERISA preemption of self-insured state plans and for self-insured plans be held legally accountable for harm to patients. Therefore, the Committee recommends that Policies H-285.915, H-285.945, D-385.984, and D-385.973 be reaffirmed in lieu of Resolution 235.

H-285.915 AMA Policy on ERISA

1. Our AMA will seek, through amendment of the ERISA statute, through enactment of separate federal patient protection legislation, through enactment of similar state patient protection legislation that is uniform across states, and through targeted elimination of the ERISA preemption of self-insured health benefits plans from state regulation, to require that such self-insured plans: (a) Ensure that plan enrollees have access to all needed health care services; (b) Clearly disclose to present and prospective enrollees any provisions restricting patient access to or choice of physicians, or imposing financial incentives concerning the provision of services on such physicians; (c) Be regulated in regard to plan policies and practices regarding utilization management, claims submission and review, and appeals and grievance procedures; (d) Conduct scientifically based and physician-directed quality assurance programs; (e) Be legally accountable for harm to patients resulting from negligent utilization management policies or patient treatment decisions through all available means, including proportionate or comparative liability, depending on state liability rules; (f) Participate proportionately in state high-risk insurance pools that are financed through participation by carriers in that jurisdiction; (g) Be prohibited from indemnifying beneficiaries against actions brought by physicians or other providers to recover charges in excess of the amounts allowed by the plan, in the absence of any provider contractual agreement to accept those amounts as full payment; (h) Inform beneficiaries of any discounted payment arrangements secured by the plan, and base beneficiary coinsurance and deductibles on these discounted amounts when providers have agreed to accept these discounted amounts as full payment; (i) Be subject to breach of contract actions by providers against their administrators; and (j) Adopt coordination of benefits provisions applying to enrollees covered under two or more plans. 2. Our AMA will continue to advocate for the elimination of ERISA preemption of self insured health plans from state insurance laws consistent with current AMA policy.

H-285.945 Establishment of Liability of Managed Care Organizations

Our AMA supports changes in federal law to prohibit the exemption from liability of managed care organizations, including ERISA plans, for damages resulting from their policies, procedures, or administrative actions taken in relation to patient care.

D-383.984 ERISA and Managed Care Oversight

Our AMA will develop, propose, and actively support (1) federal legislation clarifying that ERISA preemption does not apply to physician/insurer contracting issues; (2) federal legislation that requires all third party payers serving as administrators for ERISA plans to accept assignment of benefits by patients to physicians; and (3) federal and state legislation prohibiting "all products" clauses or linking participation in one product to participation in other products ("tied") administered or offered by third party payers or their affiliates.

D-385.973 ERISA Plans and the United States Department of Labor

1. Our AMA will seek federal legislation that would modify Employee Retirement Income Security Act law to incorporate a clause that addresses timely payment of medical claims of health care practitioners who provide treatment in good faith to the members of self-funded group employer-sponsored health plans.
2. When the federal law is amended, our AMA will work with the United States Department of Labor to devise and implement a formalized appeal process at the United States Department of Labor.

(36) RESOLUTION 241 – TIMELINESS IN OBTAINING MEDICAL RECORDS FROM OTHER PROVIDERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy D-190.992 be reaffirmed in lieu of Resolution 241.

HOD ACTION: Policy D-190.992 reaffirmed in lieu of Resolution 241.

Resolution 241 asks that our American Medical Association work in concert with hospitals, hospital associations, and accrediting organizations to achieve a universal understanding of HIPAA rules that allow the transfer of information to members of a patient's treatment team without written authorization. (Directive to Take Action)

Your Reference Committee heard testimony that the U.S. Department of Health and Human Services (HHS) Office of Civil Rights has attempted to clarify complex HIPAA requirements and has directly addressed the issue in Resolution 241. Your Reference Committee heard testimony that the guidance is clear that written authority is not required to share treatment information among health care team members. Your Reference Committee also heard testimony that our AMA has existing policy that directs our AMA to continue to review HIPAA rules to identify provisions that should be clarified, and work with HHS to communicate any needed clarifications. Therefore, your Reference Committee supports reaffirmation of policy D-190.992 in lieu of Resolution 241.

D-190.992 HIPAA Privacy Regulations Implementation

Our AMA shall continue to make it an urgent priority to undertake a comprehensive review including unfunded physicians costs of implementation of HIPAA transaction, privacy and security rules to identify provisions that should be clarified, improved or repealed and communicate there urgently needed changes to the Department of Health and Human Services and Congress for prompt action, including any necessary delays in implementation, as appropriate.

(37) RESOLUTION 242 – LEGISLATION TO REQUIRE TIMELY ACTION ON PRIOR AUTHORIZATION REQUIREMENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-320.948, H-320.952, H-320.958, and H-320.968 be reaffirmed in lieu of Resolution 242.

HOD ACTION: Policies H-320.948, H-320.952, H-320.958, and H-320.968 reaffirmed in lieu of Resolution 242.

Resolution 242 asks that our American Medical Association advocate for the initiation of legislation or regulation requiring utilization review entities to provide detailed explanations for prior authorization or step therapy denials (Directive to Take Action); and be it further, that our AMA advocate for the initiation of legislation or regulation requiring utilization review entities to make prior authorization or step therapy determinations and to notify providers within 48 hours for non-urgent care. For urgent care, determinations should be made within 24 hours of submission of necessary information (Directive to Take Action); and be it further, that our AMA advocate for the initiation of legislation or regulation requiring utilization review entities to communicate decisions on appeals within 10 calendar days. In the event that a provider determines the need for an expedited appeal, utilization review entities should communicate decisions on such appeals within 24 hours (Directive to Take Action); and be it further, that our AMA advocate for the initiation of legislation or regulation requiring that all utilization review entity appeal decisions should be made by a provider who (a) is of the same specialty, and subspecialty, whenever possible, as the prescribing/ordering provider, and (b) was not involved in the initial adverse determination. (Directive to Take Action).

Your Reference Committee heard supportive testimony on Resolution 242. Your Reference Committee heard testimony that utilization management programs, such as prior authorization and step therapy, can create significant barriers for patients by delaying the start or continuation of necessary treatment and negatively affecting patient health outcomes. Your Reference Committee agrees that these processes are very manual, time-consuming, burden physicians and divert valuable resources away from direct patient care. Testimony further underscored that AMA policy and advocacy activities including releasing Prior Authorization Principles (which was supported by over 100 stakeholder groups) already covered the salient points of the resolution. Therefore, your Reference Committee recommends reaffirming existing policies H-320.948, H-320.952, H-320.958, and H-320.968 in lieu of Resolution 242.

H-320.948 Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans

It is the policy of our AMA, when a health plan or utilization review organization makes a determination to retrospectively deny payment for a medical service, or down-code such a service, the physician rendering the service, as well as the patient who received the service, shall receive written notification in a timely manner that includes: (1) the principal reason(s) for the determination; (2) the clinical rationale used in making the determination; and (3) a statement describing the process for appeal.

H-320.952 External Grievance Review Procedures. Our AMA establishes an External Grievance procedure for all health plans including those under the Affordable Care Act (ACA) with the following basic components: (1) It should apply to all health carriers and Accountable Care Organizations; (2) Grievances involving adverse determinations may be submitted by the policyholder, their representative, or their attending physician; (3) Issues eligible for external grievance review should include, at a minimum, denials for (a) medical necessity determinations; and (b) determinations by carrier that such care was not covered because it was experimental or investigational; (4) Internal grievance procedures should generally be exhausted before requesting external review; (5) An expedited review mechanism should be created for urgent medical conditions; (6) Independent reviewers practicing in the same state should be used whenever possible; (7) Patient cost sharing requirements should not preclude the ability of a policyholder to access such external review; (8) The overall results of external review should be available for public scrutiny with procedures established to safeguard the confidentiality of individual medical information; (9) External grievance reviewers shall obtain input from physicians involved in the area of practice being reviewed. If the review involves specialty or sub-specialty issues the input shall, whenever possible, be obtained from specialists or sub-specialists in that area of medicine.

H-320.958 Emerging Trends in Utilization Management

The AMA will: (1) maintain a leadership role in coordinating private sector efforts to develop and refine utilization management and quality assessment programs; (2) establish an active role in the development of any national utilization management and quality assessment programs that are proposed in the ongoing health system reform debate; and (3) advocate strongly for utilization management and quality assessment programs that are non-intrusive, have reduced administrative burdens, and allow for adequate input by the medical profession.

H-320.968 Approaches to Increase Payer Accountability

Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability. (1) Disclosure Requirements. Our AMA supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on (a) coverage provisions, benefits, and exclusions; (b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient; (d) medical expense ratios; and (e) cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97) (2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review; (c) Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay. (3) Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above.

(38) RESOLUTION 243 – SEAMLESS DIGITAL INTERFACE FOR BEST CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies D-478.995 and D-478.972 be reaffirmed in lieu of Resolution 243.

HOD ACTION: Policies D-478.995 and D-478.972 reaffirmed in lieu of Resolution 243.

Resolution 243 asks that our AMA should advocate for the interoperability of electronic medical data platforms for the purpose of improving patient care.

Your Reference Committee heard generally supportive testimony on Resolution 243. Your Reference Committee strongly agrees that interoperability of electronic medical data, including the context of Prescription Drug Monitoring Programs (PDMP), can be invaluable in providing quality patient care. Your Reference Committee also agrees that interoperability should focus on usefulness, timeliness, correctness and completeness of data, as well as the ease and cost of information access. Your Reference Committee heard testimony that AMA already has strong

policy regarding PDMPs and for advocating for interoperability. Thus, your Reference Committee recommends reaffirming Policies D-478.995 and D-478.972 in lieu of Resolution 243.

D-478.995 National Health Information Technology.

(1) Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care. (2) Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.; and (D) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems. (3) Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs. (4) Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery. (5) Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process. (6) Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability. (7) Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

D-478.972 EHR Interoperability

Our AMA: (1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System; (2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange; (3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges; (4) will continue efforts to promote interoperability of EHRs and clinical registries; (5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates; and (6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private.

REPORT OF REFERENCE COMMITTEE C

(1) COUNCIL ON MEDICAL EDUCATION REPORT 3 - OBESITY EDUCATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 3 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 3 adopted and the remainder of the report filed.

Council on Medical Education Report 3 asks 1) That our American Medical Association (AMA) make this report available on the AMA website for use by medical students, residents, teaching faculty, and practicing physicians; and 2) That AMA Policy D-440.980 (5), “Recognizing and Taking Action in Response to the Obesity Crisis,” be rescinded, as having been fulfilled by this report.

Your Reference Committee heard unanimous support for this report’s recommendations and received additional guidance on resources to add to the report—i.e., the American Association of Clinical Endocrinologists’ Obesity Resource Center, as well as the Provider Competencies for the Prevention and Management of Obesity from the Provider Training and Education Workgroup of the Integrated Clinical and Social Systems for the Prevention and Management of Obesity Innovation Collaborative. It was also suggested that the report include hyperlinks to the organizations/resources listed therein. Therefore, your Reference Committee recommends that Council on Medical Education Report 3 be adopted.

(2) RESOLUTION 304 - SUPPORT OF EQUAL STANDARDS FOR FOREIGN MEDICAL SCHOOLS SEEKING TITLE IV FUNDING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 304 be adopted.

HOD ACTION: Resolution 304 adopted.

Resolution 304 asks that our AMA support the application of the existing requirements for foreign medical schools seeking Title IV Funding to those schools which are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding.

Your Reference Committee heard uniformly positive virtual and live testimony in favor of adoption of Resolution 304. Currently, a small number of foreign medical schools are exempt from federal eligibility requirements for Title IV funding, due to a grandfathering clause from 1992. These requirements stipulate that schools enroll at least 60% non-U.S. citizens or permanent residents, and that 75% of students pass the United States Medical Licensing Examination. Setting consistent eligibility requirements for all offshore medical schools would increase accountability among these schools for this important federal funding resource and reduce the possibility of any cavalier misuse of such funds. It would also ensure that U.S. students attending such schools are able to receive a quality education that prepares them to practice medicine in the United States and lessen the odds for these students to become burdened with a large loan debt and be unable to enter a residency program and become a practicing physician in the U.S. Therefore, your Reference Committee recommends that Resolution 304 be adopted.

(3) RESOLUTION 313 - STUDY OF DECLINING NATIVE AMERICAN MEDICAL STUDENT ENROLLMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 313 be adopted.

HOD ACTION: Resolution 313 adopted.

Resolution 313 asks that our AMA partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and lastly to propose remedies to solve the problems identified in the AMA study.

Your Reference Committee heard limited but supportive testimony on this item and on the need for increased diversity of the physician workforce, to support access to patient care among underserved populations. Testimony from the American Academy of Pediatrics noted that organization's development of a task force on diversity and inclusion, which may be able to assist in information gathering for the proposed AMA study. Existing AMA policy on diversity dovetails with the intent of this resolution, and the noted decline in the number of Native Americans entering medical school is worrisome and may hold future negative ramifications for access to care. Accordingly, your Reference Committee recommends that Resolution 313 be adopted.

(4) RESOLUTION 319 - PUBLIC ACCESS TO INITIAL BOARD CERTIFICATION STATUS OF TIME-LIMITED ABMS DIPLOMATES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 319 be adopted.

HOD ACTION: Resolution 319 adopted.

Resolution 319 asks that our AMA amend the AMA Principles of Maintenance of Certification (MOC), AMA Policy H-275.924, "Maintenance of Certification," by addition as follows:

26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards' websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards' websites or physician certification databases even if the diplomate chooses not to participate in MOC. (Modify Current HOD Policy)

Your Reference Committee heard testimony in support of inclusion of initial certification as well as the status of time-limited diplomates in all ABMS and ABMS member board websites and physician certification databases. It was noted that the preservation of information of such an achievement is worthy of permanent documentation. Therefore, your Reference Committee recommends that Resolution 319 be adopted.

(5) RESOLUTION 320 - CULTURAL COMPETENCE IN STANDARDIZED PATIENT PROGRAMS WITHIN MEDICAL EDUCATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 320 be adopted.

HOD ACTION: Resolution 320 adopted.

Resolution 320 asks that our AMA amend existing AMA Policy H-295.897, “Enhancing the Cultural Competence of Physicians” by addition as follows:

7. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.

Your Reference Committee heard overwhelmingly supportive testimony on the need for medical students to encounter diverse standardized patients so that they are prepared to address health disparities and provide culturally competent care to an increasingly diverse patient population. Therefore, your Reference Committee recommends that Resolution 320 be adopted.

(6) RESOLUTION 323 - EXCEPTIONS TO MEDICARE GME CAP-SETTING DEADLINES FOR RESIDENCY PROGRAMS IN MEDICALLY UNDERSERVED/ECONOMICALLY DEPRESSED AREAS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 323 be adopted.

HOD ACTION: Resolution 323 adopted.

Resolution 323 asks that our AMA advocate to the Centers for Medicare & Medicaid Services for flexibility beyond the current maximum of five years for the Medicare graduate medical education cap-setting deadline for new residency programs in underserved areas and/or economically depressed areas.

Your Reference Committee heard online and live testimony that supported adoption of Resolution 323. It was noted that all available and feasible avenues should be taken to help ease the shortage of physicians, especially in medically underserved and economically depressed areas. While existing AMA policy supports preserving, stabilizing and expanding funding for graduate medical education in general, this item urges support for a specific mechanism for expanding GME. The current five-year deadline for establishing a program before the funding-cap is set, as noted in virtual testimony, “is not feasible in certain underserved areas, and does not allow medical school programs to establish sufficiently robust programs before the cap goes into effect.” Therefore, your Reference Committee recommends that Resolution 323 be adopted.

(7) COUNCIL ON MEDICAL EDUCATION REPORT 1 - COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2007 HOUSE POLICIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendation in Council on Medical Education Report 1 be amended by addition, to read as follows:

Council on Medical Education Report 1 recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated, with the exception of H-295.908, Protection of Medical Students in the Event of Medical School Closure or Reduction in Enrollment, which should be retained, and the remainder of this report be filed. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendation in Council on Medical Education Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 1 adopted as amended and the remainder of the report filed.

Council on Medical Education Report 1 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.

Your Reference Committee heard testimony in general support of this item. It was noted in testimony, however, that H-295.908, Protection of Medical Students in the Event of Medical School Closure or Reduction in Enrollment, should be retained, to protect medical students in the event of an unanticipated medical school closure or enrollment reduction. Your Reference Committee agrees, and urges that this policy be retained. Additional testimony was heard concerning H-150.996, Nutrition Courses in Medicine, urging that this item be retained and not revised, as proposed in the report. Your Reference Committee, however, believes the proposed edits (as shown on page 3 of the appendix to the report) are appropriate, in that AMA Policy H-150.995, Basic Courses in Nutrition, renders this policy superfluous. That policy reads, “Our AMA encourages effective education in nutrition at the undergraduate, graduate, and postgraduate levels.” Therefore, your Reference Committee recommends that Council on Medical Education Report 1 be adopted as amended.

- (8) COUNCIL ON MEDICAL EDUCATION REPORT 2 - UPDATE ON MAINTENANCE OF CERTIFICATION AND OSTEOPATHIC CONTINUOUS CERTIFICATION (RESOLUTION 315-A-16)

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 in Council on Medical Education Report 2 be amended by addition and deletion, to read as follows:

1. That ~~the Council on Medical Education collaborate with the Council on Legislation and/or the Council on Medical Service to determine MOC alignment with legislative activities and quality, patient safety and value qualifiers, such as the Quality Payment Program (QPP) created by the Medicare Access and CHIP Reauthorization Act (MACRA)~~our American Medical Association (AMA) advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for MOC Part IV. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 2 adopted as amended and the remainder of the report filed.

Council on Medical Education Report 2 provides an update on MOC and OCC, and asks 1) That the Council on Medical Education collaborate with the Council on Legislation and/or the Council on Medical Service to determine MOC alignment with legislative activities and quality, patient safety and value qualifiers, such as the Quality Payment Program (QPP) created by the Medicare Access and CHIP Reauthorization Act (MACRA); 2) That our AMA rescind Policy D-275.954 (28), “Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC),” since that has been accomplished through this report.

Your Reference Committee heard testimony in support for the Council’s annual report to the House of Delegates. During the testimony, several specialty societies acknowledged that the Council’s efforts with the American Board of Medical Specialties and the ABMS member boards are resulting in improvements to the Maintenance of Certification (MOC) process. There was also some discussion of the work underway to develop a society maintenance pathway for some internal medicine specialty groups. It was also noted that AMA advocacy has

focused on educating state medical associations about activity around the country, as well as the risks and benefits of legislating the use of MOC. The first recommendation in the report was amended to address concerns that the recommendation may be misinterpreted to imply a role for MOC at the federal level or a nexus between MOC and federal programs, such as the Quality Payment Program. In addition, the Council on Medical Education clarified that only Part 28, of Policy D-275.954, "Maintenance of Certification (MOC) and Osteopathic Continuous Certification," was rescinded, since this has been accomplished through this report. Part 28 read, "Examine the activities that medical specialty organizations have underway to review alternative pathways for board recertification; and determine if there is a need to establish criteria and construct a tool to evaluate if alternative methods for board recertification are equivalent to established pathways." Your Reference Committee concurs that Part 28 has been accomplished and can be rescinded. Therefore, your Reference Committee recommends that Council on Medical Education Report 2 be adopted as amended.

(9) COUNCIL ON MEDICAL EDUCATION REPORT 7 - EXPANSION OF PUBLIC SERVICE LOAN FORGIVENESS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 3 in Council on Medical Education Report 7 be amended by deletion, to read as follows:

~~That our AMA reaffirm Policy D-305.993 (1-9), which asks that the AMA advocate against a cap on federal loan forgiveness programs but also advocate that any cap on loan forgiveness under the PSLF program be at least equal to the principal amount borrowed. (Reaffirm HOD policy)~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendation 6 in Council on Medical Education Report 7 be amended by addition and deletion, to read as follows:

~~That our AMA encourage medical school financial advisors to promote to medical students the Students to Service Loan Repayment Program of the National Health Service Corps (NHSC) service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas. (Directive to Take Action)~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Recommendation 7 in Council on Medical Education Report 7 be amended by addition and deletion, to read as follows:

~~That our AMA strongly advocate that the terms of any restrictive changes to the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes take effect after all individuals currently within their PSLF eligibility period are "aged out" of the PSLF program under the conditions in place when they began their eligibility. (Directive to Take Action)~~

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 7 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 7 adopted as amended and the remainder of the report filed.

Council on Medical Education Report 7 asks 1) That our AMA encourage the Accreditation Council for Graduate Medical Education (ACGME) to require programs to include within the terms, conditions, and benefits of appointment to the program (which must be provided to applicants invited to interview, as per ACGME Institutional Requirements) information regarding the Public Service Loan Forgiveness (PSLF) program qualifying status of the employer; 2) That our AMA rescind Policy D-305.993 (10), as having been fulfilled by this report; 3) That our AMA reaffirm Policy D-305.993 (1-9), which asks that the AMA advocate against a cap on federal loan forgiveness programs but also advocate that any cap on loan forgiveness under the PSLF program be at least equal to the principal amount borrowed; 4) That our AMA advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; 5) That our AMA encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; 6) That our AMA encourage medical school financial advisors to promote to medical students the Students to Service Loan Repayment Program of the National Health Service Corps (NHSC) as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; and 7) That our AMA strongly advocate that any restrictive changes to the PSLF take effect after all individuals currently within their PSLF eligibility period are “aged out” of the PSLF program under the conditions in place when they began their eligibility.

Your Reference Committee heard testimony in support of this report, especially regarding the need for transparency in the loan repayment process. Additional testimony highlighted the added financial barriers faced by larger proportions of underrepresented in medicine (URM) students, and linked loan repayment programs with enhanced opportunities for these individuals to pursue clinical training. Testimony also revealed that service-based loan repayment options encourage practice in areas that otherwise experience difficulty attracting and retaining physicians, and therefore increase patient access to care. Others noted that these types of repayment options are more important in today’s learning environment, when young physicians are graduating later in life with extremely high levels of debt, versus a previous era of medicine in which economic well-being was more assured. For these reasons, your Reference Committee recommends that CME Report 7 be adopted as amended.

(10) COUNCIL ON MEDICAL EDUCATION REPORT 9 - FEASIBILITY AND APPROPRIATENESS OF TRANSFERRING JURISDICTION OVER REQUIRED CLINICAL SKILLS EXAMINATIONS TO LCME-ACCREDITED AND COCA-ACCREDITED MEDICAL SCHOOLS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 in Council on Medical Education Report 9 be amended by substitution, to read as follows:

Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendation 2 in Council on Medical Education Report 9 be amended by substitution, to read as follows:

Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 9 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 9 adopted as amended and the remainder of the report filed.

Council on Medical Education Report 9 asks 1) That our AMA rescind Policy D-295.988 (2), “Clinical Skills Assessment During Medical School D-295.988,” due to inadequate stakeholder support for transferring jurisdiction of clinical skills examinations to medical schools, unless and until a viable alternative can be identified; 2) That AMA Policy D-295.988 (3) be amended by addition and deletion to read as follows: “3. Our AMA will work to: (a) ensure ~~rapid~~ yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through ~~immediate~~ steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow international students and graduates to take the same examination at any available testing site; and (d) ~~engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization;~~ and (e) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency.” 3) That our AMA encourage development of a post-examination feedback system for all USMLE test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas of suboptimal performance; and (c) give students who fail the exam insight into the areas of unsatisfactory performance on the examination; and 4) That our AMA, through the Council on Medical Education, continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary.

Your Reference Committee heard overwhelmingly supportive testimony for continued engagement with stakeholders regarding clinical skills assessment. Concerns were voiced regarding the predictive value of the exam and the financial barriers that arise from limited numbers of testing sites, and these types of questions will be explored through ongoing discussion with involved parties. However, speakers also acknowledged the importance of accountability to the public and the value of standardized, validated assessment. Currently, the FSMB and its member state medical boards do not support school-based examinations as an acceptable substitute for a national examination to assess clinical skills competency, and medical school support for the proposal to transfer jurisdiction has been mixed. However, the FSMB and NBME are establishing a USMLE advisory panel consisting of U.S. and international medical students, residents, and fellows, with the goal of providing direct feedback to and improving communication from the USMLE program. Therefore, your Reference Committee recommends that Council on Medical Education Report 9 be adopted as amended.

(11) RESOLUTION 301 - MENTAL HEALTH DISCLOSURES ON PHYSICIAN LICENSING APPLICATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 301 be amended by addition, to read as follows:

RESOLVED, That our AMA encourage state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 301 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA amend Policy H-275.970, “Licensure Confidentiality,” by addition and deletion to read as follows:
H-275.970, Licensure Confidentiality

The AMA (1) encourages specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (2) encourages boards to include in application forms only requests for information that can reasonably be related to medical practice; (3) encourages state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (4) encourages state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and (5) encourages state licensing boards to ~~require adopt policy that, if an applicant has disclosed a history of physical or behavioral health treatment, a treating physician submit to the board documentation that the applicant's current state of health does not interfere with the applicant's ability to practice medicine disclosure of physical or mental health history by physician health programs or providers only if they believe the illness of the physician they are treating is likely to impair the physician's practice of medicine or presents a public health danger.~~ that, if an applicant has had psychiatric treatment, the physician who has provided the treatment submit to the board an official statement that the applicant's current state of health does not interfere with his or her ability to practice medicine. (Modify Current HOD Policy); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 301 be adopted as amended.

HOD ACTION: Recommendation B referred, and the remainder of Resolution 301 adopted as amended.

