

**REPORTS OF REFERENCE COMMITTEES OF THE AMERICAN MEDICAL ASSOCIATION
HOUSE OF DELEGATES 2013 INTERIM MEETING****REPORT OF REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS**

- (1) BOARD OF TRUSTEES REPORT 7 - NATIONAL INDIAN HEALTH BOARD: OFFICIAL OBSERVER STATUS IN THE HOUSE OF DELEGATES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the Recommendations in Board of Trustees Report 7 be adopted and the remainder of the report be filed.

HOD ACTION: in Board of Trustees Report 7 adopted and the remainder of the report filed.

Board of Trustees Report 7 asks that the National Indian Health Board be granted official observer status in our AMA House of Delegates.

Testimony favored adoption of this report with no opposition. The National Indian Health Board has met all the requirements in our Bylaws to obtain official observer status and our Board of Trustees believes the NIHB would bring a strong perspective to the House of Delegates and that their inclusion is consistent with the ideals of the AMA. Therefore, your Reference Committee recommends that Board of Trustees Report 7 be adopted.

- (2) BOARD OF TRUSTEES REPORT 11 - SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES - FIVE -YEAR REVIEW

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the Recommendations in Board of Trustees Report 11 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 11 adopted and the remainder of the report filed.

Board of Trustees Report 11 summarizes the five-year review of specialty society representation in the House of Delegates. The report recommends that the American Academy of Allergy, Asthma and Immunology, American Academy of Ophthalmology, Inc., American Academy of Orthopaedic Surgeons, American Academy of Otolaryngology – Head and Neck Surgery, Inc., American Academy of Pain Medicine, American Academy of Pediatrics, American Academy of Physical Medicine and Rehabilitation, and the American Association of Neurological Surgeons retain representation in the American Medical Association House of Delegates.

The Board of Trustees introduced this report and there was no further testimony. Your Reference Committee recommends that Board of Trustees Report 11 be adopted.

(3) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 2 - AMA
WOMEN PHYSICIANS SECTION - ADDITIONAL BYLAWS

RECOMMENDATION:

Mr. 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 be adopted and the remainder of the report filed.

Council on Constitution and Bylaws Report 2 asks that our AMA amend its bylaws related to elections for the American Medical Association's Women Physicians Section (WPS). The modification would add provisions to Bylaw 7.100, to stipulate the virtual election of the Governing Council by the entire WPS membership, the election of the Chair and Vice Chair by the elected Governing Council, and a "grace period" for Governing Council members from the Medical Student, Resident and Fellow and Young Physician sections who cease to meet the eligibility requirement for membership in their respective section within 90 days of the annual WPS meeting.

Testimony supported the adoption of this report. Testimony on behalf of the WPS gave enthusiastic support for this report, and the WPS looks forward to further promoting women's health issues in our AMA. Other testimony also offered unanimous support in favor of this report. For these reasons, your Reference Committee recommends that Council on Constitution and Bylaws Report 2 be adopted.

(4) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 2 -
AMENDMENT TO E-8.061, "GIFTS TO PHYSICIANS FROM INDUSTRY"

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the Recommendations in Council on Ethical and Judicial Affairs Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Ethical and Judicial Affairs Report 2 adopted and the remainder of the report filed.

Council on Ethical and Judicial Affairs Report 2 updates ethics policy on gifts to physicians from industry to reflect best thinking in the area and to respond to growing empirical evidence about the influence of industry relationships on physician practice.

Testimony overwhelmingly supported the adoption of this report. While one piece of testimony discussed unease with use of the word "special" in the context of funding for medical residents, the remaining testimony spoke favorably to the work of CEJA in updating the report and its recommendations. Several groups noted that the report provides excellent recommendations that are clear and consistent in their guidance given the continuing dilemma presented by conflicts of interest. Because of the strength of this testimony, your Reference Committee unanimously recommends that Council on Ethical and Judicial Affairs Report 2 be adopted.

(5) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 5 -
PROFESSIONALISM IN HEALTH CARE SYSTEMS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the Recommendations in Council on Ethical and Judicial Affairs Report 5 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Ethical and Judicial Affairs Report 5 adopted and the remainder of the report filed.