Resolution 301 asks 1) That our AMA encourage state medical boards to consider physical and mental conditions similarly; 2) That our AMA encourage state medical boards to recognize that the presence of a mental health condition does not equate with an impaired ability to practice medicine; 3) That our AMA amend Policy H-275.970, "Licensure Confidentiality," by addition and deletion to read as follows:

H-275.970, Licensure Confidentiality

The AMA (1) encourages specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (2) encourages boards to include in application forms only requests for information that can reasonably be related to medical practice; (3) encourages state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (4) encourages state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and (5) encourages state licensing boards to require disclosure of physical or mental health history by physician health programs or providers only if they believe the illness of the physician they are treating is likely to impair the physician's practice of medicine or presents a public health danger. ~~that, if an applicant has had psychiatric treatment, the physician who has provided the treatment submit to the board an official statement that the applicant's current state of health does not interfere with his or her ability to practice medicine.~~; and 4) That our AMA encourage state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.

Your Reference Committee heard supportive testimony on this item from a wide variety of stakeholders, reflecting a growing concern among the profession and the public related to physician and medical student depression, burnout, and suicide. Our AMA has expressed strong support of physical and mental health care services for medical students and physicians. CME Report 1-I-16 addressed the long-standing and deeply ingrained stigma endured by physicians seeking care for either physical or mental health issues, partly due to concerns of career and licensure implications.

Policy H-295.858 (2) states that “Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.” Additionally, Policy H-275.945, Self-Incriminating Questions on Applications for Licensure and Specialty Boards, directs our AMA to encourage the Federation of State Medical Boards and its constituent members to develop uniform definitions and nomenclature for use in licensing and disciplinary proceedings to better facilitate the sharing of information, seek clarification of the application of the Americans with Disabilities Act to the actions of medical licensing and medical specialty boards, and encourage the American Board of Medical Specialties and the Federation of State Medical Boards and their constituent members to advise physicians of the rationale behind inquiries on mental illness, substance abuse or physical disabilities in materials used in the licensure, reregistration, and certification processes when such questions are asked. Policy H-345.973, Mental Health Services for Medical Students and Resident and Fellow Physicians, directs our AMA to promote the availability of timely, confidential, accessible, and affordable medical and mental health services for medical students and resident and fellow physicians, to include needed diagnostic, preventive, and therapeutic services. Finally, Policy H-275.970, Licensure Confidentiality, directs the AMA to encourage specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; to encourage boards to include in application forms only requests for information that can reasonably be related to medical practice; to encourage state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; to encourage state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and to encourage state licensing boards to require that, if an applicant has had psychiatric treatment, the physician who has provided the treatment submit to the board an official statement that the applicant's current state of health does not interfere with his or her ability to practice medicine. Despite this existing policy, testimony reflected additional concern related to stigma, deterred or deferred care seeking, and the belief that there is a lack of understanding of impairment vs. illness. For these reasons, your Reference Committee recommends that Resolution 301 be adopted as amended.

(12) RESOLUTION 302 - COMPREHENSIVE REVIEW OF CME PROCESS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 302 be amended by addition, to read as follows:

RESOLVED, That our American Medical Association, in collaboration with the Accreditation Council for Continuing Medical Education, do a comprehensive review of the continuing medical education (CME) process on a national level, with the goal of decreasing costs and simplifying the process of providing CME.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 302 be adopted as amended.

HOD ACTION: Resolution 302 adopted as amended.

Resolution 302 asks that our AMA do a comprehensive review of the continuing medical education (CME) process on a national level, with the goal of decreasing costs and simplifying the process of providing CME.

Your Reference Committee heard positive testimony on this item. The Council on Medical Education has engaged in similar efforts in the past, and continues to work closely with the Accreditation Council for Continuing Medical Education (ACCME). As noted in the testimony, the Council has a sub-committee that focuses on continuing medical education (CME) and has two AMA nominated Directors who sit on the Board of Directors of ACCME. The AMA and ACCME have a Bridge Committee, which is simplifying and better aligning the glossary and processes regarding CME on a national level and across all disciplines. The role of the AMA in CME has been to

define what constitutes a CME activity and how to award credit for it (*AMA PRA Category 1 Credit™*). Therefore, your Reference Committee recommends that Resolution 302 be adopted as amended.

(13) RESOLUTION 303 - ADDRESSING MEDICAL STUDENT MENTAL HEALTH THROUGH DATA COLLECTION AND SCREENING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 303 be amended by addition of new third Resolve, to read as follows:

RESOLVED, That our AMA work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 303 be adopted as amended.

HOD ACTION: Resolution 303 adopted as amended.

Resolution 303 asks 1) That our AMA encourage study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; and 2) That our AMA encourage medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students.

Your Reference Committee heard overwhelmingly supportive testimony of Resolution 303. Medical students are at high risk for depression and suicidal thinking, but face significant barriers to accessing care. Other nations (such as Australia) have successfully conducted national mental health surveys of physicians/medical students, but there is a dearth of equivalent data in the United States. Anonymous screening of medical students for depression and suicidal ideation can promote awareness and reduce stigma, and collecting data on this population can aid in the identification and development of more effective interventions. Therefore, your Reference Committee recommends that Resolution 303 be adopted as amended.

(14) RESOLUTION 305 - REDUCTION OF CAREGIVER BURNOUT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 305 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association encourage partner organizations to develop resources to better prepare and support lay caregivers in performing medical/nursing tasks. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 305 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA identify and disseminate resources ~~create an online educational module~~ to promote physician understanding of lay caregiver burnout and develop strategies to support lay caregivers and their patients. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 305 be adopted as amended.

HOD ACTION: Resolution 305 adopted as amended.

Resolution 305 asks 1) That our AMA encourage partner organizations to develop resources to better prepare caregivers in performing medical/nursing tasks; and 2) That our AMA create an online educational module to promote physician understanding of caregiver burnout and develop strategies to support caregivers and their patients.

Your Reference Committee heard significant testimony on the important and timely issue of lay caregiver burnout, which is increasing as hospital stays shorten and baby boomers age. The word “lay” was added to clarify the focus on the numerous friends and family members who provide care in a non-professional, non-medical capacity. Testimony also suggested that it would be better to partner with organizations, such as the AARP, that are already working in this area, rather than the AMA creating its own educational modules. Your Reference Committee agrees, and recommends that Resolution 305 be adopted as amended.

(15) RESOLUTION 306 - U.S. INTERNATIONAL MEDICAL GRADUATES IN PHYSICIAN WORKFORCE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 306 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association ~~work with~~ encourage the Educational Commission ~~on~~ for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident ~~ex~~ Matching Program (NRMP) and are therefore unable to get a residency or practice medicine. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 306 be adopted as amended.

HOD ACTION: Resolution 306 adopted as amended.

Resolution 306 asks that our AMA work with the Educational Commission on Foreign Medical Graduates (ECFMG) to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Residency Matching Program (NRMP) and are therefore unable to get a residency or practice medicine.

Your Reference Committee heard limited but supportive testimony for Resolution 306. The Council on Medical Education noted that the Educational Commission for Foreign Medical Graduates is better suited to study this issue, and recommended the change in verbiage as noted above; the authors of the resolution agreed, considering this a friendly amendment. Better information on this growing issue will help U.S. citizens and their health professions advisors make better, more informed choices about their future prospects as a physician. Additional editorial changes are proffered to ensure accuracy in the names of the ECFMG and NRMP. Therefore, your Reference Committee recommends that Resolution 306 be adopted as amended.

- (16) RESOLUTION 308 - IMMIGRATION REFORM IMPACTS ON INTERNATIONAL MEDICAL GRADUATE TRAINING AND PATIENT ACCESS
 RESOLUTION 311 - SUPPORT OF INTERNATIONAL MEDICAL STUDENTS AND GRADUATES
 RESOLUTION 312 - SUPPORTING INTERNATIONAL MEDICAL GRADUATES AND STUDENTS
 RESOLUTION 317 – IMMIGRATION
 RESOLUTION 321 - CONTINUED SUPPORT OF H-1B VISA PROGRAMS FOR INTERNATIONAL MEDICAL GRADUATES
 RESOLUTION 325 - ENSURE AN EFFECTIVE H-1B VISA PROGRAM TO PROTECT PATIENT ACCESS TO CARE
 RESOLUTION 326 - SUPPORTING INTERNATIONAL MEDICAL GRADUATES AND STUDENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolutions 308, 311, 312, 317, 321, 325, and 326.

HOD ACTION: The following resolution adopted in lieu of Resolutions 308, 311, 312, 317, 321, 325, and 326.

IMPACT OF IMMIGRATION BARRIERS ON THE NATION'S HEALTH

RESOLVED, That our American Medical Association (AMA) recognize the valuable contributions and affirm our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine (New HOD Policy); and be it further

RESOLVED, That our AMA oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion (New HOD Policy); and be it further

RESOLVED, That our AMA oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice (New HOD Policy); and be it further

RESOLVED, That our AMA work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S. (Directive to Take Action); and be it further

RESOLVED, That our AMA update the House of Delegates by the 2017 Interim Meeting on the impact of immigration barriers on the physician workforce. (Directive to Take Action)

Resolution 308 asks 1) That our AMA advocate for the timely processing of visas for physicians to fill residency and fellowship training spots; 2) That our AMA study the current impact of immigration reform efforts on residency and fellowship training programs, physician supply, and timely access of patients to healthcare throughout the US ; and 3) That our AMA report back to the House of Delegates by the 2017 Interim Meeting such study findings, including appropriate proposals to advocate on behalf of international medical graduate physicians and their patients.

Resolution 311 asks 1) That our AMA recognize the unique contributions and affirm our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine; and 2) That our AMA oppose changes to immigration policies for international and foreign-born medical graduates and students that use country of origin to restrict visa procurement and ability to travel outside of the U.S. and return with a visa.

Resolution 312 asks 1) That our AMA oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion; and 2) That our AMA oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.

Resolution 317 asks that our AMA lobby the US Congress and other appropriate US government officials to exempt physicians from any current or future ban or suspension impacting immigration or the issuance of a J1 Visa or H1-B Visa.

Resolution 321 asks that our AMA urge the Trump Administration to immediately reinstate premium processing of H-1B visas for physicians to prevent any negative impact on patient care in underserved communities.

Resolution 325 asks that our AMA proactively work with appropriate officials to secure an exemption of medical professionals from the suspension of and any future modifications to the H-1B visa program, in order to allow for efficient entry of international physicians into the United States.

Resolution 326 asks that our AMA 1) oppose laws and regulations that would broadly deny entry or re-entry to the United States by persons based on their country of origin and/or religion who currently have legal visas, including permanent resident status (green card) and student visas, and oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.

Your Reference Committee heard universal support for these timely and salient resolutions, which seek to address and rectify the multiple implications of restricting US travel for foreign-born physicians, trainees, and researchers. In addition, these travel restrictions are predicted to impact patient access to care, especially in areas of need. These same implications hold true for other foreign-born clinicians and trainees employed in this country, and, by extension, physicians' and other clinicians' family members.

Restricting travel on the basis of country of origin or religion goes against the principles and policy of our AMA, which has worked to enhance physician diversity and to address the quality of care received and experienced by diverse patients and populations. Policy D-255.991, Visa Complications for IMGs in GME, directs our AMA to work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice; promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position. It also calls on our AMA to study, in collaboration with the ECFMG and the ACGME, the frequency of such J-1 Visa reentry denials and their impact on patient care and residency training, and, with other stakeholders, to advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

Many communities, including rural and low-income areas, face challenges attracting physicians to meet their health care needs. IMGs often fill these openings. To date, one out of every four physicians practicing in the United States

is an IMG. In certain specialties, that number is even higher. These physicians are licensed by the same stringent requirements applied to U.S. medical school graduates. They are more likely to practice in underserved and poor communities, and to fill training positions in primary care and other specialties that face significant workforce shortages. Existing AMA policy, Policy D-255.985, Conrad 30 - J-1 Visa Waivers, directs our AMA to advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage; (F) work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and (G) continue to communicate with the Conrad 30 administrators and IMGs members to share information and best practices in order to fully utilize and expand the Conrad 30 program.

Additional concerns have been voiced by the biomedical research community. Restriction of travel will negatively impact the free flow of ideas and the cooperation that have historically led to advancements in the delivery of care.

For these reasons, your Reference Committee recommends adoption of the proposed resolution in lieu of these seven items.

(17) RESOLUTION 309 - FUTURE OF THE USMLE: EXAMINING MULTI-STEP STRUCTURE AND SCORE USAGE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 309 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association work with the appropriate stakeholders to study ~~investigate~~ the advantages, disadvantages, and practicality of combining the USMLE Step 1 and Step 2 CK exams into a single licensure exam measuring both foundational science and clinical knowledge competencies (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 309 be amended by addition, to read as follows:

RESOLVED, That our AMA work with the appropriate stakeholders to study alternate means of scoring USMLE exams in order to avoid the inappropriate use of USMLE scores for screening residency applicants. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 309 be adopted as amended.

HOD ACTION: Resolution 309 adopted as amended.

Resolution 309 asks 1) That our AMA work with the appropriate stakeholders to investigate the advantages, disadvantages, and practicality of combining the USMLE Step 1 and Step 2 CK exams into a single licensure exam measuring both foundational science and clinical knowledge competencies; and 2) That our AMA work with the appropriate stakeholders to study alternate means of scoring USMLE exams.

Your Reference Committee heard almost entirely supportive testimony for this resolution. A comprehensive study regarding the possibility of combining the USMLE Step 1 and Step 2 exams was completed roughly 10 years ago, and this study also addressed changing the approach to score reporting. However, innovative UME models, such as

those found in the AMA's Accelerating Change in Medical Education consortium, have altered the medical education landscape to the point that a fresh look may be warranted. This resolution calls for appropriate stakeholders to be involved in such a discussion, and a number of different parties, including state licensing boards, program directors, and trainees, will need to be heard. In addition, consistent with existing AMA policy, the Council on Medical Education cautioned against the inappropriate use of USMLE scores when screening residency program applicants. Therefore, your Reference Committee recommends that Resolution 309 be adopted as amended.

(18) RESOLUTION 310 - BREAST PUMP ACCOMMODATIONS DURING MEDICAL LICENSING EXAMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy H-295.861 be amended by addition and deletion, to read as follows:

Our AMA 1) urges all medical licensing, certification and board examination agencies, and all board proctoring centers, to grant special requests to give ~~lactating mothers~~ breastfeeding individuals additional break time and a suitable environment during examinations to express milk; and 2) encourages that such accommodations to breastfeeding individuals include necessary time per exam day, in addition to the standard pool of scheduled break time found in the specific exam, as well as access to a private, non-bathroom location on the testing center site with an electrical outlet for individuals to breast pump.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-295.861 be adopted as amended in lieu of Resolution 310.

HOD ACTION: Policy H-295.861 adopted as amended in lieu of Resolution 310.

Resolution 310 asks 1) That our AMA encourage that the accommodation of breastfeeding individuals in all medical licensing exams in all specialties be allowed if the individual can provide a note from their physician; and 2) That our AMA encourage that accommodations include necessary time per exam day in addition to the standard pool of scheduled break time found in the specific exam as well as access to a private, non-bathroom location on the testing center site with an electrical outlet for individuals to breast pump.

Your Reference Committee heard powerful testimony in support of this resolution, which is in line with AMA policies supporting breastfeeding. Testimony from the Medical Student Section noted that existing AMA policy was similar to the intent of Resolve 1; therefore, your Reference Committee recommends the proposed changes, as shown, to reflect Resolve 1 in and incorporate Resolve 2 into that policy.

H-295.861, Accommodating Lactating Mothers Taking Medical Examinations

Our AMA urges all medical licensing, certification and board examination agencies, and all board proctoring centers, to grant special requests to give lactating mothers additional break time and a suitable environment during examinations to express milk.

(19) RESOLUTION 314 - EDUCATING A DIVERSE PHYSICIAN WORKFORCE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 314 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA provide on-line educational materials for its membership that address ~~cultural, racial and religious issues in patient care~~

diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 314 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA create and support programs that introduce elementary through high school students, especially those from ~~under-represented minority~~ groups that are underrepresented in medicine (URM), to healthcare careers (Directive to Take Action); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the fifth Resolve of Resolution 314 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA recommend that medical school admissions committees use holistic ~~evaluation~~ assessments of admission applicants, ~~taking that take~~ into account the diversity of preparation and the variety of talents that applicants bring to their education (New HOD Policy); and be it further

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the sixth Resolve of Resolution 314 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to ~~race and ethnicity~~ URM status collected from Electronic Residency Application Service (ERAS) applications through the National Residency Matching Program (NRMP) (New HOD Policy); and be it further

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 314 be adopted as amended.

HOD ACTION: Resolution 314 adopted as amended.

Resolution 314 asks 1) That our AMA develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population; 2) That our AMA provide on-line educational materials for its membership that address cultural, racial and religious issues in patient care; 3) That our AMA create and support programs that introduce elementary through high school students, especially those from under-represented minority groups, to healthcare careers; 4) That our AMA create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs; 5) That our AMA recommend that medical school admissions committees use holistic evaluation of admission applicants, taking into account the diversity of preparation and the variety of talents that applicants bring to their education; 6) That our AMA advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to race and ethnicity collected from Electronic Residency Application Service (ERAS) applications through the National Residency Matching Program (NRMP); and 7) That our AMA continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

Your Reference Committee heard testimony in favor of this resolution, in light of the mismatch between the physician and patient populations and the need to increase the number of physicians from groups that are

underrepresented in medicine (URM). It was noted that the AMA has existing policy and initiatives that relate to this issue. For example, the intent of the highly successful Doctors Back to School program is reflected in the third Resolve. Testimony reflected, however, that this resolution offers a concrete plan of action versus policy that is more philosophical in nature. As noted in online testimony, this item “outlines actionable items for the AMA to enact to increase diversity by supporting current and future physicians.” Additional testimony from the Gay and Lesbian Medical Association urged a more expansive approach to diversity, to go beyond race/ethnicity. In addition, testimony noted the need to use the more precise term “underrepresented in medicine” versus “underrepresented minority,” in that not all minority populations are underrepresented in medicine. These changes are reflected in your Reference Committee’s proposed recommendations, for which we urge adoption with the amendments shown.

(20) RESOLUTION 315 - INCLUSION OF DEVELOPMENTAL DISABILITIES CURRICULUM IN UNDERGRADUATE, GRADUATE AND CONTINUING MEDICAL EDUCATION OF PHYSICIANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the fourth Resolve of Resolution 315 be amended by addition, to read as follows:

RESOLVED, That our AMA encourage the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement curriculum on the care and treatment of people with developmental disabilities (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the fifth Resolve of Resolution 315 be amended by addition, to read as follows:

RESOLVED, That our AMA encourage the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with developmental disabilities (New HOD Policy); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the sixth Resolve of Resolution 315 be amended by addition, to read as follows:

RESOLVED, That our AMA encourage the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing education programs that focus on the care and treatment of people with developmental disabilities. (New HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 315 be adopted as amended.

HOD ACTION: Resolution 315 adopted as amended.

Resolution 315 asks 1) That our AMA reaffirm AMA Policies H-90.968, “Medical Care of Persons with Developmental Disabilities,” and H-90.969, “Early Intervention for Individuals with Developmental Delay”; 2) That our AMA recognize the importance of managing the health of children and adults with developmental disabilities as a part of overall patient care for the entire community; 3) That our AMA support efforts to educate physicians on

health management of children and adults with developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with developmental disabilities; 4) That our AMA encourage allopathic and osteopathic medical schools to develop and implement curriculum on the care and treatment of people with developmental disabilities; 5) That our AMA encourage graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with developmental disabilities; and 6) That our AMA encourage continuing medical education providers to develop and implement continuing education programs that focus on the care and treatment of people with developmental disabilities.

Your Reference Committee heard unanimous testimony in support of this item, which recognizes the importance of managing persons with developmental disabilities as part of overall patient care. This patient population has unique health challenges and can be particularly at risk for health-care disparities. It was recommended that the Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, Accreditation Council for Continuing Medical Education, and specialty boards also be encouraged to address this issue in medical schools, residency, and CME programs. Therefore, your Reference Committee recommends that Resolution 315 be adopted as amended.

(21) RESOLUTION 316 - ACTION STEPS REGARDING MAINTENANCE OF CERTIFICATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 316 be amended by deletion, to read as follows:

RESOLVED, That our AMA recognize that lifelong learning for a ~~medical~~ physician is best achieved by ongoing participation in a program of high quality continuing medical education (CME) ~~course~~ appropriate to that physician's medical practice as determined by the relevant specialty society (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy D-275.954 (34) be reaffirmed in lieu of the third Resolve in Resolution 316.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the fourth Resolve of Resolution 316 be referred.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the fifth Resolve of Resolution 316 be referred.

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 316 be adopted as amended.

HOD ACTION: Resolution 316 adopted as amended.

Resolution 316 asks 1) That our AMA affirm that lifelong learning is a fundamental obligation of our profession; 2) That our AMA recognize that lifelong learning for a medical physician is best achieved by ongoing participation in a program of high quality continuing medical education (CME) course appropriate to that physician's medical practice as determined by the relevant specialty society; 3) That our AMA develop model state legislation that would bar

hospitals, health care insurers, and the state medical licensing board from using non-participation in the ABMS sponsored MOC process using lifelong, interval, high stakes testing as a exclusionary criteria for credentialing; 4) That our AMA join with state medical associations and specialty societies in directly lobbying state medical licensing boards, hospital associations, and health care insurers to adopt policy supporting the use of satisfactory demonstration of lifelong learning with high quality CME as specified by a physician's specialty society for credentialing and bar these entities from using the ABMS sponsored MOC process using lifelong interval high stakes testing for credentialing; 5) That our AMA partner with state medical associations and specialty societies to undertake a study with the goal of establishing a program that will certify physicians as satisfying the requirements for continuation of their specialty certification by successful demonstration of lifelong learning utilizing high quality CME appropriate for that physician's medical practice as determined by their specialty society with a target start date of 2020 or before, with report back biannually to the HOD and AMA members.

Your Reference Committee heard mixed testimony on this item. There was overwhelming support for the first and second resolves, which are consistent with existing HOD policy that recognizes the need for lifelong learning. Current HOD policy defines a physician as "an individual who has received a 'Doctor of Medicine' or a 'Doctor of Osteopathic Medicine' degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine." Therefore, the qualifier "medical" has been stricken from the second Resolve. In accordance with existing policy, our AMA has already developed model state legislation that would bar hospitals, health care insurers, and state medical boards from requiring participation in MOC processes as a condition of credentialing, privileging, insurance panel participation, licensure, or licensure renewal. This model legislation, which was released in 2016, is on file with the AMA Advocacy Resource Center and available upon request. Our AMA has also focused on educating state medical associations about activity around the country, as well as on the risks and benefits of legislating the use of MOC. During the testimony, it was noted that enacted and defeated state legislation related to the use of MOC is complex and its potential impact on professional self-regulation is unknown. It was therefore recommended that the fourth and fifth resolves be referred for study with a report back to the HOD on the current status of such legislation. Your Reference Committee therefore recommends that Resolution 316 be adopted as amended.

(22) RESOLUTION 324 - IMPROVE HRSA PROJECTIONS OF THE PHYSICIAN WORKFORCE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 324 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association ~~work with~~ encourage the Health Resources & Service Administration ~~and to collaborate with~~ specialty societies to determine specific changes that would improve the agency's physician workforce projections process, to potentially include more detailed projection inputs, with the goal of producing more accurate and detailed projections including specialty and subspecialty workforces. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 324 be adopted as amended.

HOD ACTION: Resolution 324 adopted as amended.

Resolution 324 asks that our AMA work with the Health Resources & Service Administration and specialty societies to determine specific changes that would improve the agency's physician workforce projections process, to potentially include more detailed projection inputs, with the goal of producing more accurate and detailed projections including specialty and subspecialty workforces.

Your Reference Committee heard limited but positive testimony in support of adoption of this item. The Council on Medical Education proffered a friendly amendment to ensure a more effective and efficient approach to this

important work, to ensure collaboration between the Health Resources and Services Administration and the relevant specialty societies. Therefore, your Reference Committee recommends that Resolution 324 be adopted as amended.

(23) COUNCIL ON MEDICAL EDUCATION REPORT 6 - STANDARDIZING THE ALLOPATHIC RESIDENCY MATCH SYSTEM AND TIMELINE (RESOLUTION 310-A-16)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Council on Medical Education Report 6 be referred.

HOD ACTION: Original Recommendation 1 of Council on Medical Education Report 6 adopted; Recommendations 2 and 3 referred.

Council on Medical Education Report 6 asks 1) That our AMA support the movement toward a unified and standardized residency application and match system for all non-military residencies; 2) That our AMA encourage the Association of University Professors of Ophthalmology, the American Urological Association, and other appropriate stakeholders to move ophthalmology and urology to the National Resident Matching Program; and 3) That our AMA encourage the National Resident Matching Program to develop a process by which sequential matches could occur for those specialties that require a preliminary year of training, allowing a match to the GY2 position, followed later in the year by a match to a GY1 position, thus reducing application and travel costs for applicants.

Your Reference Committee heard almost evenly mixed testimony on this report. Representatives of the affected disciplines (ophthalmology and urology) argued that the current match system works well and provides savings in travel costs and minimizes inconvenience. Related to Recommendation 3, as well, it was noted that it is impossible to guarantee that the National Resident Matching Program's complex match algorithm could accommodate a sequential match. In addition, those who are unsuccessful in the ophthalmology or urology match can pursue a position in the NRMP match. Others argued in favor of adoption, to level the playing field for all medical students; simplify couples' matching (particularly for couples who are in separate matches); and heighten the opportunity for students to be exposed (during their fourth year rotations) to fields that they might have otherwise enjoyed. Therefore, your Reference Committee recommends that Council on Medical Education Report 6 be referred.

(24) RESOLUTION 318 - OPPOSE DIRECT TO CONSUMER ADVERTISING OF THE ABMS MOC PRODUCT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 318 be referred.

HOD ACTION: Resolution 318 referred.

Resolution 318 asks 1) That our AMA oppose direct-to-consumer marketing of the American Board of Medical Specialties Maintenance of Certification (MOC) product in the form of print media, social media, apps, and websites that specifically target patients and their families including but not limited to the promotion of false or misleading claims linking MOC participation with improved patient health outcomes and experiences where limited evidence exists; and 2) That our AMA amend existing AMA Policy D-275.954, "Maintenance of Certification and Osteopathic Continuous Certification" by addition as follows:

36. Direct the ABMS to ensure that any publicly accessible information pertaining to maintenance of certification (MOC) available on ABMS and ABMS Member Boards' websites or via promotional materials includes only statistically validated, evidence based, data linking MOC to patient health outcomes.

Your Reference Committee heard mixed testimony on this issue. Although our AMA opposes direct-to-consumer marketing of drugs and devices, it was noted that this resolution focuses on a different kind of communication. It was also noted that the American Board of Medical Specialties is making a statement to inform the public about the

certification status of physicians. There is no precedent in AMA policy which supports this issue, and the AMA has no purview over how the ABMS communicates information about its certification process. Therefore, your Reference Committee recommends that Resolution 318 be referred for further study.

(25) RESOLUTION 307 - FORMAL BUSINESS AND PRACTICE
MANAGEMENT TRAINING DURING MEDICAL EDUCATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies D-295.316, H-405.990 (Part 3), H-295.864, and H-295.924 be reaffirmed in lieu of Resolution 307.

HOD ACTION: Policies D-295.316, H-405.990 (Part 3), H-295.864, and H-295.924 reaffirmed in lieu of Resolution 307.

Resolution 307 asks 1) That our AMA encourage the Liaison Committee for Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME), Association of American Medical Colleges (AAMC) and other entities responsible for medical education to advocate for and support the creation of a more standardized process and approach for training and education in business and practice management skills for medical practitioners across the continuum of medical school, residency, fellowship and independent practice; and 2) That our AMA encourage LCME, ACGME, AAMC and other entities responsible for the education of future physicians, to provide educational resources and programs on business administration and practice management in their medical education curriculum.

Your Reference Committee heard testimony highlighting the importance of business and practice management training, and a number of individuals commented that while medicine is indeed a calling, it is also a business in today's increasingly corporate practice atmosphere. However, testimony also opposed the resolution because of how its implied curricular mandate would affect an already crowded curriculum. The AMA has long recognized and acknowledged the importance of physician skills in business and practice management as well as the lack of options for physicians to obtain such skills. Existing policy already directs the AMA to encourage the LCME, ACGME, AAMC, and other relevant organizations to advocate for and support the creation of a more standardized process and approach for training and education in business and practice management skills as well as to provide educational resources and programs on business administration and practice management in medical education.

AMA Policy D-295.316 addresses the creation of leadership and management training opportunities. Part 2 states that our AMA will work with key stakeholders to advocate for collaborative programs between medical schools and related schools of business and management to better prepare physicians for administrative and leadership responsibilities in medical management. Part 3 states that our AMA: (a) will advocate for and support the creation of leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills, and management techniques integral to leading interprofessional team care, in the spirit of the AMA's Accelerating Change in Medical Education initiative; and (b) will advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early in medical training to promote the development of leadership capabilities.

Policy H-405.990 (Part 3) The AMA advocates for continued efforts to collect and disseminate relevant and useful data pertaining to physician managers. Policies H-295.864 and H-295.924 also support the availability of educational resources and elective rotations for medical students and resident/fellow physicians on all aspects of systems-based practice, to improve awareness of and responsiveness to the larger context and system of health care and to aid in developing the future physician leaders.

In addition, the AMA has several resources addressing the intent of the resolution. The AMA's Introduction to the Practice of Medicine, an interactive, web-based and tablet-compatible educational series, is offered by a large number of teaching institutions nationwide and helps resident/fellow physicians achieve the six general competencies, including systems-based practice and practice-based learning. This resource is being recast as the GME Competency Education Program, and will include modules such as understanding the litigation process,

coding and documentation, choosing the right type of practice, CPT coding, fraud and abuse violations, personal finance, and physician employment contracts. Similarly, the AMA's Succeeding from Medical School to Practice online program includes education on business and economics issues. The AMA is developing educational programming for medical students, residents/fellows, and practicing physicians on these topics as part of its online tutorial series, STEPSForward™. The AMA is working to develop physician leadership programs for the AMA's Education Center to assist physicians in both rethinking and transforming their traditional roles, and in preparing for leadership opportunities from which they can help shape the health care system to produce better outcomes for physicians and their patients. This education will benefit physicians no matter where they are in their career or in which type of setting they practice. Also, the AMA's new Health Systems Science textbook focuses on value in health care, patient safety, quality improvement, teamwork and team science, leadership, clinical informatics, population health, socio-ecological determinants of health, health care policy, and health care economics. Finally, members of the AMA's Accelerating Change in Medical Education consortium's Leadership and Change Management Interest Group are actively working on a compilation of existing leadership curricula at the undergraduate medical education level. Therefore, your Reference Committee recommends that the policies noted above be reaffirmed in lieu of Resolution 307.

D-295.316, Management and Leadership for Physicians

1. Our AMA will study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options.
2. Our AMA will work with key stakeholders to advocate for collaborative programs between medical schools and related schools of business and management to better prepare physicians for administrative and leadership responsibilities in medical management.
3. Our AMA: (a) will advocate for and support the creation of leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills and management techniques integral to leading interprofessional team care, in the spirit of the AMA's Accelerating Change in Medical Education initiative; and (b) will advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early in medical training to promote the development of leadership capabilities.

H-405.990 (3), Physician Managers

The AMA advocates ... (3) continued efforts to collect and disseminate relevant and useful data pertaining to physician managers.

H-295.864, Systems-Based Practice Education for Medical Students and Resident/Fellow Physicians

Our AMA: (1) supports the availability of educational resources and elective rotations for medical students and resident/fellow physicians on all aspects of systems-based practice, to improve awareness of and responsiveness to the larger context and system of health care and to aid in developing our next generation of physician leaders; (2) encourages development of model guidelines and curricular goals for elective courses and rotations and fellowships in systems-based practice, to be used by state and specialty societies, and explore developing an educational module on this topic as part of its Introduction to the Practice of Medicine (IPM) product; and (3) will request that undergraduate and graduate medical education accrediting bodies consider incorporation into their requirements for systems-based practice education such topics as health care policy and patient care advocacy; insurance, especially pertaining to policy coverage, claim processes, reimbursement, basic private insurance packages, Medicare, and Medicaid; the physician's role in obtaining affordable care for patients; cost awareness and risk benefit analysis in patient care; inter-professional teamwork in a physician-led team to enhance patient safety and improve patient care quality; and identification of system errors and implementation of potential systems solutions for enhanced patient safety and improved patient outcomes.

H-295.924, Future Directions for Socioeconomic Education

The AMA: (1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum; (2) asks medical schools to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented in didactic sessions and reinforced during

clinical experiences, in both inpatient and ambulatory care settings, at educationally appropriate times during undergraduate and graduate medical education; and

(3) will encourage representatives to the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which "socioeconomic" subjects are covered in the medical curriculum.

(26) RESOLUTION 322 - ENDING MAINTENANCE OF CERTIFICATION EXAMINATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policies H-275.924 and D-275.954 be reaffirmed in lieu of Resolution 322.

HOD ACTION: Policies H-275.924 and D-275.954 reaffirmed in lieu of Resolution 322.

Resolution 322 asks 1) That our AMA oppose the requirement of Maintenance of Certification (MOC) as currently constituted in privileging and credentialing providers by health systems, hospitals, and payers; 2) That our AMA call on the American Board of Medical Specialties to pursue ongoing meaningful continuing medical education as a pathway to MOC without the requirement for re-examination; and 3) That our AMA reaffirm Policies H-275.924 and D-275.954, and report back at the 2017 Interim Meeting with an update on progress made toward these policies.

Your Reference Committee heard testimony largely in support of this item. The first Resolve, which opposes the requirement of Maintenance of Certification (MOC) as currently constituted in privileging and credentialing providers by health systems, hospitals, and payers, is covered by existing policy, H-275.924 (15). The second Resolve, which calls for the American Board of Medical Specialties to pursue ongoing meaningful continuing medical education as a pathway to MOC without the requirement for re-examination is already HOD policy D-275.954 (5)(30)(32). As was heard in testimony, most of the ABMS member boards have already moved away from the high-stakes examinations in favor of formats that their diplomates value. The third Resolve is covered by existing Policy D-275.954, which requires preparation of a yearly report to the House of Delegates regarding the MOC and OCC process. Therefore, your Reference Committee recommends that Policies H-275.924 and D-275.954 be reaffirmed in lieu of Resolution 322.

H-275.924, Maintenance of Certification

AMA Principles on Maintenance of Certification (MOC)

1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.

9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit™, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. MOC should be used as a tool for continuous improvement.
15. The MOC program should not be a mandated requirement for licensure, credentialing, recertification, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing MOC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. MOC activities and measurement should be relevant to clinical practice.
19. The MOC process should not be cost prohibitive or present barriers to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

D-275.954, Maintenance of Certification and Osteopathic Continuous Certification

Our AMA will:

1. Continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC, and prepare a yearly report to the House of Delegates regarding the MOC and OCC process.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOC and OCC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of MOC, and encourage the ABMS to report its research findings on the issues surrounding certification and MOC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and MOC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of MOC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.

6. Work with interested parties to ensure that MOC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that MOC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from MOC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting MOC and certifying examinations.
10. Encourage the ABMS to ensure that MOC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, particularly to ensure that MOC is specifically relevant to the physician's current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for MOC; (b) support ABMS member board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet MOC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether MOC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from MOC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping MOC and OCC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and MOC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of MOC.
18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant MOC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the MOC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the MOC process be required to participate in MOC.
22. Continue to participate in the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's MOC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the MOC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Maintenance of Certification.
28. Examine the activities that medical specialty organizations have underway to review alternative pathways for board recertification; and determine if there is a need to establish criteria and construct a tool to evaluate if alternative methods for board recertification are equivalent to established pathways.
29. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to

subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on maintenance of certification activities relevant to their practice.

30. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.

31. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.

32. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.

33. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.

34. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Maintenance of Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.

35. Increase its efforts to work with the insurance industry to ensure that maintenance of certification does not become a requirement for insurance panel participation.

REPORT OF REFERENCE COMMITTEE D

(1) RESOLUTION 407 - SNAP REFORM TO IMPROVE HEALTH AND COMBAT FOOD DESERTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 407 be adopted.

HOD ACTION: Resolution 407 adopted with a change in title.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the title of Resolution 407 be changed.

SNAP REFORM TO IMPROVE ACCESS TO HEALTHFUL FOODS

Resolution 407 asks that our American Medical Association request that the federal government support Supplemental Nutrition Assistance Program (SNAP) initiatives to: (1) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (2) harmonize SNAP food offerings with those of Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Your Reference Committee heard testimony in support of Resolution 407. Your Reference Committee also heard a concern that there is no universally accepted definition of “healthful foods”, and that increasing complexity in incentives might reduce the number of retailers accepting SNAP. However, given the important role of poor diet in obesity, diabetes, cardiovascular and other diseases, and data suggesting that SNAP recipients do not consistently purchase healthful foods, incentives are thought necessary to ensure that merchants frequented by SNAP recipients stock healthful foods and reduce the availability of unhealthful foods. Therefore, your Reference Committee recommends that Resolution 407 be adopted and that the title be changed to more accurately reflect the intent.

(2) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 3 - STRATEGIES TO REDUCE THE CONSUMPTION OF BEVERAGES WITH ADDED SWEETENERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the third Recommendation of Council on Science and Public Health Report 3 be amended by addition, to read as follows:

That our AMA encourage hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 3 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Science and Public Health Report 3 adopted as amended and the remainder of the report filed.

Council on Science and Public Health Report 3 reviews the evidence to support strategies to reduce the consumption of beverages with added sweeteners. It recommends that our AMA: (1) acknowledge the adverse health impacts of sugar-sweetened beverage (SSB) consumption, and support evidence-based strategies to reduce the consumption of SSBs, including but not limited to, excise taxes on SSBs, removing options to purchase SSBs in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption, and the use of plain packaging; (2) encourage continued research into strategies that may be effective in limiting SSB consumption, such as controlling portion sizes; limiting options to purchase or access SSBs in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs to children; and changes to the agricultural subsidies system; (3) encourage hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs; (4) encourage physicians to (a) counsel their patients about the health consequences of SSB consumption and replacing SSBs with healthier beverage choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage choices for students. That Policy H-150.933, “Taxes on Beverages with Added Sweeteners,” which encourages consumer education about SSBs, encourages SSB tax revenues to be used for obesity prevention, and advocates for continued research into the potentially adverse effects of consumption of non-calorically sweetened beverages, be reaffirmed. In addition, it recommends that Policy H-150.960, “Improving Nutritional Value of Snack Foods Available in Primary and Secondary Schools,” be amended by addition and deletion to read as follows:

H-150.960, Improving Nutritional Value of Snack Foods Available in Primary and Secondary Schools

The AMA supports the position that primary and secondary schools should follow federal nutrition standards that replace foods in vending machines and snack bars, ~~which that~~ are of low nutritional value and are high in fat, salt and/or sugar, including sugar-sweetened beverages, with healthier food and beverage choices ~~which that~~ contribute to the nutritional needs of the students.

Furthermore, that Policy H-150.944, “Combating Obesity and Health Disparities,” be amended by addition and deletion to read as follows:

H-150.944, Combating Obesity and Health Disparities

Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of ~~products~~ foods and beverages low in fat, added sugars, and cholesterol.

The Council was congratulated for its thoughtful review of strategies to reduce the consumption of beverages with added sweeteners. Testimony was mostly in favor of the report’s recommendations. Several amendments were proposed. Your Reference Committee felt that the amendments that related to healthy food were outside the scope of this report. A suggestion to eliminate free refills sounded promising; however, it is not supported by scientific evidence and implementation would be difficult. Your Reference Committee did agree that calorie counts should be visible for beverages sold in vending machines. Therefore, your Reference Committee recommends that the report’s recommendation be adopted as amended.

- (3) RESOLUTION 401 – USE OF PHRASE “GUN VIOLENCE MITIGATION”
IN LIEU OF “GUN CONTROL”

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the title of Policy H-145.991 be changed to read as follows:

H-145.991 ~~Gun Control~~ Waiting Periods for Firearm Purchases

The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country. Sub. Res. 34, I-89, Reaffirmed:

BOT Rep. 8, I-93, Reaffirmed: BOT Rep. 50, I-93, Reaffirmed: CSA Rep. 8, A-05, Reaffirmation A-07.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-145.999 be amended by deletion to read as follows:

H-145.999 Gun Regulation

Our AMA supports stricter enforcement of present federal and state ~~gun control~~ legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm. Sub. Res. 31, I-81, Reaffirmed: CLRPD Rep. F, I-91, Amended: BOT Rep. I-93-50, Reaffirmed: Res. 409, A-00, Reaffirmation A-07.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Policies H-145.991 and H-145.999 be adopted as amended in lieu of Resolution 401.

HOD ACTION: Policies H-145.991 and H-145.999 adopted as amended in lieu of Resolution 401.

Resolution 401 asks that our American Medical Association employ in all official AMA actions, policies and public statements, the phrase “gun violence mitigation” in lieu of “gun control” when referencing gun violence reduction laws/legislation and related initiatives.

Your Reference Committee heard testimony in support of this Resolution. Recent policies and public statements made by the AMA on this issue have not utilized the terms “gun control.” Your Reference Committee agreed that use of the term “gun violence mitigation” may not always be an appropriate substitute for “gun control,” particularly in discussions around firearm safety. While there was support in the hearing for the use of the term “gun violence prevention,” your Reference Committee did not feel it was helpful to require use of this term in all policies and public statements. Since policies that originated in the 1980s utilize the terms “gun control,” your Reference Committee felt that updating these policies to reflect modern terminology in lieu of Resolution 401 was warranted.

(4) RESOLUTION 402 - DESTIGMATIZING OBESITY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 402 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association ~~require~~ encourage the use of ~~patient-person~~-first language (patients with obesity, patients affected by obesity) in all discussions, resolutions and reports regarding obesity (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the fourth Resolve of Resolution 402 be deleted.

~~RESOLVED, That our AMA study other diseases and conditions that may benefit from patient first language, and report back with~~

~~recommendations on preferred language for these diseases and conditions. (Directive to Take Action)~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 402 be adopted as amended.

HOD ACTION: Resolution 402 adopted as amended with a change in title.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Policy H-440.902 Obesity as a Major Health Concern be amended by addition and deletion, to read as follows:

The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of ~~obese~~ patients with obesity; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat patients affected by obesity overweight and obese patients.

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that amended Policy H-440.902 be adopted as amended.

HOD ACTION: Policy H-440.902 adopted as amended.

RECOMMENDATION F:

Madam Speaker, your Reference Committee recommends that the title of Resolution 402 be changed.

PERSON-FIRST LANGUAGE FOR OBESITY

Resolution 402 asks that our American Medical Association: (1) require the use of patient-first language (patients with obesity, patients affected by obesity) in all discussions, resolutions and reports regarding obesity; (2) encourage the use of preferred terms in discussions, resolutions and reports regarding patients affected by obesity including weight and unhealthy weight, and discourage the use of stigmatizing terms including obese, morbidly obese, and fat; (3) educate health care providers on the importance of patient-first language for treating patients with obesity; equipping their health care facilities with proper sized furniture, medical equipment and gowns for patients with obesity; and having patients weighed respectfully; and (4) study other diseases and conditions that may benefit from patient-first language, and report back with recommendations on preferred language for these diseases and conditions.

Your Reference Committee heard testimony in support this Resolution and on the importance of using sensitive language with patients. It was noted that while the resolution states “patient-first,” the common vernacular is “person-first.” The Council on Science and Public Health testified that the AMA Manual of Style already encourages the use of person-first language. Your Reference Committee felt that having our AMA conduct a study on the issue would not be worthwhile. Your Reference Committee recommends adoption of Resolution 402 as amended, and that existing obesity policy be amended to incorporate person-first language.

(5) RESOLUTION 404 - SUPPORT FOR STANDARDIZED DIAGNOSIS AND TREATMENT OF HEPATITIS C VIRUS IN THE POPULATION OF INCARCERATED PERSONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that second Resolve of Resolution 404 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA advocate for the initiation of treatment for HCV when appropriate in all-incarcerated patients with the ~~disease~~ infection who are seeking treatment (New HOD Policy);

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-440.902 be adopted as amended.

HOD ACTION: Policy H-440.902 adopted as amended.

Resolution 404 asks that our American Medical Association: (1) support the implementation of routine screening for Hepatitis C virus (HCV) in prisons; (2) advocate for the initiation of treatment for HCV in all incarcerated patients with the disease and seeking treatment; and (3) support negotiation for affordable pricing for therapies to treat and cure HCV among correctional facility health care providers, correctional facility health care payors, and drug companies to maximize access to these disease-altering medications.

Your Reference Committee heard supportive testimony on the issue of treatment of patients with HCV in prisons. While testimony unanimously supported the screening of incarcerated patients and the need for affordable pricing for HCV treatment, some testimony illuminated that many factors can impact a patient’s ability to complete treatment while in prison (e.g., medical necessity, potential release date, patient refusal, unstable clinical conditions) as well as outside of prison upon release (e.g., access to care, cost, contraindications). Your Reference Committee is sensitive to the needs of this population and therefore recommends adoption of this resolution as amended.

(6) RESOLUTION 405 - DECREASING SCREEN TIME AND INCREASING OUTDOOR ACTIVITY TO OFFSET MYOPIA ONSET AND PROGRESSION IN SCHOOL CHILDREN

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 405.

HOD ACTION: The following resolution adopted in lieu of Resolution 405.

INCREASING OUTDOOR ACTIVITY TO PREVENT MYOPIA ONSET AND PROGRESSION IN SCHOOL CHILDREN

RESOLVED, That our American Medical Association support efforts to increase outdoor time and promote other activities that have been demonstrated to reduce the progression of myopia in children. (New HOD Policy)

Resolution 405 asks that our American Medical Association support the efforts of the American Academy of Pediatrics and American Academy of Ophthalmology to educate, promote public awareness, and promote guidelines to reduce the incidence and burdens of myopia to physicians, public health agencies and schools.

Your Reference Committee heard limited testimony in favor of increasing outdoor activity to prevent myopia onset and progression in school children. Testimony also indicated that there presently was no conclusive evidence linking screen time to myopia. It was also recommended that language related to specific medical societies be limited in the resolution. Your Reference Committee agrees and recommends adoption of this alternative language in lieu of 405.

(7) RESOLUTION 406 - HEALTHFUL HOSPITAL FOODS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 407 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association hereby call on US hospitals to improve the health of patients, staff, and visitors by (1) providing a variety of healthful food, including and promoting plant-based meals, and meals that are low in fat, sodium, and added sugars ~~for hospital patients, staff, and visitors,~~ and (2) eliminating ~~the use of~~ processed meats from ~~patient~~ menus, and (3) providing and promoting healthful beverages. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 406 be adopted as amended.

HOD ACTION: Resolution 406 adopted as amended.

Resolution 406 asks that our American Medical Association hereby call on U.S. hospitals to improve the health of patients, staff, and visitors by (1) providing and promoting plant-based meals that are low in fat, sodium, and added sugars for hospital patients, staff, and visitors and (2) eliminating the use of processed meats from patient menus.

Your Reference Committee heard testimony in support of this Resolution, which noted the importance of hospitals serving as models of wellness in the nourishment that they provide to all. While testimony noted specifics such as the different forms of protein in a healthy diet, the limitations of a plant-based diet for some people, and the value of lean meat versus processed meat, your Reference Committee decided to keep the resolution broad in order to strengthen the intent. Your Reference Committee recommends adoption of this resolution as amended.

(8) RESOLUTION 408 - INCREASED OVERSIGHT OF SUICIDE PREVENTION TRAINING FOR CORRECTIONAL FACILITY STAFF

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 408 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association strongly encourage all state and local adult and juvenile correctional facilities

to develop a suicide prevention plan that meets current National Commission on Correctional Health Care ~~guidelines~~ standards for accreditation (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 408 be amended by addition, to read as follows:

RESOLVED, That our AMA strongly encourage all state and local adult and juvenile correctional facility officers to undergo suicide prevention training annually. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 408 be adopted as amended.

HOD ACTION: Resolution 408 adopted as amended.

Resolution 408 asks that our American Medical Association: (1) strongly encourage all state and local correctional facilities to develop a suicide prevention plan that meets current National Commission on Correctional Health Care guidelines and (2) strongly encourage all state and local correctional facility officers to undergo suicide prevention training annually.

Your Reference Committee heard testimony unanimously supportive of Resolution 408. Testimony was also given in support of finding ways to improve access to mental health services in rural areas. An amendment was offered to specify that this policy should apply to both juvenile and adult facilities, your Reference Committee agrees. Given the high prevalence of suicide in correctional facilities, your Reference Committee supports the development of suicide prevention plans and officer training and thus recommends adoption as amended.

(9) RESOLUTION 410 - IMPROVING ACCESS TO DIRECT ACTING ANTIVIRALS FOR HEPATITIS C-INFECTED INDIVIDUALS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 410 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association amend current Policy H-440.845 by addition to read as follows:

H-440.845, Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment

Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) support ~~educational~~ programs aimed at training primary care providers in the treatment and management of patients infected with HCV; (4) (5) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between, the

government, insurance companies, and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; ~~and (5)~~ (6) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines; and (7) encourage equitable reimbursement for those providing treatment.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 410 be adopted as amended.

HOD ACTION: Resolution 410 adopted as amended.

Resolution 410 asks that our American Medical Association amend current Policy H-440.845 by addition to read as follows:

H-440.845, Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment
Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) support educational programs aimed at training primary care providers in the treatment and management of patients infected with HCV; ~~(4)~~ (5) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between, the government, insurance companies and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; ~~and (5)~~ (6) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines.

Your Reference Committee heard testimony in support of this resolution as well as the amendments offered. While some testimony noted concern regarding price negotiation, you Reference Committee felt that it should be handled separately. Your Reference Committee recommends adoption of this resolution with the incorporation of the amendments.

- (10) RESOLUTION 411 - PRESERVING VACCINE POLICY IN THE UNITED STATES
RESOLUTION 420 – EVIDENCED-BASED VACCINATION RECOMMENDATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the following Resolution be adopted in lieu of Resolutions 411 and 420.

HOD ACTION: The following Resolution adopted in lieu of Resolutions 411 and 420.

VACCINE SAFETY

RESOLVED, that our American Medical Association: (1) supports the rigorous scientific process of the Advisory Committee on Immunization Practices as well as its development of recommended immunization schedules for the nation, (2) recognizes the substantial body of scientific evidence that has disproven a link between vaccines and autism, and (3) opposes the creation of a new federal commission

on vaccine safety whose task is to study an association between autism and vaccines.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policies H-440.830 and H-440.875 be reaffirmed.

HOD ACTION: Policies H-440.830 and H-440.875 reaffirmed.

Resolution 411 asks that our American Medical Association: (1) support evidence that vaccines are an effective mechanism for controlling communicable disease and protecting public health; (2) continue to support vaccine guidance that is evidence-based; and (3) oppose the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines.

Resolution 420 asks that our American Medical Association: (1) supports the rigorous scientific process of the ACIP and, encourages education of parents and patients on the safety, risks, and benefits of vaccination and (2) shall support both national and state scientifically-based policies that promote the safety of vaccinations and effectively serve to increase the number of individuals vaccinated against communicable diseases.

Your Reference Committee heard testimony in support of both Resolutions 411 and 420. The AMA already has strong policy in support of vaccine safety and efficacy and this existing policy was utilized in developing the AMA's media statement in opposition to the reported creation of a federal commission on vaccine safety. Your Reference Committee believes it is beneficial to adopt policy in support of the ACIP and in opposition to the creation of a federal commission to study the association between autism and vaccines. Therefore, your Reference Committee recommends adopting this alternate language in lieu of Resolutions 411 and 420. Your Reference Committee also recommends reaffirming existing policy on vaccine safety.

H-440.830, Education and Public Awareness on Vaccine Safety and Efficacy

Our AMA (1) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (2) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (3) supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (4) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (5) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; and (6) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths.

H-440.875, Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines

1. It is AMA policy that all persons, regardless of economic and insurance status, receive all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as soon as possible following publication of these recommendations in the Centers for Disease Control and Prevention's (CDC) Morbidity and Mortality Weekly Report (MMWR). 2. Our AMA will continue to work with the federal government, Congress, and other stakeholders to improve liability protection for vaccine manufacturers and health care professionals who provide immunization services and to examine and improve compensation mechanisms for patients who were legitimately injured by a vaccine. 3. Our AMA will continue to work with the federal government, Congress, and other appropriate stakeholders to enhance public opinion of vaccines and to monitor and ensure the continued safety of existing and newly approved vaccines (including providing adequate resources for post-approval surveillance) so as to maintain and improve public confidence in the safety of vaccines. 4. Our AMA will work with appropriate stakeholders, including vaccine manufacturers, vaccine distributors, the federal government, medical specialty societies, and third

party payers, to guarantee a robust vaccine delivery infrastructure (including but not limited to, the research and development of new vaccines, the ability to track the real-time supply status of ACIP-recommended vaccines, and the timely distribution of ACIP-recommended vaccines to providers). 5. Our AMA will work with appropriate federal and state agencies and private sector entities to ensure that state Medicaid agencies and private insurance plans pay health care professionals at least the approved Relative Value Unit (RVU) administration Medicare rates for payment when they administer ACIP-recommended vaccines. 6. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to address barriers associated with Medicare recipients receiving live zoster vaccine and the routine boosters Td and Tdap in physicians' offices. 7. Our AMA will work through appropriate state entities to ensure all health insurance plans rapidly include newly ACIP-recommended vaccines in their list of covered benefits, and to pay health care professionals fairly for the purchase and administration of ACIP-recommended vaccines. 8. Our AMA will urge Medicare to include Tdap (Tetanus, Diphtheria, Acellular Pertussis) under Medicare Part B as a national public health measure to help prevent the spread of Pertussis. 9. Until compliance of AMA Policy H-440.875(6) is actualized to the AMA's satisfaction regarding the tetanus vaccine, our AMA will aggressively petition CMS to include tetanus and Tdap at both the "Welcome to Medicare" and Annual Medicare Wellness visits, and other clinically appropriate encounters, as additional "triggering event codes" (using the AT or another modifier) that allow for coverage and payment of vaccines to Medicare recipients. 10. Our AMA will aggressively petition CMS to include coverage and payment for any vaccinations administered to Medicare patients that are recommended by the ACIP, the US Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical health guidelines.

(11) RESOLUTION 412 - DOMESTIC WATER TESTING FOR LEAD TOXIC KIDS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following Resolution be adopted in lieu of Resolution 412.

HOD ACTION: The following Resolution adopted in lieu of Resolution 412.

ENVIRONMENTAL ASSESSMENTS FOR CHILDREN WITH ELEVATED BLOOD LEAD LEVELS

RESOLVED, That our American Medical Association supports requiring an environmental assessment of dwellings, residential buildings, or child care facilities following the notification that a child occupant or frequent inhabitant has a confirmed elevated blood lead level, to determine the potential source of lead poisoning, including testing the water supply. (New HOD Policy)

Resolution 412 asks that our American Medical Association advocate for the health of children via modification of current U.S. health law to include mandatory domestic water lead testing for proven cases of lead poisoning.

Your Reference Committee heard testimony largely in support of this resolution. The Council on Science and Public Health testified that there are multiple possible sources of lead poisoning, and that mandating the testing of water may not identify the source. There was broad support for the language offered by the Council. Your Reference Committee also agrees with the Council's recommendation to require that a complete environmental assessment be conducted on dwellings or child care facilities when a child is determined to have an elevated blood lead level to determine any potential source of lead.

(12) RESOLUTION 413 - OCULAR BURNS FROM LIQUID LAUNDRY PACKETS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 413 be amended by addition to read as follows:

RESOLVED, That our American Medical Association encourage the Consumer Product Safety Commission in conjunction with the American Association of Poison Control Centers to study the impact of “F3159-15 - Consumer Safety Specification for Liquid Laundry Packets” to ensure that the voluntary ASTM standard adequately protects children from injury, including eye injury. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 413 be adopted as amended.

HOD ACTION: Resolution 413 adopted as amended.

Resolution 413 asks that our American Medical Association study the impact of “F3159-15 - Consumer Safety Specification for Liquid Laundry Packets” to ensure that the voluntary ASTM standard adequately protects children from injury, including eye injury.

Limited testimony was heard in support of this Resolution. The Council on Science and Public Health testified that obtaining the data to complete this study would be difficult and suggested that the Consumer Product Safety Commission and the American Association of Poison Control Centers would be better suited to study this issue. Your Reference Committee agrees with the Council that the study would best be accomplished by another organization and recommends this resolution be adopted as amended.

(13) RESOLUTION 414 – IMPOSING TAXES ON SUGAR-SWEETENED BEVERAGES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 414 be amended by deletion of the first Resolve.

~~RESOLVED, That our American Medical Association endorse the efforts of states, counties, and cities that seek to impose sugary beverage taxes to reduce obesity and the attendant risks of chronic disease (Directive to Take Action); and be it further~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 414 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA will: (1) encourage state and local medical societies to support the adoption of state and local excise taxes on sugar-sweetened beverages, with the investment of the resulting revenue in public health programs to combat obesity soft drinks and (2)

assist state and local medical societies in advocating for excise taxes on sugar-sweetened beverages as requested. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 414 be adopted as amended.

HOD ACTION: Resolution 414 adopted as amended with a change in title.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the title of Resolution 414 be changed, to read as follows:

SUPPORTING TAXES ON SUGAR-SWEETENED BEVERAGES

Resolution 414 asks that our American Medical Association: (1) endorse the efforts of states, counties, and cities who seek to impose sugary beverage taxes to reduce obesity and the attendant risks of chronic disease and (2) encourage state and local medical societies to support the adoption of state and local taxes on sugar-sweetened soft drinks.

Limited testimony was heard in support of this resolution. Questions were raised as to whether it was appropriate for the AMA to endorse the efforts of state and local medical societies seeking to impose taxes on sugar-sweetened beverages. It was also suggested that the revenue raised by these taxes be invested in public health programs to combat obesity. Your Reference Committee agreed with these concerns and recommends amending this resolution to encourage our AMA to assist states seeking to adopt excise taxes on sugar-sweetened beverages. The word “excise” was added for consistency with the Council’s review of the evidence on this issue. Therefore, Your Reference Committee recommends that Resolution 414 be adopted as amended.

(14) RESOLUTION 415 - FOOD BANK AND PANTRY DISTRIBUTION OF NUTRIENT-DENSE FOODS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy H-150.930 be amended by addition and deletion, to read as follows:

H-150.930 National Nutritional Guidelines for Food Banks and Pantries

Our AMA: (1) supports the use of existing national nutritional guidelines for food banks and food pantries and (2) will promote sustainable sourcing of healthier food options and the dissemination of user-friendly resources and education on healthier eating for food banks and food pantries.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-150.930 be adopted as amended in lieu of Resolution 415.

HOD ACTION: Policy H-150.930 adopted as amended in lieu of Resolution 415.

Resolution 415 asks that our American Medical Association advocate for programs that incentivize and provide resources for food banks and pantries to design and institute translatable nutrient-driven food distribution

methodologies, initiatives that promote sustainable sourcing of healthier food options, and dissemination of user-friendly resources and education on healthier eating.

Testimony was limited but supportive for this Resolution. Existing policy already addresses nutrition guidelines for food banks and food pantries. Since these are voluntary programs, there was some concern expressed that limiting donations to healthy items may reduce food available to those in need. However, your Reference Committee agrees with the need to promote sustainable sourcing of healthier food and disseminate resources on healthier eating. Therefore, your Reference Committee recommends adoption of amended Policy H-150.930 in lieu of Resolution 415.

(15) RESOLUTION 418 - POLICY ON QUARANTINE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 418.

HOD ACTION: The following resolution adopted in lieu of Resolution 418.

DUE PROCESS FOR CDC IMPOSED QUARANTINES

RESOLVED, That the American Medical Association seek changes to federal quarantine law to ensure the availability of an expedited judicial review of all CDC-imposed quarantines.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policies H-440.835 and E- 8.4 be reaffirmed.

HOD ACTION: Policies H-440.835 and E- 8.4 reaffirmed.

Resolution 419 asks that our American Medical Association: (1) adopt policy acknowledging that government quarantines are developed based on evidence-based medicine and have strong due process protections and (2) support that the medical profession collaborate with federal, state and local public health officials to take an active role in ensuring that quarantine and isolation interventions are evidence based.

Your Reference Committee heard testimony in support of the intent of this resolution. However, it was noted that the resolution as written is current policy. The authors suggested the addition of a third Resolve, which addresses the due process provisions within the CDC's new quarantine regulations. Your Reference Committee agrees with need for strengthened due process provisions within these regulations. Therefore, Your Reference Committee recommends this language be adopted in lieu of Resolution 418 and that existing policy be reaffirmed.

H-440.835, AMA Role in Addressing Epidemics and Pandemics

1. Our AMA strongly supports U.S. and global efforts to fight epidemics and pandemics, including Ebola, and the need for improved public health infrastructure and surveillance in affected countries.; 2. Our AMA strongly supports those responding to the Ebola epidemic and other epidemics and pandemics in affected countries, including all health care workers and volunteers, U.S. Public Health Service and U.S. military members.; 3. Our AMA reaffirms Ethics Policy E-2.25, The Use of Quarantine and Isolation as Public Health Interventions, which states that the medical profession should collaborate with public health colleagues to take an active role in ensuring that quarantine and isolation interventions are based on science.; 4. Our AMA will collaborate in the development of recommendations and guidelines for medical professionals on appropriate treatment of patients infected with or potentially infected with Ebola, and widely disseminate such guidelines through its communication channels.; 5. Our AMA will continue to be a trusted source of information and education for physicians, health professionals and the public on urgent epidemics or pandemics affecting the U.S. population, such as Ebola.; 6. Our AMA encourages relevant

specialty societies to educate their members on specialty-specific issues relevant to new and emerging epidemics and pandemics. Sub. Res. 925, I-14.

E- 8.4, Ethical Use of Quarantine & Isolation

Although physicians' primary ethical obligation is to their individual patients, they also have a long recognized public health responsibility. In the context of infectious disease, this may include the use of quarantine and isolation to reduce the transmission of disease and protect the health of the public. In such situations, physicians have a further responsibility to protect their own health to ensure that they remain able to provide care. These responsibilities potentially conflict with patients' rights of self-determination and with physicians' duty to advocate for the best interests of individual patients and to provide care in emergencies.

With respect to the use of quarantine and isolation as public health interventions in situations of epidemic disease, individual physicians should: (a) Participate in implementing scientifically and ethically sound quarantine and isolation measures in keeping with the duty to provide care in epidemics. (b) Educate patients and the public about the nature of the public health threat, potential harm to others, and benefits of quarantine and isolation. (c) Encourage patients to adhere voluntarily to quarantine and isolation. (d) Support mandatory quarantine and isolation when a patient fails to adhere voluntarily. (e) Inform patients about and comply with mandatory public health reporting requirements. (f) Take appropriate protective and preventive measures to minimize transmission of infectious disease from physician to patient, including accepting immunization for vaccine-preventable disease, in keeping with ethics guidance. (g) Seek medical evaluation and treatment if they suspect themselves to be infected, including adhering to mandated public health measures.

The medical profession, in collaboration with public health colleagues and civil authorities, has an ethical responsibility to: (h) Ensure that quarantine measures are ethically and scientifically sound: (i) use the least restrictive means available to control disease in the community while protecting individual rights; (ii) without bias against any class or category of patients. (i) Advocate for the highest possible level of confidentiality when personal health information is transmitted in the context of public health reporting. (j) Advocate for access to public health services to ensure timely detection of risks and implementation of public health interventions, including quarantine and isolation. (k) Advocate for protective and preventive measures for physicians and others caring for patients with communicable disease. (l) Develop educational materials and programs about quarantine and isolation as public health interventions for patients and the public. *AMA Principles of Medical Ethics: I,III,VI,VII,VIII*

(16) RESOLUTION 419 – IMPROVING PHYSICIANS' ABILITY TO DISCUSS FIREARM SAFETY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 419 be amended by deletion, to read as follows:

RESOLVED, That our American Medical Association work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related ~~accidental~~ injury or death ~~by suicide~~, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 419 be adopted as amended.

HOD ACTION: Resolution 419 adopted as amended.

Resolution 419 asks that our American Medical Association work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related accidental injury or death by suicide, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.

Testimony was supportive of this resolution. Your Reference Committee amended the resolution to broaden it beyond just accidental injury or suicide. It was noted that the AMA has existing policy opposing restrictions on physicians' ability to inquire and talk about firearm safety issues and risks with their patients. The Council on Science and Public Health acknowledged this resolution and noted that a report is forthcoming on the physician's role in promoting firearm safety. Your Reference Committee recommends adoption of this resolution as amended and looks forward to the CSAPH report.

(17) RESOLUTION 416 - POLICY AND ECONOMIC SUPPORT FOR EARLY CHILD CARE**RECOMMENDATION:**

Madam Speaker, your Reference Committee recommends that Resolution 416 be referred.

HOD ACTION: Resolution 416 referred.

Resolution 416 asks that our American Medical Association advocate for: (1) improved social and economic support for paid family leave to care for newborns, infants and young children and (2) federal tax incentives to support early child care and unpaid child care by extended family members.

Your Reference Committee heard testimony in favor of family leave. Testimony also noted concern regarding the economic burden it could place on small business owners. Given the nuances and sensitive nature of this topic, your Reference Committee recommends that this Resolution be referred for study in order to better inform this House of Delegates.

(18) RESOLUTION 409 - PEDIATRIC/ADOLESCENT INFORMED CONSENT CONCUSSION DISCUSSION**RECOMMENDATION:**

Madam Speaker, your Reference Committee recommends that Resolution 409 be referred for decision.

HOD ACTION: Resolution 409 referred for decision.

Resolution 409 asks that our American Medical Association support federal legislation that includes informed consent prior to participation in intramural and interscholastic athletics and that this consent discuss the risk of short and long term impact of mild traumatic brain injuries.

Your Reference Committee heard testimony both in support of and in opposition to this resolution. Those in favor of the resolution agreed that informed consent would be helpful, but raised questions about who would give consent, and the effect on liability. While some wanted education to be available for parents and children, some requested evidence-based, accurate, medically sound information. The development of model state legislation was proposed and should be considered. There was testimony in favor of referral for decision; therefore, your Reference Committee recommends that Resolution 409 be referred for decision so that these questions can be considered.

(19) RESOLUTION 417 - MANDATORY PUBLIC HEALTH REPORTING OF LAW-ENFORCEMENT-RELATED INJURIES AND DEATH

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 417 be referred for decision.

HOD ACTION: Resolution 417 referred.

Resolution 417 asks that our American Medical Association encourage the CDC and state departments of health to collect data on serious law-enforcement-related injuries and deaths and make law-enforcement-related deaths a notifiable condition.

Your Reference Committee heard mixed testimony on this issue. It was noted that some data is collected on this issue through the National Violent Death Reporting System. However, there was confusion regarding what exactly would be reported. Specifically, questions were raised regarding the definition of “serious.” Furthermore, the resolution conflates mandatory reporting, which is a state function, with nationally notifiable conditions, which is a voluntary process led by the CDC and the Council on State and Territorial Epidemiologists. Given these issues, your Reference Committee recommends that Resolution 417 be referred for decision.

(20) RESOLUTION 403 - TOBACCO HARM REDUCTION: A COMPREHENSIVE NICOTINE POLICY TO REDUCE DEATH AND DISEASE CAUSED BY SMOKING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-495.972 and H-495.973 be reaffirmed in lieu of Resolution 403.

HOD ACTION: Resolution 403 referred.

Resolution 403 asks that our American Medical Association: (1) advocate for tobacco harm reduction approaches to be added to existing tobacco treatment and control efforts; (2) educate physicians and patients on the myriad health effects of different nicotine products and emphasize the critical role of smoke and combustion in causing disease; (3) encourage physicians to adopt patient-specific, individualized approaches to smoking cessation, particularly for patients with disease secondary to smoking and for patients who have otherwise failed traditional methods for smoking cessation; (4) continue its focus on research to identify and expand options that may assist patients to transition away from smoking, including nicotine replacement therapies and noncombustible nicotine products (including e-cigarettes); and (5) reaffirm its position on strong enforcement of US Food and Drug Administration and other agency regulations for the prevention of use of all electronic nicotine delivery systems and tobacco products by anyone under the legal minimum purchase age. This shall include marketing to children, direct use or purchasing by children and indirect diversion to children. Further, that our AMA reaffirm physician education of patients to limit these products for children in any and all capacity.

Testimony was heard both in support of and opposition to this resolution. It was noted that several Resolve statements are contradictory to existing AMA policy that promotes the use of FDA-approved smoking cessation tools and prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until credible evidence is available. However, there was support for the fourth and fifth Resolves, which call for additional research to expand options for cessation and prohibit the marketing of electronic nicotine delivery system and tobacco products to children, respectively. Since these issues are already addressed by existing AMA policy, your Reference Committee recommends reaffirming existing policies in lieu of Resolution 403.

H-495.972, Electronic Cigarettes, Vaping, and Health: 2014 Update

1. Our AMA urges physicians to: (a) educate themselves about electronic nicotine delivery systems (ENDS), including e-cigarettes, be prepared to counsel patients about the use of these products and the potential for nicotine addiction and the potential hazards of dual use with conventional cigarettes, and be

sensitive to the possibility that when patients ask about e-cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical interviews to inquire about "vaping" or the use of e-cigarettes; (c) promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers; and (d) advise patients who use e-cigarettes to take measures to assure the safety of children in the home who could be exposed to risks of nicotine overdose via ingestion of replacement e-cigarette liquid that is capped or stored improperly. 2. Our AMA encourages further clinical and epidemiological research on e-cigarettes. 3. Our AMA supports education of the public on electronic nicotine delivery systems (ENDS) including e-cigarettes. CSAPH Rep. 2, I-14, Modified in lieu of Res. 412, A-15, Modified in lieu of Res. 419, A-15, Reaffirmed: Res. 421, A-15.

H-495.973, FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products

Our AMA: (1) supports the U.S. Food and Drug Administration's (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act, as amended by the Family Smoking Prevention and Tobacco Control Act; and (2) supports legislation and/or regulation of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that: (a) establishes a minimum legal purchasing age of 18; (b) prohibits use in all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health care is delivered; (c) applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople; (d) prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA; (e) requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on containers of replacement fluids (e-liquids) used in e-cigarettes; (f) establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use; (g) requires transparency and disclosure concerning product design, contents, and emissions; and (h) prohibits the use of characterizing flavors that may enhance the appeal of such products to youth. Res. 206, I-13, Modified in lieu of Res. 511, A-14, Modified in lieu of Res. 518, A-14, Modified in lieu of Res. 519, A-14, Modified in lieu of Res. 521, A-14, Modified: CSAPH Rep. 2, I-14, Reaffirmation A-15 Reaffirmed in lieu of Res. 412, A-15, Reaffirmed in lieu of Res. 419, A-15, Reaffirmed: Res. 421, A-15, Reaffirmation A-16.

REPORT OF REFERENCE COMMITTEE E

- (1) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 1 – CSAPH
SUNSET REVIEW OF 2007 HOUSE POLICIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Science and Public Health Report 1 adopted and the remainder of the report filed.

Council on Science and Health Report 1 presents the Council's recommendations on the disposition of the House policies and directives from 2007 that were assigned to it. The report recommends that House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of the Report be filed.

The Council introduced its Sunset report, and no other testimony was heard. Your Reference Committee therefore recommends adoption.

- (2) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 2 – EMERGING
DRUGS OF ABUSE ARE A PUBLIC HEALTH THREAT

RESOLUTION 507 – EDUCATING PHYSICIANS AND YOUNG ADULTS
ON SYNTHETIC DRUGS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 2 be adopted in lieu of Resolution 507 and the remainder of the report be filed.

HOD ACTION: Council on Science and Public Health Report 2 adopted in lieu of Resolution 507 and the remainder of the report filed.

Council on Science and Public Health Report 2 was initiated to bring attention to the public health issue of emerging drugs of abuse known as new psychoactive substances (NPS). The frequent emergence of NPS with unknown dangers and a potentially high death toll, especially NPS opioids, is a distinct challenge that will require a concerted and coordinated effort and response to mitigate risks to the public health and improve outcomes. The Council on Science and Public Health recommends that the following be adopted and the remainder of the report be filed:

1. That Policy H-95.940, "Addressing Emerging Trends in Illicit Drug Use," be amended by addition and deletion as follows:

Addressing Emerging Trends in Illicit Drug Use

Our AMA: (1) recognizes that emerging drugs of abuse, especially new psychoactive substances (NPS), are a public health threat;

~~(1)~~(2) supports ongoing efforts of the National Institute on Drug Abuse, the Drug Enforcement Administration, the Centers for Disease Control and Prevention, the Department of Justice, the Department of Homeland Security, state departments of health, and poison control centers to assess and monitor emerging trends in illicit drug use, and to develop and disseminate fact sheets, ~~and~~ other educational materials, and public awareness campaigns;

(3) supports a collaborative, multiagency approach to addressing emerging drugs of abuse, including information and data sharing, increased epidemiological surveillance, early warning systems informed by laboratories and epidemiologic surveillance tools, and population driven real-time social media resulting in actionable information to reach stakeholders;

(4) encourages adequate federal and state funding of agencies tasked with addressing the emerging drugs of abuse health threat;

~~(2)~~ (5) encourages the development of continuing medical education on emerging trends in illicit drug use; and ~~(3)~~

(6) supports efforts by the federal, state, and local government agencies to identify new drugs of abuse and to institute the necessary administrative or legislative actions to deem such drugs illegal in an expedited manner. (Modify Current HOD policy)

2. That our AMA participate as a stakeholder in a CDC/DEA taskforce for the development of a national forum for discussion of NPS-related issues. (Directive to Take Action)

Resolution 507 asks that our AMA amend existing AMA policy H-95.940 by addition to read as follows:

Addressing Emerging Trends in Illicit Drug Use H-95.940

Our AMA: (1) supports ongoing efforts of the National Institute on Drug Abuse, the Drug Enforcement Administration, and poison control centers to assess and monitor emerging trends in illicit and legal synthetic drug use, and to develop and disseminate fact sheets and other educational materials; (2) encourages the development of continuing medical education on emerging trends in illicit and legal synthetic drug use; and (3) supports efforts by the federal government to identify new drugs of abuse and to institute the necessary administrative or legislative actions to deem such drugs illegal in an expedited manner.

Testimony was overwhelmingly supportive of the Council's report and recommendations. The Council was thanked for their effort and comments noted the timeliness of the topic and need for physicians to be more involved in addressing the emerging drug abuse problems facing the public and agreed that NPS are a threat to public health. The multidisciplinary efforts recommended in the report were strongly supported as a viable approach to ensuring the safety of patients. The sponsors of Resolution 507 thanked the Council for its excellent report. Your Reference Committee believes that the report recommendations address the intent of Resolution 507 and therefore recommends adoption of CSAPH Report 2 in lieu of Resolution 507.

(3) RESOLUTION 511 – FUTURE OF PAIN CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 511 be adopted.

HOD ACTION: Resolution 511 adopted.

Resolution 511 asks that 1) our AMA convene a task force from organized medicine to discuss medicine's response to the public health crisis of undertreated and mistreated pain; 2) this task force explore and make recommendations for augmenting medical education designed to educate healthcare providers on how to help patients suffering from pain with evidence-based treatment options; 3) this task force discuss strategies that may prevent or mitigate acute pain, educate physicians about these strategies, and suggest research to study if these strategies prevent the development of chronic pain; and 4) this task force involve many primary care, medical and surgical specialties that are involved in providing pain care.

Extensive supportive testimony was offered on this resolution. Creation of the AMA Opioid Task was noted. The Task Force is working to reduce opioid-related harm, promote evidence-based pain management practices and policies, reduce stigma, and increase access to treatment for opioid use disorder. Testimony highlighted the need for

efforts to improve education on pain management, as well as training and payment reforms to increase access to non-pharmacologic and multimodal strategies for pain management. Your Reference Committee strongly supports the intent of this resolution and recommends adoption with the understanding that, as an AMA-convened Federation-based effort, additional decision-making will be needed on how to best implement a coordinated approach.

(4) RESOLUTION 523 – AMA SUPPORT FOR EVIDENCE-BASED ENVIRONMENTAL STATUTES AND REGULATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 523 be adopted.

HOD ACTION: Resolution 523 adopted.

Resolution 523 asks that our AMA 1) strongly support evidence-based environmental statutes and regulations intended to regulate air and water pollution and to reduce greenhouse gas emissions and 2) advocate that environmental health regulations should only be modified or rescinded with scientific justification.

Supportive testimony was offered for Resolution 523, with limited dissent. The importance of science and evidence-based rules and regulations intended to reduce pollution and benefit public health is keenly apparent and your Reference Committee recommends adoption.

(5) RESOLUTION 503 – WOMEN AND MENTAL HEALTH

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the following Resolve be adopted in lieu of the first Resolve of Resolution 503.

RESOLVED, That Policy D-345.997 be amended by addition to read as follows:

D-345.997 Access to Mental Health Services

Our AMA will: (1) continue to work with relevant national medical specialty societies and other professional and patient advocacy groups to identify and eliminate barriers to access to treatment for mental illness, including barriers that disproportionately affect women and at-risk populations; (2) advocate that psychiatrists and other physicians who provide treatment for mental illness be paid by both private and public payers for the provision of evaluation and management services, for case management and coordination efforts, and for interpretive and indirect services; and (3) advocate that all insurance entities facilitate direct access to a psychiatrist in the referral process.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 503 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~publicize~~ recognize the impact of violence and social determinants on women's mental health (New HOD Policy); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Policy H-345.981 be reaffirmed in lieu of the third Resolve of Resolution 503.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the fourth Resolve of Resolution 503 be amended by addition to read as follows:

RESOLVED, That AMA Policy H-420.953 “Improving Mental Health Services for Pregnant and Postpartum Mothers,” be amended by addition to read as follows:

H-420.953, Improving Mental Health Services for Pregnant and Postpartum Mothers

Our AMA: 1. supports improvements in current mental health services for women during pregnancy and postpartum; 2. supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; 3. supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and 4. will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs. (Modify Current HOD Policy)

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 503 be adopted as amended.

HOD ACTION: Resolution 503 adopted as amended.

Resolution 503 asks that our AMA 1) encourage key organizations to identify barriers in access to mental health services and improve treatment models in order to address gender disparities in mental health; 2) publicize the impact of violence and social determinants on women’s mental health; 3) encourage the development of gender-specific risk factor reduction strategies, including gender sensitive services that focus on psychosocial resources and reproductive health, in order to improve women’s mental health; and 4) amend AMA Policy H-420.953 “Improving Mental Health Services for Pregnant and Postpartum Mothers” by addition to read as follows:

H-420.953, Improving Mental Health Services for Pregnant and Postpartum Mothers

Our AMA: 1. supports improvements in current mental health services for women during pregnancy and postpartum; 2. supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; 3. supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and 4. will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis through research, public awareness, and support programs.

Testimony noted that women are affected by mental health disorders differently than men. The Council on Science and Public Health studied sex differences in health and disease in an A-16 report, including mental health disorders. Women show higher prevalence rates of major and mild depression, generalized anxiety disorder, panic disorder, social phobia, and specific phobia than do men, and nearly twice as many women report experiencing a major depressive episode in the past year than men. Your Reference Committee notes that extensive policy addresses the diagnosis and treatment of mental health, and suggests that these policies be amended to include women and those at

risk, such as incarcerated women, and reaffirmed as appropriate. In addition, your Reference Committee supports recognizing, rather than publicizing, that violence and social determinants are factors affecting mental health in women, since that will result in a more long-standing foundational policy rather than a one-time action. Testimony supported the addition of substance use disorder to the conditions being added to Resolve 4.

Policy recommended for reaffirmation:

H-345.981, Access to Mental Health Services

Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness: (1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public; (2) improving public awareness of effective treatment for mental illness; (3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents; (4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity; (5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and (6) reducing financial barriers to treatment. (CMS Rep. 9, A-01 Reaffirmation A-11 Reaffirmed: CMS Rep. 7, A-11 Reaffirmed: BOT action in response to referred for decision Res. 403, A-12 Reaffirmed in lieu of Res. 804, I-13 Reaffirmed in lieu of Res. 808, I-14)

(6) RESOLUTION 504 – RESEARCH INTO PRETERM BIRTH AND RELATED CARDIOVASCULAR (CV) AND CEREBROVASCULAR RISKS (CVD) IN WOMEN

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 504 be amended by deletion of the first Resolve.

~~RESOLVED, That our American Medical Association work with partner organizations to provide education on the potential risks of cardiovascular or cerebrovascular disease in pregnant woman, particularly among vulnerable population. (Directive to Take Action); and be it further~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 504 be amended by addition and deletion to read as follows:

~~RESOLVED, That our AMA advocate for more research on ways to identify modifiable risk factors for linking preterm birth (PTB) and its association with~~ to cardiovascular or cerebrovascular disease in pregnant women. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 504 be adopted as amended.

HOD ACTION: Resolution 504 adopted as amended.

Resolution 504 asks that our AMA 1) work with partner organizations to provide education on the potential risks of cardiovascular or cerebrovascular disease in pregnant women, particularly among vulnerable populations; and 2) advocate for more research on ways to identify modifiable risk factors for preterm birth (PTB) and its association with cardiovascular or cerebrovascular disease in pregnant women.

Your Reference Committee heard testimony detailing the increase in risk for heart disease and cerebrovascular disease among women who have experienced preterm birth. Testimony noted support for the issue, but your Reference Committee recognized that more research is needed on the issue and that the development of evidence-based educational materials with partner organizations is dependent on this research. It therefore recommends supporting research as a first step before providing education.

(7) RESOLUTION 506 – EXPANDING ACCESS TO BUPRENORPHINE FOR THE TREATMENT OF OPIOID USE DISORDER

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 506 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association's Opioid Task Force publicize existing resources that provide advice on overcoming study solutions to overcome the barriers and implementing solutions for preventing appropriately trained physicians from prescribing buprenorphine for treatment of Opioid Use Disorder. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 506 be amended by addition of a new Resolve to read as follows:

RESOLVED, That our AMA supports eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 506 be adopted as amended.

HOD ACTION: Recommendation A of Resolution 506 adopted as amended, Recommendation B of Resolution 506 referred for decision.

Resolution 506 asks that our AMA study solutions to overcome the barriers preventing appropriately trained physicians from prescribing buprenorphine for treatment of Opioid Use Disorder.

Testimony indicated that although some success has been achieved in increasing the number of physicians who have become certified to prescribe office-based buprenorphine for the treatment of opioid use disorder, a significant number of waived physicians are not providing treatment due to various barriers, even though caps on the number of patients to whom one physician may prescribe have been increased. A recent systematic review by the Agency for Healthcare Research and Quality (Technical Brief Number 28) described promising and innovative medication-assisted therapy (MAT) models of care in primary care settings, the barriers to MAT implementation, available evidence on MAT models of care in primary care settings, gaps in the evidence base, and guidance for future research. A summary of the findings of this report was published (Korthuis et al, *Ann Intern Med.* 2017). Accordingly, your Reference Committee believes that further study is not required. Rather, steps should be taken to implement proposed solutions. The AMA can assist in this effort by making such resources more widely available through the new microsite established for the AMA Opioid Task Force. One obvious barrier is the requirement for special training, record keeping and federal oversight to prescribe buprenorphine for opioid use disorder. Strong sentiment also was expressed for including the waiver requirement in any study that might be undertaken, or rescinding it altogether. Your Reference Committee agrees with eliminating this requirement that reduces access to treatment.

- (8) RESOLUTION 513 – SUPERVISED INJECTION FACILITIES
RESOLUTION 524 – SUPERVISED INJECTION FACILITIES AS HARM
REDUCTION TO ADDRESS OPIOID CRISIS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following Resolution be adopted in lieu of Resolutions 513 and 524.

HOD ACTION: The following Resolution adopted in lieu of Resolutions 513 and 524.

PILOT IMPLEMENTATION OF SUPERVISED INJECTION FACILITIES

RESOLVED, That our American Medical Association support the development and implementation of pilot supervised injection facilities (SIFs) in the United States that are designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug use.

Resolution 513 asks that our American Medical Association conduct a comprehensive study of Supervised Injection Facilities in the United States.

Resolution 524 asks that our American Medical Association work with state and local health departments to achieve the legalization and implementation of facilities that provide a supervised framework and enhanced aseptic conditions for the injection of self-provided illegal substances with medical monitoring, with legal and liability protections for persons working or volunteering in such facilities and without risk of criminal penalties for recipients of such services.

Testimony supported the establishment of supervised injection facilities (SIFs) in the U.S. because studies from other countries have shown that SIFs reduce infection, prevent overdose deaths, and increase treatment uptake without increasing drug trafficking or crime in the surrounding environments. U.S. cities, including San Francisco, Seattle, and New York City, are considering the establishment of SIFs. Others testified that while the results in other countries were promising, the differences in culture and regulatory oversight between the U.S. and other countries may mean that SIF outcomes could be different in the U.S. Some suggested that the AMA study these potential differences. The Massachusetts Medical Society recently completed a comprehensive study of the literature on SIFs and other implementation aspects that could apply in the U.S. The report recommended that pilot SIFs be supported. Testimony also noted that The American Society of Addiction Medicine is considering supporting well-designed pilot SIFs that could help evaluate their potential benefits in the U.S. The Council on Science and Public Health proposed alternate language that the AMA support pilot SIFs so that data on their effectiveness as a harm reduction and cost-savings measure in the U.S. can be collected and evaluated. Your Reference Committee believes that this is a reasonable approach and recommends adoption of this alternate language.

- (9) RESOLUTION 515 – SAFE USE, STORAGE AND DISPOSAL OF
LEFTOVER OPIOIDS AND OTHER CONTROLLED SUBSTANCES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 515 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association and its Opioid Task Force ~~to Reduce Opioid Abuse~~ continue to adapt current educational materials to distribute to prescribers and patients, emphasizing the importance of safe storage and disposal of opioids, and encouraging prescribers and patients to investigate and advocate for more local drug take back programs (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 515 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA and its Opioid Task Force ~~to Reduce Opioid Abuse~~ encourage all prescribers to work with local organizations and pharmacists to develop and disseminate the most up-to-date information on local Take Back resources ~~and the most up-to-date information~~ (New HOD Policy); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 515 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA and its Opioid Task Force ~~to Reduce Opioid Abuse~~ continue to educate all prescribers on the importance of optimal use of opioids, including appropriately limiting the quantities of opioid prescriptions and advocating for e-prescription capabilities for controlled substances.
(Directive to Take Action)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 515 be adopted as amended.

HOD ACTION: Resolution 515 adopted as amended.

Resolution 515 asks that our AMA and its Task Force to Reduce Opioid Abuse 1) continue to adapt current educational materials to distribute to prescribers and patients, emphasizing the importance of safe storage and disposal of opioids, and encouraging prescribers and patients to investigate and advocate for more local drug take back programs; 2) encourage all prescribers to work with local organizations and pharmacists to develop and disseminate information on local Take Back resources and the most up to date information; and 3) continue to educate all prescribers on the importance of optimal use of opioids, including appropriately limiting the quantities of opioid prescriptions and advocating for e-prescription capabilities for controlled substances.

Testimony was universally supportive of the importance of this Resolution. The AMA Opioid Task Force has already developed and adopted a statement on safe storage and disposal that is consistent with the asks of this Resolution, therefore your Reference Committee recommends adoption with amendments to reflect the recent name change of the Task Force.

(10) RESOLUTION 517 – CHOLINE SUPPLEMENTATION IN PRENATAL VITAMINS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 517 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support ~~and advocate for an increase~~ evidence-based amounts of choline in all prenatal vitamins ~~to 450 mg/day~~. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 517 be adopted as amended.

HOD ACTION: Resolution 517 adopted as amended.

Resolution 517 asks that our AMA support and advocate for an increase of choline in all prenatal vitamins to 450 mg/day.

There was limited but supportive testimony for this resolution. The different guidance for choline intake during pregnancy and breastfeeding was noted, and an even higher amount is recommended during lactation. Your Reference Committee recognizes the importance of choline, but believes that including a specific daily amount in AMA policy would be inappropriate given the lack of clear evidence. It therefore recommends language supporting the inclusion of an evidence-based amount of choline in prenatal vitamins without specifying a target amount.

(11) RESOLUTION 518 – RECOGNITION OF INFERTILITY AS A DISEASE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 518 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~recognize~~ support the World Health Organization’s designation of infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and prevention (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 518 be amended by deletion of the second Resolve.

~~RESOLVED, That our AMA strongly advocate for greater access to established fertility treatments inclusive of broader insurance coverage. (Directive to Take Action)~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 518 be adopted as amended.

HOD ACTION: Resolution 518 adopted as amended.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Policy H-165.856 be reaffirmed.

HOD ACTION: Policy H-165.856 reaffirmed.

Resolution 518 asks that our AMA 1) recognize infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and prevention; and 2) strongly advocate for greater access to established fertility treatments inclusive of broader insurance coverage.

Unanimously supportive testimony was offered for defining infertility as a disease with an emphasis on how this would promote insurance coverage and payment. Many cited experience in treating couples with infertility, and

noted the complicated testing and treatments that are used to diagnose and manage infertility. Several specialty societies testified that they recognize infertility as a disease and urged the AMA to do the same. Your Reference Committee is concerned that adoption of the first Resolve as written would signal support for the creation of a disease-specific policy compendium. Your Reference Committee believes that recognizing the World Health Organization's designation of infertility as a disease is appropriate and would avoid the AMA engaging in disease classification in the absence of established AMA principles on disease classification. Your Reference Committee also notes that AMA Policy H-165.856 urges minimization of benefit mandates and therefore recommends deletion of the second resolve and reaffirmation of that policy.

Policy recommended for reaffirmation:

H-165.856, Health Insurance Market Regulation

Our AMA supports the following principles for health insurance market regulation: (1) There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan; (2) State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection; (3) Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges; (4) Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium; (5) Insured individuals should be protected by guaranteed renewability; (6) Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices; (7) Guaranteed issue regulations should be rescinded; (8) Health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability. (9) Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage; and (10) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically: (a) Legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed; (b) Benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and (c) Any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed. (CMS Rep. 7, A-03 Reaffirmed: CMS Rep. 6, A-05 Reaffirmation A-07 Reaffirmed: CMS Rep. 2, I-07 Reaffirmed: BOT Rep. 7, A-09 Appended: Res. 129, A-09 Reaffirmed: CMS Rep. 9, A-11 Reaffirmed in lieu of Res. 811, I-11 Reaffirmed in lieu of Res. 109, A-12 Reaffirmed in lieu of Res. 125, A-12 Reaffirmed: Res. 239, A-12 Reaffirmed: CMS Rep. 9, A-14)

- (12) RESOLUTION 505 – RECOGNITION OF SEPSIS IN THE COMMUNITY
RESOLUTION 522 – NATIONAL COORDINATED STRATEGY FOR SEPSIS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 522 be amended by addition to read as follows:

RESOLVED, That our American Medical Association support innovations and public awareness campaigns that facilitate the early recognition and treatment of sepsis in pediatric and adult populations. (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 522 be amended by deletion of the second Resolve.

~~RESOLVED, That our AMA study current and proposed sepsis policies, and will make recommendations for the evidence based policies that appear most likely to reduce morbidity and mortality from sepsis (Directive to Take Action); and be it further~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 522 be amended by deletion of the third Resolve.

~~RESOLVED, That our AMA report its findings, and any recommendations based on these findings, at the 2018 Annual Meeting of the House of Delegates. (Directive to Take Action)~~

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 522 be amended by the addition of a new Resolve to read as follows:

RESOLVED, that our AMA believes that medical screening, diagnosis, and treatment protocols for sepsis should not be mandated by governmental entities in the absence of substantial scientific consensus. (New HOD Policy)

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 522 be adopted as amended in lieu of Resolution 505.

HOD ACTION: Resolution 522 adopted as amended in lieu of Resolution 505 with a change in title.

RECOMMENDATION F:

Madam Speaker, your Reference Committee recommends that the title of Resolution 522 be changed to read as follows:

IMPROVED TREATMENT OF SEPSIS

Resolution 505 asks that our AMA 1) encourage educational and public awareness programs to assure that physicians actively educate their patients and/or caregivers on the signs and symptoms of sepsis; and 2) encourage increased enrollment in clinical studies with all appropriate sepsis and septic shock patients, to better identify predictors of short and long-term adverse outcomes, and to advance the treatment of sepsis and sepsis-related complications.

Resolution 522 asks that our AMA 1) support innovations that facilitate the early recognition and treatment of sepsis; 2) study current and proposed sepsis policies, and will make recommendations for the evidence-based policies that appear most likely to reduce morbidity and mortality from sepsis; and 3) report its findings, and any recommendations based on these findings, at the 2018 Annual Meeting of the House of Delegates.

Your Reference Committee heard substantial testimony noting the prevalence of sepsis and the difficulties in recognition and early treatment, before it becomes serious and potentially deadly. There was recognition that a distinction is necessary in addressing sepsis in pediatric versus adult populations. While there is support for increased research and education on sepsis, other testimony noted that more evidence and stakeholder alignment is necessary before treatment protocols and mandates could be established. Since there are more than 500 clinical trials addressing sepsis currently underway, your Reference Committee believes that the second resolve of Resolution 505 is unnecessary. However, your Reference Committee believes that this is an issue of great importance, and offers amended language combining concepts from Resolutions 505 and 522 that encourage research on treatment and

short- and long-term outcomes, education for patients and caregivers, and innovations that support early recognition, as well as new language opposing protocols before scientific consensus exists.

(13) RESOLUTION 526 – NIH FUNDING FOR BASIC AND TRANSLATIONAL PAIN RESEARCH

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 526 be amended by deletion of the first Resolve to read as follows:

~~RESOLVED, That our American Medical Association actively advocate for increased funding, and monitor other efforts to expand funding, for the National Institutes of Health (NIH) specifically for basic and translational pain research, with regular updates to AMA membership (Directive to Take Action); and be it further~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 526 be amended by deletion of the second Resolve to read as follows:

~~RESOLVED, That our AMA submit supportive testimony on behalf of increased funding for basic and translational pain research at the President's Commission on Combating Drug Addiction (Directive to Take Action); and be it further~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third resolve of Resolution 526 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate for ~~current legislation that will~~ increased funding for basic and translational pain research. (Directive to Take Action)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 526 be adopted as amended.

HOD ACTION: Resolution 526 adopted as amended with a change in title.

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that the title of Resolution 526 be changed to read as follows:

FUNDING FOR BASIC AND TRANSLATIONAL PAIN RESEARCH

Resolution 526 asks that our asks that our AMA 1) actively advocate for increased funding, and monitor other efforts to expand funding, for the National Institutes of Health (NIH) specifically for basic and translational pain research, with regular updates to AMA membership; 2) submit supportive testimony on behalf of increased funding for basic and translational pain research at the President's Commission on Combating Drug Addiction; and 3) advocate for current legislation that will increase funding for basic and translational pain research.

Testimony was largely supportive of this resolution. Pain is the single most expensive symptom to treat in the United States. Given this reality, the potential significance of reduced funding for the National institutes of Health

(NIH) cannot be overstated. Our AMA has already submitted a letter of general support to the President's Commission on Combating Drug Addiction and the Opioid Crisis that detailed eight specific recommendations for the Commission's consideration. Therefore, the second resolve has already been implemented. Given that the goal of both the first and third resolves is similar, and that some other agencies besides the NIH also receive funding for pain research, your Reference Committee recommends deletion of the first resolve and amendment of the third resolve to call for increased funding, which could apply to all research bodies.

(14) RESOLUTION 508 – SUPPORT FOR SERVICE ANIMALS, EMOTIONAL SUPPORT ANIMALS, ANIMALS IN HEALTHCARE, AND MEDICAL BENEFITS OF PET OWNERSHIP

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 508 be referred.

HOD ACTION: Resolution 508 referred.

Resolution 508 asks that our AMA (1) recognize the potential medical benefits of animal-assisted therapy and animals as companions; and (2) encourage research into the use and implementation of service animals, emotional support animals and animal-assisted therapy as both a therapeutic and management technique of disorders and handicaps when expert opinion and the scientific literature show a potential benefit.

Your Reference Committee heard testimony citing many anecdotal instances of health benefits from service animals, emotional support animals, and companion animals. Others noted that research studies are underway to elucidate the benefits of such animals, but that evidence of their widespread use is insufficient at the moment. There is a need for a clearer definition of emotional support animals. There was anecdotal testimony stating that it is relatively easy to obtain certification for one's pet as a support animal, but it is unclear what the standards are for certification or if people are obtaining certification out of a desire to travel with their pet. It was noted that there is a need for better understanding of the current landscape with regard to service and emotional pet assistance, including standards and protocols. Your Reference Committee therefore believes that it would be most appropriate to refer the resolution for further research and understanding on the topic.

(15) RESOLUTION 525 – PROVIDING FOR PRESCRIPTION DRUG DONATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 525 be referred.

HOD ACTION: Resolution 525 referred.

Resolution 525 asks that our AMA 1) advocate for new federal legislation that would allow nursing homes to recycle prescription drugs that are unused, sealed, and dated; 2) advocate for new federal legislation that would allow physician offices and clinics to donate prescription drugs that are unused, sealed, and dated to patients in need who are uninsured or underinsured; and 3) advocate for new federal legislation that would allow cancer programs and clinics to accept and recycle cancer-specific drugs to patients in need who are uninsured or underinsured.

Your Reference Committee heard opposing viewpoints on this resolution. The Council on Science and Public Health suggested reaffirming current policy H-280.959 as the primary action. Those in support emphasized that some prescription drug products go to waste, including some that are very expensive, and that some pilot projects have been successful. Those in opposition emphasized that in order to recycle or donate leftover prescription drugs, many substantive issues must be addressed in order to maintain product integrity, ensure track and trace technology, and avoid counterfeit or substandard products. The National Association of Boards of Pharmacy has model legislative principles in place. Given that pharmacy and medical practice are regulated at the state level, your Reference

Committee opposes federal oversight. Because so many potentially conflicting issues are apparent, referral is recommended.

(16) RESOLUTION 501 – AIRPLANE EMISSIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 501 not be adopted.

HOD ACTION: Resolution 501 not adopted.

Resolution 501 asks that our AMA urge the President and the Environmental Protection Agency to expeditiously publish regulations, including binding limits on carbon dioxide emissions and other hazardous byproducts, that will stimulate development of clean aviation technology.

Testimony was significant, noting the large amount of data already existing on this topic and also noting that airplane manufacturers and airlines are actively working to reduce emissions and fuel consumption, and such emissions are a very small contributor to greenhouse gases. Several organizations, including the Air Force and the International Civil Aviation Organization, offered to provide copies of recently released reports on this topic. Because of the available data and the successful efforts of the aviation industry that are already underway, your Reference Committee believes that not adopting this Resolution is the best course of action.

(17) RESOLUTION 510 – BAN ON THE USE OF PARAQUAT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 510 not be adopted.

HOD ACTION: Resolution 510 not adopted.

Resolution 510 asks that our AMA seek appropriate legislation to permanently ban the use of Paraquat in all forms in the United States.

Testimony was limited on this Resolution. The toxicity of paraquat was noted; however, others testified to the importance of paraquat in industrial farming. The special license and specialized training course required to obtain paraquat products in the United States were mentioned. Your Reference Committee believes that the EPA already has stringent regulations on paraquat, which were recently strengthened in a 2016 registration review, and that a permanent ban is not warranted, therefore, your Reference Committee recommends not adopting Resolution 510.

(18) RESOLUTION 520 – COMBINATION
CLOTRIMAZOLE/BETAMETHASONE DIPROPIONATE CREAM
WARNING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 520 not be adopted.

HOD ACTION: Resolution 520 not adopted.

Resolution 520 asks that our AMA work with the U.S. Food and Drug Administration to review the safety and indications of the combination clotrimazole/betamethasone dipropionate cream and lotion.

Testimony on this item was limited and mixed, especially with regard to whether the approved drug product identified in the resolution has clinical value. The FDA-approved indication for this drug combination is for the

topical treatment of symptomatic inflammatory tinea pedis, tinea cruris, and tinea corporis due to *Epidermophyton floccosum*, *Trichophyton mentagrophytes*, and *Trichophyton rubrum* in patients 17 years and older. Published literature supports use in specific clinical situations. The reference to relevant guidelines from the American Academy of Dermatology was not confirmed. Your Reference Committee does not believe that the requests of this resolution would represent a wise investment of AMA resources, nor is it the role of the AMA, and therefore recommends against adoption.

(19) RESOLUTION 521 – RETAIL PRESCRIPTION BOTTLE LABEL PRIVACY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 521 not be adopted.

HOD ACTION: Resolution 521 not adopted.

Resolution 521 asks that our AMA petition the American Pharmacists Association, the U.S. Food and Drug Administration and other relevant agencies, to recommend that labels used for retail prescription bottles be affixed in a manner that allows easy removal or destruction to protect patient privacy.

Limited testimony was offered indicating the extent of the problem regarding the adhesive properties of prescription drug labels, and the organizations and agencies referred to in the resolution do not have authority over this issue. Considerable testimony stated concerns regarding safety and legal issues of medication containers with labels that may inadvertently fall off. Your Reference Committee believes that it is most important that identification and instruction labels affixed to the prescription drug container remain in place, especially for older patients who are often taking multiple medications. Other easy solutions (e.g., using a permanent marker, soaking in water) are available as alternatives.

(20) RESOLUTION 502 – ACCESS TO COSMETIC PRODUCT INGREDIENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-440.855 be reaffirmed in lieu of Resolution 502.

HOD ACTION: Policy H-440.855 reaffirmed in lieu of Resolution 502.

Resolution 502 asks that our AMA 1) encourage the U.S. Food and Drug Administration to mandate that all manufacturers of cosmetics, skincare products, nail polish, and sunscreens make their full ingredient lists available on the package and online to consumers; and 2) prepare a report to increase awareness of acrylate allergy, update potential sources of occupational and non-occupational exposure, and provide an update as to the best ways and barrier methods to avoid acrylate exposure by susceptible individuals, with a report back to the AMA HOD at the 2017 Interim Meeting.

Mixed testimony was offered for this item. Sensitivities to certain cosmetic ingredients were noted, as well as difficulties in identifying the ingredients in some products. The FDA testified that the Federal Food, Drug, and Cosmetic Act already requires manufacturers to list ingredients on product packaging in descending order of predominance. Your Reference Committee also notes that Policy H-440.855 supports the creation of a publicly available registry of all cosmetics and their ingredients. Some questioned whether the resolution language should refer to “personal care products” rather than “cosmetics” so that it would also apply to sunscreens, which are regulated as over-the-counter (OTC) drug products. However, the FDA noted that OTC drug products also are required to list active and inactive ingredients on their labels. Your Reference Committee was made aware of draft legislation requiring ingredient lists for personal care products. Regarding acrylate, testimony pointed out the large number of products that contain acrylates. Your Reference Committee heard testimony from the Dermatology Section Council noting that acrylate awareness efforts are already a part of dermatology practice. Additionally, your Reference Committee is aware of several other existing regulatory and educational efforts intended to limit acrylate exposure. The Occupational Safety and Health Administration has set permissible occupational exposure limits for

several acrylate compounds and the Environmental Protection Agency has published hazard summaries for many individual acrylate compounds. Additionally, the National Institute for Occupational Safety and Health has published guidance for nail technicians to prevent exposure. Accordingly, your Reference Committee does not believe that Resolve 2 is necessary. Also, since current law already requires ingredient lists for cosmetics and sunscreen, and current policy supports a registry of cosmetics and ingredients, your Reference Committee recommends that this policy be reaffirmed in lieu of Resolution 502.

Policy recommended for reaffirmation:

H-440.855 National Cosmetics Registry and Regulation

1. Our AMA: (a) supports the creation of a publicly available registry of all cosmetics and their ingredients in a manner which does not substantially effect the manufacturers; proprietary interests and (b) supports providing the Food and Drug Administration with sufficient authority to recall cosmetic products that it deems to be harmful. 2. Our AMA will monitor the progress of HR 759 (Food and Drug Administration Globalization Act of 2009) and respond as appropriate. BOT Action in response to referred for decision Res. 907, I-09

(21) RESOLUTION 514 – RETINOBLASTOMA DUE TO PRE-NATAL RESIDENTIAL PESTICIDE EXPOSURE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-135.926 be reaffirmed in lieu of Resolution 514.

HOD ACTION: Policy H-135.926 reaffirmed in lieu of Resolution 514.

Resolution 514 asks that our AMA 1) encourage the development of appropriate educational materials designed to enhance physician and general public awareness of the potential risks of using pesticides at home for pregnant women, including unilateral retinoblastoma; and 2) encourage physicians to discuss with patients the potential risks of using pesticides at home for pregnant women, including unilateral retinoblastoma.

Testimony regarding this issue was limited. Some studies have hypothesized that sporadic mutations leading to retinoblastoma are caused by prenatal exposure to pesticides. However, this research is limited, and has been criticized as having important limitations. Because of the uncertainty linking pesticide exposure to retinoblastoma, your Reference Committee believes it would be inappropriate to adopt this resolution as worded but believes that reaffirmation of current policy regarding study of the transgenerational effects of environmental toxins on reproductive health is warranted.

Policy recommended for reaffirmation:

H-135.926 Transgenerational Effects of Environmental Toxins on Reproductive Health

Our AMA encourages study of the transgenerational effects of environmental toxins on reproductive health and development. Res. 521, A-16

(22) RESOLUTION 516 – IN-FLIGHT EMERGENCIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-45.978 and H-45.979 be reaffirmed in lieu of Resolution 516.

HOD ACTION: Policies H-45.978 and H-45.979 reaffirmed in lieu of Resolves 1, 2, and 4 of Resolution 516. Resolves 3 and 5 of Resolution 516 referred.

Resolution 516 asks that our AMA 1) support and advocate for a requirement that all U.S. based commercial carriers consult with the Air Transport Medicine Committee Aerospace Medical Association every six months to determine

the minimal medical equipment that should be available on domestics and international commercial flights and provide easy access to that information to passengers in order to aid in responding to likely emergencies such as adding naloxone to target potential opioid overdoses and a glucometer given the increase prevalence of diabetes; 2) support and advocate for a requirement that medical supplies, equipment, and medications available for an inflight medical emergency are standardized based upon the size and mission of the aircraft across all domestic and international commercial U.S. based airlines with careful consideration of flight crew training requirements; 3) support and advocate for a requirement that flight crews will no longer be required to verify a medical professional's credentials before allowing that person to assist with an inflight medical emergency; 4) support and advocate for a requirement that U.S. based commercial carriers develop an online process for health providers to become credentialed in advance of a flight in order to respond to an inflight emergency; and 5) offer medical trainees and physicians medical education courses to prepare for addressing in-flight emergencies during its meetings and/or by strongly encouraging its affiliated state and local branches to offer similar education courses.

Mixed testimony was offered on this resolution. The sponsors cited a recent incident during which an African-American physician who was willing to assist in an in-flight medical emergency (IFME) was not permitted to do so by the airline staff because they did not believe she was a physician and she was not carrying proof of licensure. Others noted the high incidence of IFMEs and the need to ensure that onboard medical supplies are appropriate for treating the most common emergencies, and that physicians who volunteer to assist be well-prepared to do so. The Aerospace Medical Association (AsMA) testified that it went through an extensive process beginning in 2015 to develop guidance on the topic of IFMEs, and with the collaboration of other medical organizations, including the AMA, finalized recommendations in 2016 that address what IFMEs are and how often they occur, on-board medical supplies, cabin crew training, automated external defibrillators, and legal aspects. Several other aviation organizations, including the International Air Transport Association and the International Civil Aviation Organization, regularly study and make recommendations on IFMEs. Regarding credentialing, the AsMA and others noted that the Federal Aviation Administration does not require that physicians present their credentials before they are permitted to assist in a medical emergency. While some supported the requirement that those volunteering to assist be required to prove they are a physician, other testimony posited that the requirement for an online process for credentialing could be a barrier since a physician who has not registered but who is willing and able to provide care during an emergency may not be allowed to provide care. Your Reference Committee believes that the extensive work by AsMA and others, as well as current AMA policy, address IFMEs in depth, and therefore recommends reaffirmation of those policies in lieu of the resolution.

Policies recommended for reaffirmation:

H-45.978, In-flight Medical Emergencies

Our AMA urges: (1) urges that decisions to expand the contents of in-flight emergency medical kits and place emergency lifesaving devices onboard commercial passenger aircraft be based on empirical data and medical consensus; in-flight medical supplies and equipment should be tailored to the size and mission of the aircraft, with careful consideration of flight crew training requirements; and (2) the Federal Aviation Administration to work with appropriate medical specialty societies and the airline industry to develop and implement comprehensive in-flight emergency medical systems that ensure: (a) rapid 24-hour access to qualified emergency medical personnel on the ground; (b) at a minimum, voice communication with qualified ground-based emergency personnel; (c) written protocols, guidelines, algorithms, and procedures for responding to in-flight medical emergencies; (d) efficient mechanisms for data collection, reporting, and surveillance, including development of a standardized incident report form; (e) adequate medical supplies and equipment aboard aircraft; (f) routine flight crew safety training; (g) periodic assessment of system quality and effectiveness; and (h) direct supervision by physicians with appropriate training in emergency and aerospace medicine. (CSA Rep. 3, I-99 Reaffirmed: CSAPH Rep. 1, A-09 Reaffirmation I-14 Reaffirmed in lieu of: Res. 502, A-16)

H-45.982, Improvement in US Airlines Aircraft Emergency Kits

Our AMA urges federal action to require all US air carriers to report data on in-flight medical emergencies, specific uses of in-flight medical kits and emergency lifesaving devices, and unscheduled diversions due to in-flight medical emergencies; this action should further require the Federal Aviation Administration to work with the airline industry and appropriate medical specialty societies to periodically review data on the incidence and outcomes of in-flight medical emergencies and issue recommendations regarding the contents of in-flight medical kits and the use of emergency lifesaving devices aboard commercial aircraft.

(Res. 507, A-97 Amended: CSA Rep. 3, I-99 Reaffirmed: CSAPH Rep. 1, A-09 Reaffirmed in lieu of: Res. 502, A-16)

H-45.979, Air Travel Safety

Our AMA: (1) encourages the ongoing efforts of the Federal Aviation Administration, the airline industry, the Aerospace Medical Association, the American College of Emergency Physicians, and other appropriate organizations to study and implement regulations and practices to meet the health needs of airline passengers and crews, with particular focus on the medical care and treatment of passengers during in-flight emergencies; (2) encourages physicians to inform themselves and their patients on the potential medical risks of air travel and how these risks can be prevented; and become knowledgeable of medical resources, supplies, and options that are available if asked to render assistance during an in-flight medical emergency; and (3) will support efforts to educate the flying physician public about in-flight medical emergencies (IFMEs) to help them participate more fully and effectively when an IFME occurs, and such educational course will be made available online as a webinar. (CSA Rep. 5, I-98 Appended: CSA Rep. 3, I-99 Reaffirmed: CSAPH Rep. 1, A-09 Appended: Res. 718, A-14 Reaffirmation I-14 Reaffirmed in lieu of Res. 503, A-15 Reaffirmed in lieu of: Res. 502, A-16)

REPORT OF REFERENCE COMMITTEE F

(1) BOARD OF TRUSTEES REPORT 4 - AMA 2018 DUES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 4 be adopted and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 4 adopted and the remainder of the Report filed.

Board of Trustees Report 4 recommends no changes to our AMA membership dues levels for 2018. The Report further notes that our AMA last raised its dues in 1994.

Regular Members	\$420
Physicians in Their Second Year of Practice	\$315
Physicians in Military Service	\$280
Physicians in Their First Year of Practice	\$210
Semi-Retired Physicians	\$210
Fully Retired Physicians	\$84
Physicians in Residency Training	\$45
Medical Students	\$20

No testimony was presented in response to response to Board of Trustees Report 4. Your Reference Committee wishes to draw attention to the stability of our AMA dues since 1994 when the last increase took place. Most importantly, the close of 2016 reflects the sixth consecutive year of overall membership growth and expansion of our AMA’s influence.

(2) BOARD OF TRUSTEES REPORT 10 - CREATION OF AN AMA FUND FOR PHYSICIAN CANDIDATES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 10 be adopted and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 10 adopted and the remainder of the Report filed.

Board of Trustees Report 10 is presented as follow-up to Board of Trustees Report 16-A-16, Board of Trustees Report 18-A-15, and Resolution 606-I-14. In this report, the Board of Trustees highlights that testimony presented at the 2016 Annual Meeting reflected a deviation from the intent of the original resolution to request the study of a new proposal to create a fund for physician candidates for the US House of Representatives and Senate.

The Board of Trustees continues to express concerns about expending corporate treasury funds to influence federal elections for reasons that include, but are not limited to:

- there are significant tax implications for our AMA;
- the portion of AMA dues allocated for lobbying and political purposes would become nondeductible for individual physician members;
- there is a potential for negative reaction from AMA members because of personal political and ethical viewpoints; and
- two recent physician polls indicate little support for this concept.

Therefore, the Board of Trustees recommends, in lieu of Resolution 606-I-14, that our American Medical Association not use AMA corporate treasury funds to engage in partisan political activity.

Your Reference Committee has received extensive testimony on this issue over a number of meetings. What remains consistent is that regardless of what the “AMA Fund” may be titled, or what the specific purpose may be, the actual costs for overall expenses, taxes (35% excise tax on political expenditures), and potential loss of members are significant. Furthermore, the return on investment is not guaranteed.

In their role as fiduciary for our AMA, the Board of Trustees has repeatedly advised against this initiative and physician polls do not suggest sufficient support for implementing and sustaining the fund. In addition, the author of Resolution 606-I-14 expressed support for the Board of Trustees’ recommendation at this time, but suggested that our AMA seek additional ways to encourage and support physician candidates for public office.

(3) BOARD OF TRUSTEES REPORT 16 - OPPOSE PHYSICIAN GUN GAG
RULE POLICY BY TAKING OUR AMA BUSINESS ELSEWHERE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 16 be adopted and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 16 adopted and the remainder of the Report filed.

Board of Trustees Report 16 comes in response to Resolution 604-I-16, which called upon our AMA to adopt policy that bars our AMA from holding House of Delegates meetings in states that enact physician gun gag laws.

Resolution 604-I-16 further called upon our AMA to contact governors and convention bureaus of states that have enacted physician gun gag rules to inform them that our AMA will no longer hold House of Delegates meetings in their state, until the restrictive physician gun gag rule is repealed or struck down by the courts.

In this report, the Board of Trustees highlights that AMA management considers multiple factors when selecting AMA meeting venues, including the directives of the House of Delegates. Venue selection occurs years in advance and includes cancellation policies. State and local jurisdictions may at any time adopt or eliminate laws or rules that are not aligned with AMA policy.

Therefore, the Board of Trustees recommends, in lieu of adopting Resolution 604-I-16, that our AMA remain alert to gun gag laws and similar types of laws when selecting future meeting venues without adopting specific policy.

No testimony was presented in response to Board of Trustees Report 16. Your Reference Committee is supportive of our AMA Board of Trustees recommendation to remain vigilant of all gag laws affecting the practice of medicine when selecting meeting venues without the need for specific directives from the House of Delegates to do so.

Your Reference Committee was reminded of the fact that our AMA meetings are complex events, which are contracted approximately five years in advance. The variability in state and local laws has the potential to limit venue selections as laws can change during the time between contracting for a venue and the actual event.

(4) BOARD OF TRUSTEES REPORT 17 - EQUALITY FOR FUTURE
MEETINGS ORGANIZED OR SPONSORED BY THE AMA

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 17 be adopted and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 17 adopted and the remainder of the Report filed.

Board of Trustees Report 17 comes in response to Resolution 602-I-16, which called for all future meetings and conferences organized and/or sponsored by our AMA and not yet contracted to be held in towns, cities, counties, and states that do not have discriminatory policies based on race, color, religion, ethnic origin, national origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age.

In this report, the Board of Trustees highlights that our AMA already has strong policies against discrimination in all forms, but the policies do not specifically address towns, cities, counties, and states. Therefore, the Board of Trustees recommends, in lieu of adopting Resolution 602-I-16, that our AMA Policy G-630.140 be amended by addition to read as follows:

AMA policy on lodging and accommodations includes the following: (1) Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors. (2) Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meeting in the House of Delegates Meeting hotel or in a hotel in close proximity. (3) All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has enacted comprehensive legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy. (4) It is the policy of our AMA not to hold meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or pay member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy. (5) Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping.

Having received only supportive testimony in response to Board of Trustees Report 17, your Reference Committee favors adoption of the Board of Trustees recommendation to expand current AMA Policy G-630.140 to include consideration of the anti-discrimination policies of towns, cities, counties, and states when selecting meeting venues. In addition, your Reference Committee appreciates the Board of Trustees efforts to incorporate into AMA policy a more inclusive list of discriminatory forms.

(5) BOARD OF TRUSTEES REPORT 23 - ANTI-HARASSMENT POLICY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 23 be adopted and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 23 adopted and the remainder of the Report filed.

Board of Trustees Report 23 raises awareness of the fact that while our AMA has a comprehensive anti-harassment policy in place for employees, there is no such policy for our AMA House of Delegates, sections, councils, or other governance entities. Therefore, the Board of Trustees recommends that our AMA adopt the thorough “Anti-Harassment Policy Applicable to AMA Entities,” as outlined in the body of the report.

Testimony on Board of Trustees Report 23 was supportive of the Board of Trustees’ efforts to establish a comprehensive anti-harassment policy for our AMA governance entities. Your Reference Committee believes that adoption of the report will contribute to the ongoing collegiality and professionalism that already exists at our AMA-sponsored meetings and events.

(6) REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON COMPENSATION OF THE OFFICERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in the Report of the House of Delegates Committee on Compensation of the Officers be adopted and the remainder of the Report be filed.

HOD ACTION: Report of the House of Delegates Committee on Compensation of the Officers adopted and the remainder of the Report filed.

The Report of the House of Delegates Committee on Compensation of the Officers addresses the variability in the number of Internal Representation days by Officers and offers the following recommendations:

1. That the proposed changes, as annotated in the report, to the current definitions appearing in the Travel and Expenses Standing Rules for AMA Officers for the Governance Honorarium, Per Diem for External Representation, and Telephonic Per Diem for External Representation become effective July 1, 2017.
2. That except as noted above, there be no other changes to the Officers' compensation for the period beginning July 1, 2017.

Your Reference Committee heard limited but supportive testimony in response to the Report of the House of Delegates Committee on Compensation of the Officers.

Your Reference Committee wishes to extend its appreciation to the Committee for its thorough report and ongoing oversight of the compensation of our AMA Officers.

(7) RESOLUTION 602 - STUDYING HEALTHCARE INSTITUTIONS THAT PROVIDE CHILD CARE SERVICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 602 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association (AMA) work with relevant entities to study ~~which~~ healthcare institutions ~~currently provide accessible, affordable to determine whether they provide~~ childcare care services; ~~including~~ Survey elements should include the size of the institutions (in terms of the number of physicians, physicians-in-training, and medical students), ~~providing these services, the impact of these services on residents and faculty (especially in terms of decreasing stress and increasing retention)~~ how these services are organized, and the various funding ~~models~~ mechanisms used for these (Directive to Take Action); and be it further

RESOLVED, That our AMA report back to the House of Delegates at the 2018 Annual Meeting the results of its study on models used to provide ~~which~~ healthcare institutions are ~~providing accessible and affordable~~ childcare care services, how these services are organized, and the various funding ~~models~~ mechanisms that are utilized. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 602 be adopted as amended.

HOD ACTION: Resolution 602 adopted as amended.

Resolution 602 calls upon our AMA to survey healthcare institutions to identify all healthcare institutions that provide accessible, affordable childcare services, including details regarding:

- institution size, in terms of the number of physicians;
- impact on reducing stress on residents/faculty, thereby improving staff retention rates; and
- funding models used to provide childcare services.

Resolution 602 further calls upon our AMA to report to the House of Delegates on the results of the study at the 2018 Annual Meeting.

Your Reference Committee received considerable testimony identifying the importance of child care services that meet the unique utilization needs of physicians who often work extended and non-traditional hours.

Your Reference Committee believes the proffered language included in the amendments establishes parameters for the study that will aid in containing the survey costs while allowing our AMA to identify best practices of health care institutions that have implemented successful childcare programs for physician and medical student parents.

(8) RESOLUTION 603 - SEXUAL ORIENTATION AND GENDER IDENTITY DEMOGRAPHIC COLLECTION BY THE AMA

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 603 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA develop and implement a plan with input from the Advisory Committee on LGBTQ Issues to expand demographics ~~we collected~~ about our members to include both sexual orientation and gender identity information, which may be given voluntarily by members and will be handled in a confidential manner. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 603 be adopted as amended.

HOD ACTION: Resolution 603 adopted as amended.

Resolution 603 calls upon our AMA to develop a plan, with input from the Advisory Committee on LGBTQ Issues, to expand voluntary and confidential collection of AMA membership demographics, including both sexual orientation and gender identity information.

Your Reference Committee heard supportive testimony for this resolution. Sponsors of the resolution emphasized to the Reference Committee that gender identity demographic information would be provided only on a voluntary basis. While concerns were expressed that such data may be subject to data breaches, this could also happen to any other AMA-owned data elements that are collected online. The Council on Long Range Planning and Development, which issues reports on the demographic composition of the House of Delegates, expressed its support for collecting this data but warned that if given on a voluntary basis, it is unlikely to be complete. Your Reference Committee believes that these limitations and concerns are outweighed by the potential usefulness to our AMA's understanding of its membership.

- (9) RESOLUTION 608 - IMPROVING MEDICAL STUDENT, RESIDENT/FELLOW AND ACADEMIC PHYSICIAN ENGAGEMENT IN ORGANIZED MEDICINE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 608 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association study the participation of academic and teaching physicians, residents, fellows, and medical students in organized medicine and legislative advocacy ~~on medical school campuses and in teaching hospitals~~ (Directive to Take Action); and be it further

RESOLVED, That our AMA study the participation of community-based faculty members of medical schools and graduate medical education programs in organized medicine and legislative advocacy (Directive to Take Action); and be it further

RESOLVED, That our AMA identify successful, innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine and legislative advocacy ~~at the training sites~~ (Directive to Take Action).

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 608 be adopted as amended.

HOD ACTION: Resolution 608 adopted as amended with a change in title

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 608 be changed to read as follows:

IMPROVING MEDICAL STUDENT, RESIDENT/FELLOW AND ACADEMIC PHYSICIAN ENGAGEMENT IN ORGANIZED MEDICINE AND LEGISLATIVE ADVOCACY

Resolution 608 calls upon our AMA to study the participation of academic and teaching physicians, residents, fellows, and medical students in organized medicine on medical school campuses and in teaching hospitals.

Resolution 608 further calls upon our AMA to study the participation of community-based faculty members of medical schools and graduate medical education programs in organized medicine.

Lastly, Resolution 608 calls upon our AMA to identify successful, innovative, and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine at the training sites.

Your Reference Committee heard uniformly supportive testimony for this resolution and recognizes that many of the suggestions made in the resolution may already be under consideration by our AMA. Your Reference Committee has incorporated a suggested change to the title and subsequent directives that emphasizes the importance of educating physicians about best practices in legislative advocacy.

(10) RESOLUTION 601 - REINSTATE THE AMA COMMISSION TO ELIMINATE HEALTH CARE DISPARITIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 601 be referred.

HOD ACTION: Resolution 601 referred.

Resolution 601 calls upon our AMA to reinstate the Commission to Eliminate Health Care Disparities, including goals and objectives that are Specific, Measurable, Agreed Upon, Realistic, and Time Related (SMART) metrics.

Testimony reflected that the original governing members (National Hispanic Medical Association, National Medical Association, and our American Medical Association) of the Commission to Eliminate Health Care Disparities unanimously recommended sunset of the Commission in 2016 due to a decrease in financial support, emergence of other organizations' meetings with similar agendas, and the potential for member organizations to have more impact in other ways. Since that time, our AMA has expanded a number of internal activities with the goal of improving health equity.

Your Reference Committee was influenced by testimony indicating that governing members opted to sunset the Commission and might not rejoin the partnership if the Commission were reinstated by our AMA. Therefore, your Reference Committee welcomed our AMA Board of Trustees request for referral of Resolution 601, which will result in a report back to the House of Delegates with a more comprehensive and sustainable plan for continued progress toward health equity.

(11) RESOLUTION 604 - HIGH COST TO AUTHORS FOR OPEN SOURCE PEER REVIEWED PUBLICATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 604 be referred.

HOD ACTION: Resolution 604 referred.

Resolution 604 calls upon our AMA to investigate the impact of the high costs of open source publication practices on the dissemination of research, especially by less well-funded and/or smaller entities, and to make recommendations to correct the imbalance of knowledge suppression that may occur because of financial limitations.

Although the title in original Resolution 604 refers open source peer reviewed publications, the preferred phrase is Open Access (OA).

Your Reference Committee has learned that many US, and all EU research funders, require that journals offer OA options to authors supported by their grants. OA journals do not sell subscriptions or charge for site licenses, and they do not sell advertising. Their only revenue is from Article Processing Charges (APCs), which help cover costs to review, edit, process, distribute, and host the articles. These fees are typically between \$3,000 and \$5,000 per article.

Scholarly society journals like JAMA® and the New England Journal of Medicine do not offer or charge APCs in exchange for OA. All original research articles published in JAMA® are made free to everyone after six months. However, with the launch of JAMA Oncology® in 2015, AMA began to offer an OA option to authors whose research funders required that they use OA. The JAMA Network® OA fees are \$4500 to \$5000 per article. For this reason, JAMA Oncology® is called a "hybrid" journal, as authors may choose either an OA model or a conventional subscription model for their submission. This model recognizes the needs and limited resources of independent researchers and authors but also appears to balance the demands of funders, changing markets, and business

practices. The hybrid model was extended to JAMA Cardiology®, which was launched in 2016, and subsequently to all of AMA's specialty journals across The JAMA Network® on April 1, 2017.

Your Reference Committee heard testimony that many medical journals still offer no-fee publication, and many journals, including those of The JAMA Network®, will waive OA fees if authors cannot afford them. Your Reference Committee believes that our AMA is not in a position to direct or recommend that other medical journal publishers reduce or eliminate their OA article fees, nor can our AMA instruct international research funders to abandon their OA requirements and support only subscription-based journals.

Testimony reminded the Reference Committee that our AMA House of Delegates has adopted clear policy on editorial independence, affirming "JAMA® and The JAMA Network® journals shall continue to have full editorial independence as set forth in our AMA Policy G-630.090.

While testimony also expressed concerns about the quality of journal articles being published by some OA journals, and that the lack of peer review for these articles has a negative impact on scientific and medical literature, the resolution does not specifically address issues of quality, peer review, or concerns about predatory journals. However, the resolution raises a need to increase awareness about and address the complexities of current publishing practices.

Your Reference Committee recommends referral of Resolution 604 to allow our AMA Board of Trustees to review OA publication practices and the impact on the availability of new scientific research, as well the role of predatory journals, which was referenced in the testimony but not addressed by Resolution 604.

(12) RESOLUTION 607 - AMA TO PROTECT HUMAN HEALTH FROM THE EFFECTS OF CLIMATE CHANGE BY ENDING ITS INVESTMENTS IN FOSSIL FUEL COMPANIES (DIVESTMENT)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 607 be referred.

HOD ACTION: Resolution 607 referred.

Resolution 607 calls upon our AMA, Foundation, and any affiliated corporations to work in a timely and fiscally responsible manner to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels. Resolution 607 further calls upon our AMA, when fiscally responsible, to choose vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuel consumption.

Lastly, Resolution 607 directs our AMA to support efforts of physicians and other health professional associations to proceed with divestment, including creating policy analyses, to support continuing medical education, and to inform our patients, the public, legislators, and government policy makers.

Your Reference Committee recognizes that the intent of Resolution 607 is to make a strong statement on behalf of our profession and for the benefit of our patients, as well as our environment. The resolution includes a fiscal note that reads, "The potential adverse impact on the AMA's financial returns cannot be determined with precision at this time."

Your Reference Committee received testimony urging that transitioning away from our nation's dependence upon fossil fuels is a moral and public health imperative that can be accelerated by eliminating financial investments in and relationships with companies tied to the fossil fuel industry. Testimony pointed out that our AMA has policy preventing investments in the tobacco industry as part of our AMA's broad strategy to oppose tobacco use. Those in support of the resolution reasoned that the avoidance of tobacco investments has not impaired the Board of Trustees' ability to exercise its fiduciary duties; therefore, the same should be true of fossil fuel divestment.

Your Reference Committee recognizes that, compared to the tobacco industry, the fossil fuel industry is a much larger segment that broadly supports many aspects of modern society, including raw materials used to manufacture medical devices and machinery. In addition, transaction costs to implement such a divestiture will incur a significant increase in investment management fees and compliance monitoring costs.

Given the complexity of the issues raised by Resolution 607, your Reference Committee believes referral of this item will allow our AMA Board of Trustees, in their role as fiduciaries, to study and explain the potential financial consequences to our AMA.

(13) RESOLUTION 609 - MODEL HOSPITAL MEDICAL STAFF BYLAWS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 609 be referred.

HOD ACTION: Resolution 609 referred.

Resolution 609 calls upon our AMA to:

1. develop model hospital medical staff bylaws that incorporate currently believed to be best practices, meet the requirements of the Medicare Conditions of Participation, hospital accreditation organizations with deeming authority, and state laws and regulations, including annotations to show the source of all legal, regulatory, and accreditation requirements; and
2. post this resource on the AMA website, continuously updated and available on demand to medical staffs, medical staff offices, and medical society staff, and widely distributed as an adjunct to the next edition of the *AMA Physician's Guide to Medical Staff Bylaws*.

Resolution 609 further calls upon our AMA to ask the legal counsels of State Medical Societies to outline state specific restrictions of medical staff self-governance so that these may be posted on the AMA-OMSS website for use by all AMA members.

Your Reference Committee heard mostly supportive testimony for this resolution. While some states already provide this resource to their members, need was expressed for a comprehensive up-to-date resource on medical staff self-governance that is readily accessible. Understanding the state-specific regulations is critical to the success of both hospital medical staff and the growing employed physician segment.

Your Reference Committee believes that in order to produce the most useful tool, more study is needed to determine the need for such a tool, analyze the complexities of its creation, and address the uncertain financial impact to our AMA and the state medical organizations. In addition, more thought should be given about how such a resource will be best executed, maintained, and accessed. For these reasons, your Reference Committee recommends referral.

(14) RESOLUTION 605 - PRONUNCIATION OF PHARMACEUTICAL NAMES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 605 not be adopted.

HOD ACTION: Resolution 605 not adopted.

Resolution 605 calls upon our AMA to adopt policy that its AMA-sponsored medical journals develop a means to convey the proper pronunciation of all new pharmaceutical names.

Your Reference Committee received testimony indicating that the United States Adopted Names (USAN) Council assigns non-proprietary names to new drugs. When a drug is assigned a name by the Council, an Adoption

Statement is issued that includes the proper pronunciation of the non-proprietary name. Testimony also specified that the US Pharmacopeia Convention (USP) Dictionary of USAN and International Drug Names is currently the only source available that includes pronunciation of non-proprietary drug names. Your Reference Committee points out that the resolution asks for a pronunciation guide for “all new pharmaceutical names;” therefore, the USP Dictionary, even if available to our AMA for its use, would not include all desired information requested by this Resolution.

Your Reference Committee was reminded that JAMA® and the JAMA Network® family of specialty journals are independent from our AMA, as established by previously adopted House of Delegates policy. However, your Reference Committee recommends that our AMA Board of Trustees relay the concerns expressed in this resolution to JAMA® and the JAMA Network® family of specialty journals.

(15) RESOLUTION 606 – ADD PATIENTS TO THE AMA MISSION STATEMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 606 not be adopted.

HOD ACTION: Resolution 606 not adopted.

Resolution 606 calls upon our AMA to modify its mission statement to read, “The American Medical Association promotes the art and science of medicine, the betterment of public health, and the improvement and accessibility of health care to our patients.”

Your Reference Committee agrees that the improvement and accessibility of health care is at the core of our profession; it is in fact included as one of the principles in our AMA Code of Medical Ethics.

Your Reference Committee received compelling testimony from our AMA Board of Trustees that a mission statement should provide a useful characterization of an organization. The value of a mission statement is often diminished by attempts to include too much information. It should be short enough for people to remember, thereby reinforcing the basic identity of the organization. Strategies, objectives, and values that may change from year to year or are related to implementation should not be included in the mission statement. Furthermore, our AMA vision, “To be an essential part of the professional life of every physician,” provides a goal that encompasses both our membership aspirations and the advocacy and professional standards activities that are the core of what the AMA does on behalf of physicians and patients.

Your Reference Committee agrees with the opinion of our AMA Board of Trustees that the current Mission and Vision, as written, reflect the broader range of AMA activity, advocacy, and House of Delegates’ policy, which reflect our AMA’s long-standing commitment to patients. Therefore, your Reference Committee recommends that Resolution 606 not be adopted.

(16) BOARD OF TRUSTEES REPORT 1 - ANNUAL REPORT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 1 be filed.

HOD ACTION: Board of Trustees Report 1 filed.

Board of Trustees Report 1 introduces our AMA’s 2015 and 2016 Consolidated Financial Statements and an Independent Auditor’s report, which are featured in a separate document titled, “2016 Annual Report” that was made available with the Handbook materials.

On behalf of our entire AMA membership, your Reference Committee extends appreciation to the Board of Trustees for executing sound fiscal responsibility throughout this past year, which was the 16th time in the last 17 years that our AMA has reported positive operating results. Additionally, your Reference Committee wishes to draw attention to the fact that in the 2016 Annual Report, it is noted that our AMA was ranked as The Number 1 most effective professional and trade organization in the United States by a leading public relations firm.

REPORT OF REFERENCE COMMITTEE G

(1) BOARD OF TRUSTEES REPORT 20 – STUDY OF MINIMUM COMPETENCIES AND SCOPE OF MEDICAL SCRIBE UTILIZATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 20 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 20 adopted and the remainder of the report filed.

Board of Trustees Report 20 recommends that our AMA reaffirm Policy H-35.966, “Protecting Physician-Led Health Care,” continue to review and promote strategies that help improve physician practice workflow, and monitor the medical scribe industry periodically to identify important trends.

Your Reference Committee heard limited yet supportive testimony on Board of Trustees Report 20. A member of the Board of Trustees introduced the report and reviewed the recommendations, namely calling on our AMA to continue to monitor the medical scribe industry to identify trends that can help improve physician office workflow and encourage greater EHR innovation. Additional testimony noted the thoroughness of the report and emphasized the importance of medical scribes, especially for medical students. Accordingly, your Reference Committee recommends that the recommendations in Board of Trustees Report 21 be adopted and the remainder of the report be filed.

(2) COUNCIL ON MEDICAL SERVICE REPORT 5 – HOSPITAL CONSOLIDATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 5 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 5 adopted and the remainder of the report filed.

Council on Medical Service Report 5 recommends that our AMA reaffirm policy on competition among health care facilities, antitrust relief, and opposition to the ban on self-referrals, and recommends reaffirmation of additional policies intended to help guide and protect physicians working in consolidated systems, including support for physician involvement in integrated leadership structures.

Testimony strongly supported Council on Medical Service Report 5. A member of the Council introduced the report and described the findings from a recent AMA analysis of hospital market concentration that found that the vast majorities (90 percent) of hospital markets are highly concentrated, and 70 percent of hospitals are members of hospital systems. The Council member acknowledged concerns regarding potential negative consequences for physicians and patients in highly concentrated hospital markets, underscoring the Council’s belief that highly concentrated markets dominated by any type of health care entity may be harmful and that competition in the marketplace is essential to a well-functioning health care system. Testimony recognized that our AMA is a strong advocate for competitive health care markets and for physician involvement in integrated leadership structures.

A member of the Board of Trustees reiterated that our AMA strongly supports and encourages competition in health care markets because competitive marketplaces provide more choices for physicians and patients. Testimony from the Board of Trustees also referenced the findings of our AMA’s newly released Physician Practice Benchmark Survey, which shows that physician movement toward hospital-owned practices and direct hospital employment appears to have leveled off.

The author of the referred resolution addressed by Council on Medical Service Report 5 stated that the negative effects of hospital consolidation were correctly identified by the Council and asked that our AMA study the issue. The Reference Committee believes our AMA has studied the issue and also points out, in response to testimony, that Recommendation 3 reaffirms longstanding AMA policy (Policy H-140.984) opposing an across-the board ban on self-referrals, which would allow for the expansion and new construction of physician-owned hospitals, which would in turn increase competition. Your Reference Committee recommends that the recommendations in Council on Medical Service Report 5 be adopted and the remainder of the report be filed.

(3) COUNCIL ON MEDICAL SERVICE REPORT 8 – PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT REFORM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 8 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 8 adopted and the remainder of the report filed.

Council on Medical Service Report 8 recommends that our AMA reaffirm Policies H-320.948, H-320.961, and H-320.949; continue its widespread prior authorization advocacy and outreach; and oppose health plan determinations on physician appeals based solely on medical coding.

Considerable supportive testimony was received on Council on Medical Services Report 8. Testimony noted that prior authorization continues to be a significant source of frustration and administrative burden for physicians and staff, with representatives from various specialties emphasizing the negative impact prior authorization has on care delivery and physician and staff burnout.

The majority of testimony supported Council on Medical Service Report 8 and adoption of its recommendations; however, limited testimony was also offered in support of rescinding language in the report that states physicians should not be compensated for their time spent pursuing prior authorization. One speaker noted that prior authorization is not a patient care issue but rather a payer approval and reimbursement issue. As such, since physician time spent on prior authorization is for the benefit of health plans, physicians should be compensated for this time. Additional testimony was offered in opposition to this request to rescind, noting that there are two paths available for our AMA to pursue with regards to prior authorization moving forward: either physicians are compensated for prior authorization, signaling to health plans that prior authorization is an acceptable practice which could ultimately limit physicians' ability to push back on future prior authorization expansion, or our AMA can continue to push back against prior authorization expansion through its current legislative and advocacy efforts. Although the Reference Committee understands and appreciates physicians' desire to be compensated for time spent on prior authorization, there is concern making prior authorization an advocacy priority would run counter to and negatively impact our AMA's current prior authorization advocacy efforts. Recently, our AMA has dedicated significant resources to improving the prior authorization process for physicians including: identifying the burden of prior authorization through a national physician survey, releasing a collection of 21 Prior Authorization and Utilization Management Reform Principles, and working with states' legislatures on prior authorization regulations, among others. Throughout all of these advocacy efforts, our AMA has abstained from promoting prior authorization compensation out of concern that it would lead to more widespread use of prior authorization without a guarantee that physicians would be fairly compensated for their time. With this concern in mind, the Reference Committee does not wish to modify the Report to promote prior authorization compensation or make this a prior authorization advocacy priority; however, the Reference Committee believes it is worth monitoring potential physician prior authorization reimbursement opportunities in the future.

Overall, there was significant testimony offered in support of Council on Medical Services Report 8 and as such the Reference Committee supports adoption of the recommendations.

(4) COUNCIL ON MEDICAL SERVICE REPORT 10 – PHYSICIAN-FOCUSED
ALTERNATIVE PAYMENT MODELS: REDUCING BARRIERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 10 be adopted.

HOD ACTION: Recommendations in Council on Medical Service Report 10 adopted and the remainder of the report filed.

Council on Medical Service Report 10 offers a set of recommendations intended to address the barriers that interfere with the shift to value-based payment including health information technology and resource use measurement, including risk adjustment, attribution, and performance targets.

Testimony on Council on Medical Service Report 10 was unanimously supportive. A member of the Council introduced the report. Testimony thanked the Council on Medical Service for its thorough report and focus on reducing barriers to the development and implementation of Alternative Payment Models. Accordingly, your Reference Committee recommends that the recommendations in Council on Medical Service Report 10 be adopted and the remainder of the report be filed.

(5) RESOLUTION 713 – URGE AMA TO RELEASE A WHITE PAPER ON
ACOs

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 713 be adopted.

HOD ACTION: Resolution 713 adopted.

Resolution 713 asks that our AMA seek objective, independent data on Accountable Care Organizations and release a whitepaper regarding their effect on cost savings and quality of care.

There was limited testimony on Resolution 713. Your Reference Committee notes the utility of such a study on Accountable Care Organizations. Accordingly, your Reference Committee recommends adoption Resolution 713.

(6) RESOLUTION 717 – ALLOWING EXCEPTIONS TO THE CENTERS FOR
MEDICARE & MEDICAID SERVICES' LOCUM TENENS 60-DAY LIMIT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 717 be adopted.

HOD ACTION: Resolution 717 adopted.

Resolution 717 asks that our AMA request that the Centers for Medicare & Medicaid Services (CMS) create an exception process to the 60-day locum tenens limit for those physicians with unforeseen circumstances, such as serious illness, physical impairment, or family emergency; and to ensure that the exception process contains the same requirements as are necessary to currently bill under a CMS locum tenens arrangement.

There was limited testimony on Resolution 717. A concern was raised that there may not be due process to evaluate the locum tenens physicians and that they may not be going through proper credentialing. Your Reference Committee notes that CMS already requires that a locum tenens physician be a credentialed Medicare provider, and that the exception called for is only for exceptional circumstances and is not calling for a fundamental change in policy. Further, your Reference Committee notes that the second Resolve of this resolution requests that our AMA

ensure that the exception process contains the same requirements as are necessary to currently bill under a CMS locum tenens arrangement. Therefore, your Reference Committee does not believe this concern should preclude the exception called for in this resolution. Accordingly, your Reference Committee recommends that Resolution 717 be adopted.

(7) RESOLUTION 719 – SYSTEM APPROACH TO MEDICAL STAFF GOVERNANCE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 719 be adopted.

HOD ACTION: Resolution 719 adopted.

Resolution 719 asks that our AMA provide guidance to medical staffs on the potential benefits and risks of applying a system approach to medical staff governance, including but not limited to guidance on instituting system-wide processes and leadership structures and otherwise standardizing medical staff bylaws.

Testimony on Resolution 719 was limited and supportive of the recommended guidance. In addition to the sponsor's introduction of the item, other testimony noted that multi-hospital systems can have either an individual or a system-wide medical staff, but that the choice must be specified in the bylaws. Accordingly, your Reference Committee recommends adoption.

(8) RESOLUTION 720 – MEDICAL STAFF NON-PUNITIVE REPORTING PROCESS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 720 be adopted.

HOD ACTION: Resolution 720 adopted.

Resolution 720 asks that our AMA provide guidance, including but not limited to model medical staff bylaws language, to help medical staffs develop and implement reporting procedures that effectively protect medical staff members from retaliation when they report deficiencies in the quality, safety, or efficacy of patient care.

Testimony on Resolution 720 was limited and supportive of the recommended guidance. In addition to the sponsor's introduction of the item, other testimony noted the importance of contractual language to protect "whistle blowers." Accordingly, your Reference Committee recommends adoption.

(9) BOARD OF TRUSTEES REPORT 9 – PHYSICIAN AND MEDICAL STAFF MEMBER BILL OF RIGHTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 in Board of Trustees Report 9 be amended by addition to read as follows:

II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff's ability to fulfill its responsibilities:

a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, ~~and~~ (iv) being advised by independent

legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.

- b. The right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body.
- c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.
- d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments.
- e. The right to be represented and heard, with or without vote, at all meetings of the health care organization's governing body.
- f. The right to engage the health care organization's administration and governing body on professional matters involving their own interests.
- ~~g. The right to determine which individual non-physician health care professionals may be members of the medical staff.~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendation 1 in Board of Trustees Report 9 be amended by addition and deletion to read as follows:

IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, ~~or contractual, or independent~~ status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:

- a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.
- b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.
- c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the health care organization's administration or governing body.
- d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.
- e. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.
- f. The right to immunity from civil damages, injunctive or equitable relief, and criminal liability when participating in good faith peer review activities.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 9 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 9 adopted as amended and the remainder of the report filed.

Board of Trustees Report 9 recommends the adoption and widespread distribution of a concise series of fundamental medical staff rights and responsibilities based on existing AMA policy.

Testimony on Board of Trustees Report 9 was supportive. A member of the Board of Trustees noted that the report takes a fresh look at the bill of rights for medical staff and that all of the points included in the report's recommendation are supported by existing AMA policy. An amendment was offered to add "independent" to Section IV of the report's recommendation to ensure that the rights apply to physicians practicing independently. An additional amendment suggested the addition of new language to Section II to affirm that our AMA recognizes the right of medical staffs to determine which non-physician health care professionals may be members of the medical staff. Your Reference Committee concurs with these suggestions and recommends that the recommendations in Board of Trustees Report 9 be adopted as amended and the remainder of the report be filed.

(10) BOARD OF TRUSTEES REPORT 12 – UNFORESEEN CONSEQUENCES OF CORE MEASURES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 12 be amended by addition of a new Recommendation to read as follows:

That our American Medical Association discourage the implementation of indiscriminant and not medically indicated screening or testing for "pre-existing" infection in patients in order to avoid penalties. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 12 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 12 adopted as amended and the remainder of the report filed.

Board of Trustees Report 12 recommends that Resolution 716-A-16 not be adopted and the remainder of the report be filed.

There was minimal testimony on this report. A member of the Board of Trustees introduced the report. An amendment was offered to add a recommendation to specifically discourage inappropriate screenings, and your Reference Committee agrees with the amendment. An additional amendment was offered stating that our AMA oppose any elected officials or elected legislative body from enacting a medical screening, diagnosis, or treatment protocol into statute. Your Reference Committee believes this amendment may have numerous undesirable and unintended consequences. Accordingly, your Reference Committee recommends that Board of Trustees Report 12 be adopted as amended and the remainder of the report be filed.

(11) COUNCIL ON MEDICAL SERVICE REPORT 4 – SURVEY OF ADDICTION TREATMENT CENTERS' AVAILABILITY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Council on Medical Service Report 4 be amended by addition of a new Recommendation to read as follows:

That our AMA encourage SAMHSA to include private and group practice physicians in its online treatment locator for addiction treatment facilities. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 4 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 4 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 4 recommends that our AMA encourage the Substance Abuse and Mental Health Services Administration (SAMHSA) to use its national surveys to increase the information available on the type of insurance (e.g., Medicaid, Medicare, private insurance) accepted by substance use disorder treatment programs listed in SAMHSA's "treatment locators," and encourage physicians who are authorized to provide medication assisted treatment to opt in to be listed publicly in SAMHSA's "treatment locators."

Testimony on Council on Medical Service Report 4 was generally supportive. A member of the Council introduced the report, stating that the Council concluded after thorough study that a costly national survey of practicing physicians will do little to accomplish the intent of the referred resolution, and that the report's recommendations are intended to increase the inclusiveness of existing "treatment locators." Additional testimony noted that increased awareness of community treatment providers as well as a breakdown of public and private insurance accepted by these programs would be extremely useful to physicians looking to make patient referrals. An amendment from the American Society of Addiction Medicine suggested the addition of a third recommendation that would encourage SAMHSA to include private and group practice physicians in its online treatment locator for addiction treatment facilities. Your Reference Committee heard supportive testimony of this amendment and recommends that the recommendations in Council on Medical Service Report 4 be adopted as amended and the remainder of the report be filed.

(12) COUNCIL ON MEDICAL SERVICE REPORT 7 – RETAIL HEALTH CLINICS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 6 of Council on Medical Service Report 7 be amended by addition and deletion to read as follows:

6. That our AMA supports that any individual, company, or other entity that establishes and/or operates retail health clinics adhere to the following principles:
 - a. Retail health clinics must help patients who do not have a primary care physician or usual source of care to identify one in the community;
 - b. Retail health clinics must use electronic health records to transfer a patient's medical records to his or her primary care physician and to other health care providers, with the patient's consent;
 - c. Retail health clinics must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information;
 - ~~d. Retail health clinics make provisions for all appropriate follow up patient care;~~
 - e. d. Retail health clinics should work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made;
 - ~~f. e.~~ Retail health clinics should use local physicians as medical directors or supervisors of retail clinics; ~~and~~
 - ~~g. f.~~ Retail health clinics should neither not expand their scope of services beyond minor acute illnesses including but not limited to sore throat, common

cold, flu symptoms, cough, and sinus infection nor expand their scope of services to include infusions or injections of biologics; and
g. Retail health clinics should have a well-defined and limited scope of clinical services, provide a list of services provided by the clinic, provide the qualifications of the on-site health care providers prior to services being rendered, and include that any marketing materials the qualifications of the on-site health care providers. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 7 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 7 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 7 recommends that our AMA reaffirm policies on store-based health clinics, the corporate practice of medicine, the physician-led health care team, physician choice of practice and method of earning a living, and proper vaccination protocol; and recommends the adoption of additional safeguards and guidelines to encourage value in retail health clinics consistent with current AMA policy.

Testimony on Council on Medical Service Report 7 was unanimously supportive. A member of the Council introduced the report emphasizing the importance of the recommended safeguards and guidelines. An amendment was offered to add that a retail health clinic should provide a list of services provided by the clinic and the qualifications of the on-site provider. Your Reference Committee agrees and accepts this amendment. An amendment was offered to note that retail health clinics should not expand their scope of services to include injectable medications or biologics. The Council on Medical Service accepts this amendment with a change to reflect that disallowing all injectable medications may not be necessary or feasible. For example, many retail health clinics provide basic injectables such as flu shots and tetanus, among others. Therefore, your Reference Committee offers language saying that retail health clinics should not expand their scope of service to infusions or injections of biologics. Your Reference Committee believes this captures the spirit of the amendment offered. A further amendment was offered to delete Recommendation 6(d) and amend Recommendation 6(e) to reflect that all action should be taken through the primary care physician or usual source of care. This amendment takes into consideration the fact that not all follow-up care arranged by the retail health clinic is necessary and therefore should be undertaken in consultation with the primary care provider. Your Reference Committee agrees.

Accordingly, your Reference Committee recommends that the recommendations in Council on Medical Service Report 7 be adopted as amended and the remainder of the report be filed.

(13) RESOLUTION 701 – THIRD PARTY PAYERS MANDATING DOCTOR AND PATIENT TRANSFERS OF PRESCRIPTIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 701 be amended by addition to read as follows:

RESOLVED, That our AMA advocate that when an insurance company or other third party payer mandates prescription transfers due to a change in their retail pharmacy network, that the payer and pharmacies within network have mechanisms in place to seamlessly transfer the prescription, as initially prescribed with regard to refills, substitutions, and other pertinent prescription details, to the patient's pharmacy of choice without the need for the patient/physician to initiate such transfer, as well as safety mechanisms to ensure that the formulation which has been established and tolerated is available to the patient without a lapse in dispensing. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 701 be adopted as amended.

HOD ACTION: Resolution 701 adopted as amended.

Resolution 701 asks that our AMA advocate that insurers or other third party payers must provide 60 days advance notice of changes in retail pharmacy networks to both patients and all physicians treating these patients; advocate that insurers or other third party payers making changes to their pharmacy network must allow patients to designate a new pharmacy of choice within the network; and advocate that when an insurance company or other third party payer mandates prescription transfers due to a change in their retail pharmacy network, that the payer and pharmacies within network have mechanisms in place to seamlessly transfer the prescription to the patient's pharmacy of choice without the need for the patient/physician to initiate such transfer.

There was generally supportive testimony on Resolution 701. Three amendments were proposed to the third Resolve clause. These amendments were intended to highlight the importance of transferring prescriptions as originally prescribed, both with regards to avoiding substitutions and any potential refill calculation errors, and patient safety, especially with regard to receiving properly formulated drugs. Supporting testimony for these amendments focused on concerns about patients receiving incorrect drugs or additional refills appearing following the pharmacy transfer. One proposed hypothetical situation outlined a scenario wherein a patient's prescription has been transferred to a new pharmacy, but the pharmacy does not acquire its drugs from the same source as the patient's former pharmacy. Testimony was presented that this could potentially lead to complications for patients who receive individually prepared drugs. Another hypothetical offered involved a patient who currently has one refill left on his or her prescription but was originally prescribed five refills. After the prescription transfer, due a system error the patient received a prescription with five more refills, rather than the one he or she actually has remaining. A third hypothetical situation outlined concerns about generics being substituted in lieu of a name brand drug after the transfer, despite the original prescription not allowing for generic substitution.

Limited testimony was offered with regard to amending the language of the resolution to allow for prescriptions to be transferred across state lines. However, due to regulatory concerns surrounding this practice, the Reference Committee has decided not to pursue this amendment at this time.

Accordingly, your Reference Committee recommends that Resolution 701 be adopted as amended.

(14) RESOLUTION 706 – CONCURRENT AND OVERLAPPING SURGERY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 706:

HOD ACTION: The following resolution adopted in lieu of Resolution 706.

RESOLVED, That our American Medical Association work with interested national medical specialty societies on issues related to concurrent and overlapping surgery. (New HOD Policy)

Resolution 706 asks that our AMA advocate for physicians to have an opportunity to engage in policy development related to concurrent and overlapping surgery; recommend that any new policies be based on best available evidence; participate in efforts to educate physicians on various issues associated with concurrent and overlapping surgery, such as quality of care, patient safety, and medical liability; and work with key entities to explore the potential impacts of changing policies regarding concurrent and overlapping surgeries on the future of medical education, physician reimbursement and productivity, physician wellness, and patient access to care.

Testimony on Resolution 706 was supportive of alternate language that simplified the original Resolution 706. It was noted in testimony that there has been media attention on safety issues associated with concurrent surgery. The American College of Surgeons and other surgical specialties testified in support of the alternate language. A speaker also noted that the Federation of State Medical Boards should be consulted on these issues. There was strong support for the alternate language. Your Reference Committee points out that AMA policy must be established by the House of Delegates and recommends adoption of alternate language, which calls on our AMA to work with interested national medical specialty societies on concurrent and overlapping surgery, in lieu of Resolution 706.

(15) RESOLUTION 709 – MANAGEMENT OF PHYSICIAN AND MEDICAL STUDENT STRESS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 709:

HOD ACTION: The following resolution adopted in lieu of Resolution 709.

RESOLVED, That our AMA produce a report on administrative and regulatory burdens placed on physicians, residents and fellows, and medical students, and pursue strategies to reduce these burdens. (Directive to Take Action)

Resolution 709 asks that our AMA produce a report summarizing current research and efforts to address physician practice sustainability and satisfaction.

At the start of testimony, alternate language was offered by the sponsor, who stated that the original resolution crafted by the New York delegation had lost some of its intent before being transmitted to our AMA. The sponsor added that the resolution had come from a state task force on physician stress and burnout. Testimony largely supported the alternate language. A representative of the Federation of State Medical Boards testified about some of our AMA's work on stress and burnout, including the Joy in Medicine Research Summit and the STEPS Forward™ Practice Improvement Strategies. Your Reference Committee recommends that alternate language directing be adopted in lieu of Resolution 709.

(16) RESOLUTION 715 – PRESCRIPTION AVAILABILITY FOR WEEKEND DISCHARGES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 715 be amended by addition of a fourth Resolve to read as follows:

RESOLVED, That these PBMs, health insurers, and pharmacists are always available to resolve these issues of coverage and/or formulary on holidays and weekends to protect patient safety and prevent readmissions.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 715 be adopted as amended.

HOD ACTION: Resolution 715 adopted as amended.

Resolution 715 asks that our AMA work with pharmacy benefit managers (PBMs), health insurers, and pharmacists at a national level to address the problem of patients, discharged by a health care facility on a weekend or holiday, being denied access to vital medications because the patient's health insurance carrier or applicable PBM does not have staff available on weekends or holidays to resolve coverage and/or formulary issues.

There was limited but supportive testimony for Resolution 715; however, some testimony highlighted concern that the current language does not go far enough to protect patient safety. Additional testimony proposed amending the resolution by adding a second Resolve clause that is intended to provide patients with greater support in the event of a weekend or holiday discharge. Your Reference Committee recommends that Resolution 715 be adopted as amended.

(17) RESOLUTION 716 – UNDERSTANDING AND CORRECTING
IMBALANCES IN PHYSICIAN WORK ATTRIBUTABLE TO
ELECTRONIC HEALTH RECORDS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that that the following resolution be adopted in lieu of Resolution 716.

HOD ACTION: The following resolution adopted in lieu of Resolution 716.

RESOLVED, That our American Medical Association work with health care leaders and policymakers to use industrial engineering principles and evidence-based best practices to study and then propose systematic reforms to reduce physicians' electronic health record workload. (Directive to Take Action)

Resolution 716 asks that our AMA work with leaders of the health care delivery system (clinics, hospitals and health systems) and federal governmental leaders at the highest level to use industrial engineering and quality improvement principles and practices to examine the imbalances that have evolved in the time allocation of physician work in order to propose systematic reforms that will reduce the amount of a physician's time in data entry tasks and allow physicians to maximize the time available in their daily work to interact directly with patients and families and maximize the time available for them to design and implement treatment plans within health care teams and to be able to do what they are uniquely trained to do: make appropriate evidence-based medical decisions on behalf of patients.

Testimony on Resolution 716 and the alternate language offered in lieu of the item was very supportive. The author stated that the resolution is not about eliminating electronic health records (EHRs) and that it does not relate to existing AMA policy on interoperability, usability, government mandates or linking payment to EHR use. The author also testified that the resolution calls for involving people from outside as well as inside medicine "to go back to square one" to design and build a system of electronic storage and sharing of health information. Several speakers emphasized that a fresh start is indeed needed and that they would be extremely displeased if existing AMA policy is reaffirmed in lieu of this item. Because testimony unanimously supported the intent of the resolution, your Reference Committee recommends adoption of alternate language which maintains the resolution's intent.

(18) RESOLUTION 721 – SECRET BALLOTS IN MEDICAL STAFF VOTING
PROCESSES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 721 be amended by addition of a third Resolve to read as follows:

RESOLVED, That our AMA support the inclusion of provisions for secret balloting and confidential requests for secret balloting in model medical staff bylaws.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 721 be adopted as amended.

HOD ACTION: Resolution 721 adopted as amended.

Resolution 721 asks that our AMA advocate for the use of secret ballots by medical staffs in all decision-making matters where voting members of the medical staff may be unwilling to publicly vote due to employer or other pressures that could impact how individual members vote; and provide guidance to help organized medical staffs develop and implement secret balloting processes, including specific procedures that allow for individual members of the medical staff to confidentially request a vote by secret ballot.

Testimony on Resolution 721 was limited and supportive of secret ballots by medical staffs, and the ability of medical staffs to confidentially request secret ballots. In addition to the sponsor's introduction of the item, other testimony noted the importance of incorporating these provisions in model medical staff bylaws. Accordingly, your Reference Committee recommends that Resolution 712 be adopted as amended.

(19) BOARD OF TRUSTEES REPORT 18 – ELIMINATE THE REQUIREMENT OF H&P UPDATE**RECOMMENDATION:**

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 18 be referred.

HOD ACTION: Board of Trustees Report 18 referred.

Board of Trustees Report 18 recommends that Resolution 710-A-16 be adopted and the remainder of the report be filed.

Testimony on Board of Trustees Report 18 was mixed but mostly negative. While there was some support for the report's recommendation, a preponderance of the testimony expressed concerns about adopting Resolution 710-A-16. Testimony emphasized the importance of documenting the medical history and physician examination (H&P) updates on the day of a procedure or surgery and the potential risks associated with not documenting these encounters. A speaker noted that failing to document the H&P update would be a violation of conventional risk management practices. Others questioned whether the documentation is in fact an H&P update. The importance of pre-operative visits was also emphasized and it was noted that patients can change their minds about surgeries at the last minute. Because a preponderance of the testimony was in opposition to the report's recommendation, your Reference Committee believes clarification is needed and recommends that it be referred.

(20) RESOLUTION 705 – REGULATING HEALTH PLANS MEDICAL ADVICE**RECOMMENDATION:**

Madam Speaker, your Reference Committee recommends that Resolution 705 be referred.

HOD ACTION: Resolution 705 referred.

Resolution 705 asks that our AMA define when medical advice is the practice of medicine; and study options for regulating medical advice given by health plans.

Testimony on Resolution 705 was mixed, with a preponderance of testimony requesting that the item be referred for further study. While there was general agreement that it is problematic for health plans to be giving medical advice to patients, several speakers emphasized the complexity of the issues raised in the resolution. Additional testimony noted that our AMA has policy affirming that diagnosis of disease constitutes the practice of medicine and that physician-patient relationships should be reinforced and not disrupted by health plan communications to patients. Because several speakers asked for thorough study of the issue of health plans giving medical advice and how states have addressed the issue, your Reference Committee recommends that Resolution 705 be referred.

(21) RESOLUTION 714 – TIMELY REFERRAL TO PAIN MANAGEMENT SPECIALIST

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 714 be referred.

HOD ACTION: Resolution 714 referred.

Resolution 714 asks that our AMA urge the Centers for Medicare and Medicaid Services and the Medicare Contractor Advisory Committee to endorse and adopt evidence-based clinical practice guidelines on the management and treatment of pain including but not limited to timely and appropriate referral to pain management specialists.

A majority of testimony on Resolution 714 opposed mandating that physicians should refer patients to pain management specialists. Several speakers described the lack of access to pain management specialists in their communities as well as long waiting times to see pain specialists, making timely referrals to see these specialists problematic. Testimony emphasized the need to address these issues due to opioid epidemic and the need to help patients manage acute and chronic pain. Your Reference Committee points out the complexities of this resolution because a variety of clinical guidelines for managing pain and referring patients to pain management specialists have already been developed. Your Reference Committee believes that these clinical guidelines should be examined further before new AMA policy is developed and recommends that Resolution 714 be referred.

(22) RESOLUTION 707 – INCLUSION OF CONTINUING CARE RETIREMENT CENTERS & LONG-TERM CARE FACILITIES IN ACCOUNTABLE CARE ORGANIZATIONS INVESTMENT MODEL

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 707 be referred for decision.

HOD ACTION: Resolution 707 referred for decision.

Resolution 707 asks that our AMA advocate to the Centers for Medicare & Medicaid Services to enable Continuing Care Retirement Centers and long-term care facilities and physicians working in those settings to initiate ACO Investment Models.

Testimony on Resolution 707 was mixed. Numerous speakers raised concerns that the action called for in the resolution may result in the potential for abuse and that more information is needed on this issue. A member of the Council on Medical Service offered an amendment by an additional resolve to increase the reach of this resolution to include not only those physicians wanting to participate in ACOs but also those looking to participate in Comprehensive Primary Care Plus and other medical home models. Your Reference Committee sees the potential for Resolution 707 to increase the availability of Alternative Payment Models available to physicians yet also agrees with the concerns raised by numerous speakers that this action may require more thoughtful analysis. Accordingly, your Reference Committee recommends that Resolution 707 be referred for decision.

- (23) RESOLUTION 708 – REMOVING ‘THREE STAR MINIMUM’ REQUIREMENT FOR SKILLED NURSING FACILITIES TO PARTICIPATE IN NEXT GEN ACCOUNTABLE CARE ORGANIZATIONS & BUNDLED PAYMENTS FOR CARE IMPROVEMENT PROGRAMS AND CARE FOR PATIENTS WITH WAIVER OF THREE NIGHT HOSPITAL STAY REQUIREMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 708 be referred for decision.

HOD ACTION: Resolution 708 referred for decision.

Resolution 708 asks that our AMA advocate to the Centers for Medicare & Medicaid Services to remove the three star quality requirement for skilled nursing facilities to participate in Next Gen Accountable Care Organizations and the Bundled Payments for Care Improvement programs with waiver of three night hospital stays for patients.

Testimony on Resolution 708 was mixed. Concerns were raised that there is difficulty obtaining quality data from skilled nursing facilities and that this resolution may be premature. The sponsor of the resolution addressed concerns by clarifying that this resolution is not a mandate to send patients to a facility with less than three stars but rather that this resolution removes the government requirement that transfer may only occur to facilities with at least three stars. Furthermore, the sponsor clarified that the resolution is particular to risk-bearing models participating in an Alternative Payment Model (APM). A member of the Council on Medical Service offered an amendment to broaden the resolution such that the removal of minimum quality requirements would apply across all post-acute care settings, including skilled nursing facilities, and in all Medicare APMs, included Next Gen ACOs and the Bundled Payment for Care Improvement program. The member stated that this amendment is consistent with our AMA’s current efforts to remove the three night stay requirement and efforts to increase the availability of APMs for physicians. Additionally, the member raised concerns whether the star rating system is a true measure of quality and therefore does not believe that this resolution in any way compromises patient care or quality of care. The author welcomed this amendment. Despite the author’s testimony and the amendment offered, your Reference Committee agrees with the numerous speakers citing concerns with this resolution, including those around patient safety. Accordingly, your Reference Committee recommends that Resolution 708 be referred for decision.

- (24) RESOLUTION 711 – EXPANDING ACCESS TO SCREENING TOOLS FOR SOCIAL DETERMINANTS OF HEALTH

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 711 be referred for decision.

HOD ACTION: Resolution 711 referred with report back.

Resolution 711 asks that our AMA provide access to evidence-based screening tools for evaluating and addressing social determinants of health in their physician resources; support the continued integration of evidence-based screening tools evaluating social determinants of health into the electronic medical record and electronic health record; and support fair compensation for the use of evidence-based social determinants of health screening tools and interventions in clinical settings.

Testimony on Resolution 711 was largely supportive; however, there were concerns about adopting the resolution as written because of the need to better understand the variety of available screening tools and the time it takes to screen patients. A member of the Medical Student Section, which sponsored the resolution, testified that physicians must be adequately equipped to screen their patients for social determinants, which have been shown to impact patient health and quality of life, and that disparities created by social determinants of health have been shown to negatively affect health outcomes. Other testimony emphasized that existing policy already encourages screening for social and economic risk factors in order to improve patient care and pointed out that our AMA generally does not

provide screening tools to physicians, as requested by the first Resolve clause. Your Reference Committee agrees that the resolution addresses an important and timely issue but believes that there are complexities to screening for social determinants of health (e.g., usability, availability and evidence supporting current tools; and how to address issues uncovered during screenings) that should be explored further. Accordingly, your Reference Committee recommends that Resolution 711 be referred for decision.

(25) RESOLUTION 718 – DEVELOPING PHYSICIAN LEADERSHIP IN THE IMPLEMENTATION OF DIAGNOSTIC ERROR SURVEILLANCE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 718 be referred for decision.

HOD ACTION: Resolution 702 referred for decision.

Resolution 718 asks that our AMA endorse the recommendations of the Improving Diagnosis in Health Care report published by the National Academy of Medicine in 2015; support having physician satisfaction with administrative and support systems as a standard measure when assessing diagnostic error; analyze from a policy perspective how best to position physicians in what may be increasing review of a physician's diagnostic skills; and report the findings of this analysis, and any recommendations based on these findings, at the 2018 Annual Meeting of the House of Delegates.

Testimony on Resolution 718 was mixed. The Council on Medical Service offered alternative language advocating that measures of diagnostic accuracy should incorporate the perspective of physicians including physician satisfaction. As testimony noted, our AMA generally does not endorse reports promulgating a complex set of recommendations without a thorough review. The resolution calls for our AMA to endorse complex, multifaceted recommendations on clinical practice, scientific diagnostic processes, and medical liability issues. In the interest of prudence, the Council member noted that such an endorsement should only take place after a comprehensive review of the report. Further, as testimony indicated, the third Resolve clause of Resolution 718 may be problematic because the creation of diagnostic accuracy programs or the development of recommendations on how physicians should handle this type of assessment in practice is outside the scope of our AMA. Additional testimony highlighted the importance of expeditious action on this item because the National Quality Forum is releasing a report on measuring diagnostic accuracy, and that taking action on this resolution would allow us the opportunity to comment and take expedient action on this issue. Accordingly, your Reference Committee recommends that Resolution 718 be referred for decision.

(26) RESOLUTION 702 – CREDENTIALS/SPECIALTY ADDED TO CLINICAL NOTE SIGNATURES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 702 not be adopted.

HOD ACTION: Resolution 702 not adopted.

Resolution 702 asks that our AMA work collaboratively with appropriate national and state hospital associations and other appropriate organizations to encourage those entities, when feasible, to provide the treating practitioner's specialty/credentials to signed progress/consult/operative notes.

There was mixed testimony on Resolution 702 with numerous speakers citing concerns with this resolution. Testimony noted that providing credentials is a more complex and burdensome issue than the resolution recognizes. For example, such credentials include board certification, additional degrees, and fellow status, among others, and the Reference Committee believes such options to be numerous and potentially limitless. Further, testimony stated that undertaking this work may not be within the purview of our AMA but rather should be dealt with at a local level and with hospitals and hospital associations. Your Reference Committee agrees and believes that our AMA and

others must balance the additional demands requested in EHR design versus focusing on issues such as interoperability and easing the administrative burden of EHRs. As such, your Reference Committee recommends that Resolution 702 not be adopted.

(27) RESOLUTION 703 – CERTIFIED TRANSLATION SERVICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies D-385.978, D-160.992, and H-160.924 be reaffirmed in lieu of Resolution 703.

HOD ACTION: Resolution 703 adopted as amended with change in title.

CERTIFIED TRANSLATION AND INTERPRETER SERVICES

RESOLVED, That our American Medical Association work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act. (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services, with a progress report at the 2017 Interim Meeting of the AMA House of Delegates. (Directive to Take Action)

Resolution 703 asks that our AMA work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act.

There was supportive testimony on Resolution 703. A member of the Council on Medical Service stressed that existing policy already fulfills the issue outlined in the resolution and noted that our AMA is actively engaging the Administration on the burden of providing translation services. An amendment was offered by the sponsor to request that payment for such services be furnished from the insurer directly to the translator. However, your Reference Committee not only believes that this request is potentially problematic but also finds the abundance of current AMA policy and advocacy on the issue to be appropriate. Your Reference Committee agrees that our AMA is already working to relieve the burden associated with translation services and is exploring all avenues of relieving this burden on physicians. Accordingly, Reference Committee recommends that Policies D-385.978, D-160.992, and H-160.924 be reaffirmed in lieu of Resolution 703.

D-385.978, Language Interpreters

Our AMA will: (1) continue to work to obtain federal funding for medical interpretive services; (2) redouble its efforts to remove the financial burden of medical interpretive services from physicians; (3) urge the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement; (4) consider the feasibility of a legal solution to the problem of funding medical interpretive services; and (5) work with governmental officials and other organizations to make language interpretive services a covered benefit for all health plans inasmuch as health plans are in a superior position to pass on the cost of these federally mandated services as a business expense. (Res. 907, I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation A-09; Reaffirmation A-10; Reaffirmed: CMS Rep. 5, A-11; Reaffirmed in lieu of Res. 110, A-13)

Appropriate Reimbursement for Language Interpretive Services D-160.992

1. Our AMA will seek legislation to eliminate the financial burden to physicians, hospitals and health care providers for the cost of interpretive services for patients who are hearing impaired or do not speak English.
2. Our AMA will seek legislation and/or regulation to require health insurers to fully reimburse physicians and other health care providers for the cost of providing sign language interpreters for hearing impaired

patients in their care. (Res. 209, A-03; Reaffirmation A-09; Reaffirmation A-10; Appended: Res. 114, A-12; Reaffirmed: Res. 702, A-12; Reaffirmation A-14)

H-160.924, Use of Language Interpreters in the Context of the Patient-Physician Relationship
AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care;
(2) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive;
(3) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid LEP patients' involvement in meaningful decisions about their care; and
(4) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements. (BOT Rep. 8, I-02; Reaffirmation I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation A-09; Reaffirmed: CMS Rep. 5, A-11; Reaffirmed in lieu of Res. 110, A-13)

(28) RESOLUTION 712 – PAY-FOR-PERFORMANCE INCENTIVES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-450.947, H-155.960, H-390.849, and H-165.838 be reaffirmed in lieu of Resolution 712.

HOD ACTION: Policies H-450.947, H-155.960, H-390.849, and H-165.838 reaffirmed in lieu of Resolution 712.

Resolution 712 asks that our AMA advocate with payers and other physician performance review organizations a new standard whereby performance incentives would be linked to the performance of the physician in providing and documenting appropriate advice on preventative care and self-care to patients and/or their parents and applicable incentives would be earned through delivery and documentation of appropriate advice that are considered equal to the performance incentive based on a clinical outcome; and work with any organization measuring physicians through incentive or performance programs to adopt standards that do not penalize physicians for the actions of patients who cannot or who will not comply with excellence in clinical recommendations.

Testimony on Resolution 712 was limited. Several speakers called for reaffirmation of current policy in lieu of Resolution 712. A member from the Council on Medical Service noted numerous policies that already state that pay-for-performance (PFP) programs must recognize outcome limitations caused by patient non-adherence, PFP designs should attempt to minimize non-adherence effects, PFP programs must not financially penalize physicians based on factors outside their control, and PFP programs should attempt to minimize non-adherence through plan design. Testimony went on to state that current policy supports continued AMA advocacy that physicians be supported in providing lifestyle counseling to patients through adequate third-party payment and inclusion of lifestyle counseling in quality measurement and PFP incentives. Your Reference Committee agrees and therefore recommends reaffirmation of policy in lieu of Resolution 712.

H-450.947, Pay-for-Performance Principles and Guidelines

PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS

Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:

1. Ensure quality of care - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate

specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.

2. Foster the patient/physician relationship - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.

3. Offer voluntary physician participation - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.

4. Use accurate data and fair reporting - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.

5. Provide fair and equitable program incentives - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS

Safe, effective, and affordable health care for all Americans is the AMA's goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA's "Principles for Pay-for-Performance Programs" and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.

Quality of Care

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.

- Evidence-based quality of care measures must be the primary measures used in any program.

1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties.

2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.

3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.

4. Performance measures should be scored against both absolute values and relative improvement in those values.

5. Performance measures must be subject to the best-available risk- adjustment for patient demographics, severity of illness, and co-morbidities.

6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.

7. Performance measures must be selected for clinical areas that have significant promise for improvement.

- Physician adherence to PFP program requirements must conform with improved patient care quality and safety.

- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.

- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.

- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.

- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties.

Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.

- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

Patient/Physician Relationship

- Programs must be designed to support the patient/physician relationship and recognize that physicians are

ethically required to use sound medical judgment, holding the best interests of the patient as paramount.

- Programs must not create conditions that limit access to improved care.

1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients.

2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).

- Programs must neither directly nor indirectly encourage patient de-selection.

- Programs must recognize outcome limitations caused by patient non-adherence, and sponsors of PFP programs should attempt to minimize non-adherence through plan design.

Physician Participation

- Physician participation in any PFP program must be completely voluntary.

- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.

- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.

- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.

- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).

1. Programs should provide physicians with tools to facilitate participation.

2. Programs should be designed to minimize financial and technological barriers to physician participation.

- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.

- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.

- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.

- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

Physician Data and Reporting

- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).

- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner.

1. Programs should use accurate administrative data and data abstracted from medical records.

2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.

3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.

- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.

- Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.

- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.

1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives.

2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.

- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely

promulgated.

- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.
- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards

- Programs must be based on rewards and not on penalties.
- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.
- Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.
- Programs must finance bonus payments based on specified performance measures with supplemental funds.
- Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.
- Programs must not reward physicians based on ranking compared with other physicians in the program.
- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.
- **Programs must not financially penalize physicians based on factors outside of the physician's control.**
- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.
- Programs must not financially penalize physicians when they follow current, accepted clinical guidelines that are different from measures adopted by payers, especially when measures have not been updated to meet currently accepted guidelines.

2. Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-Performance." (BOT Rep. 5, A-05; Reaffirmation A-06; Reaffirmed: Res. 210, A-06; Reaffirmed in lieu of Res. 215, A-06; Reaffirmed in lieu of Res. 226, A-06; Reaffirmation I-06; Reaffirmation A-07; Reaffirmation A-09; Reaffirmed: BOT Rep. 18, A-09; Reaffirmed in lieu of Res. 808, I-10; Modified: BOT Rep. 8, I-11; Reaffirmed: Sub. Res. 226, I-13; Appended: BOT Rep. 1, I-14; Reaffirmed in lieu of Res. 203, I-15; Reaffirmed in lieu of Res. 216, I-15; Reaffirmation I-15; Reaffirmed: BOT Rep. 20, A-16)

H-155.960, Strategies to Address Rising Health Care Costs

- (1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government;
- (2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease;
- (b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and
- (d) promote "value-based decision-making" at all levels;
- (3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and medical education and training;
- (4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers;
- (5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to

- support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors;
- (6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings;
- (7) encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and
- (8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care.
- (9) Our AMA will, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system. (CMS Rep. 8, A-07; Reaffirmed: CMS Rep. 7, A-08; Reaffirmed in lieu of Res. 828, I-08; Reaffirmation A-09; Reaffirmation I-09; Reaffirmation A-11; Reaffirmation I-11; Appended: Res. 239, A-12; Reaffirmed in lieu of Res. 706, A-12; Reaffirmed: CMS Rep. 1, I-12; Modified: CMS Rep. 2, A-13; Reaffirmed in lieu of Res. 122, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed: CMS Rep. 05, I-16; Reaffirmation I-16)

H-390.849, Physician Payment Reform

1. Our AMA will advocate for the development and adoption of physician payment reforms that adhere to the following principles:
 - a) promote improved patient access to high-quality, cost-effective care;
 - b) be designed with input from the physician community;
 - c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions;
 - d) not require budget neutrality within Medicare Part B;
 - e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice;
 - f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process;
 - g) make participation options available for varying practice sizes, patient mixes, specialties, and locales;
 - h) use adequate risk adjustment methodologies;
 - i) incorporate incentives large enough to merit additional investments by physicians;
 - j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols;
 - k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization;
 - l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and
 - m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.
2. Our AMA opposes bundling of payments in ways that limit care or otherwise interfere with a physician's ability to provide high quality care to patients.
3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data.
4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment. (CMS Rep. 6, A-09; Reaffirmation A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-12; Modified: CMS Rep. 6, A-13; Reaffirmation I-15; Reaffirmation: A-16)

Health System Reform Legislation H-165.838

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:

- a. Health insurance coverage for all Americans
- b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
- c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
- d. Investments and incentives for quality improvement and prevention and wellness initiatives
- e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
- f. Implementation of medical liability reforms to reduce the cost of defensive medicine
- g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens
2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.
4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.
5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.
6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.
8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
 - a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
 - b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
 - c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
 - d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
 - e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
 - f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest
9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.
10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.
11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.
12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.
13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform. (Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-

10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15)