Council on Ethical and Judicial Affairs Report 5 recommends that Opinions E-8.051, Conflicts of Interest Under Capitation; E-8.054, Financial Incentives and the Practice of Medicine; E-8.056, Physician Pay-for-Performance Programs; E-8.13, Managed Care; and E-8.135, Cost Containment Involving Prescription Drugs in Health Care Plans be amended by substitution of the Recommendations of this report (new Opinion). The report examines professionalism in health care systems, and based on the guidance in these earlier opinions regarding various aspects of professionalism in physicians' relationships with health care organizations and payers, provides guidance pertaining to core ethical considerations for physician professionalism in the context of efforts to contain costs and improve quality in health care systems.

Testimony was given for both adoption and referral. The testimony in support of adoption noted that it is a timely report and accurately places professional goals in line with patient care. The notion that physicians should be expected to work at full capacity but not beyond was noted by several members as laudable, given that patient care can ultimately suffer when physicians are overworked or expected to adhere to unreasonable employment demands. Concerns urging referral suggested the report does not adequately respect a physician's primary duty to the patient, and further that physicians may be coerced or adversely pressured by non-physician leaders in a health care system to accept patients or duties beyond their capacity. However, CEJA addressed these concerns in further testimony, noting that in the first instance physician health and wellness needs to be addressed in order to preserve patient care, and that recommendation (f) notes to "recognize physicians' primary obligation to their patients[...]" In the latter instance, CEJA responded that the *Code of Medical Ethics* cannot speak to non-physicians, but that recommendation (h) states to "hold physician-leaders accountable to meeting conditions for professionalism in health care systems". Your Reference Committee believes that CEJA's responses to the concerns were appropriate. Therefore, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 5 be adopted.

(6) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 1 - PHYSICIAN EXERCISE OF CONSCIENCE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 1 be amended by addition and deletion on page 9, lines 4-5 to read as follows:

(b) Prospectively notify patients about ~~any~~ those services the physician declines to offer for reasons of deeply held, well-considered personal belief.

RECOMMENDATION B:

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

HOD ACTION: Council on Ethical and Judicial Affairs Report 1 referred.

Council on Ethical and Judicial Affairs Report 1 examines the implications for patients, physicians, and the medical profession when tensions arise between a physician's professional commitments and his or her deeply held personal moral beliefs. It offers guidance on when a physician's professional commitments should outweigh personal beliefs as well as when physicians should have freedom to act according to the dictates of conscience while still protecting patients' interests.

Testimony from CEJA suggested an amendment to the language of recommendation (b) to change "any services" to "those services". Testimony in favor of this report was strong, however some testimony spoke to concerns with the current content of the recommendations. Those arguing in favor of approving the report applauded the revisions made by CEJA since the 2013 Annual Meeting, and testimony noted that the recommendations provide a suitable

framework for discussion on a physician's right of conscience, striking a balance of ethical consideration. Other testimony stated that the current recommendations fall in line with the ethics policy of their respective groups. Concerns about the report were raised, however. Several groups discussed problems with the content of recommendation (e), which concerns referral of patients. Some felt the language of (e) was not strong enough in its position, and others expressed dissatisfaction with this section's potential applicability to vulnerable populations who may be unable to seek alternative sources of care. Testimony from others expressed unease with the language in recommendations (b) and (c). In response to these apprehensions, members of CEJA provided testimony on the reasoning behind these recommendations, and spoke to the exhaustive efforts undertaken in researching and deliberating the language in these recommendations. Having carefully considered the arguments in favor of this report, as well as objections to the report's recommendations, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 1 be adopted as amended.

(7) RESOLUTION 001 - TUBAL LIGATION AND VASECTOMY CONSENTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first Resolve of Resolution 001 be amended by addition to read as follows:

RESOLVED, That our American Medical Association work closely with the American Congress of Obstetricians and Gynecologists, the American Urological Association, and any other interested organizations, to advocate to Congress for the legislative or regulatory elimination of the required 30 day interval between informed consent and a permanent sterilization procedure (Directive to Take Action);

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 001 be adopted as amended.

HOD ACTION: Resolution 001 adopted as amended.

Resolution 001 asks that our American Medical Association work closely with the American Congress of Obstetricians and Gynecologists, and any other interested organizations, to advocate to Congress for the legislative or regulatory elimination of the required 30 day interval between informed consent and a permanent sterilization procedure; work with the Centers for Medicare & Medicaid Services to eliminate the time restrictions on informed consent for permanent sterilization procedures; and study the current ramifications of the existing regulations mandating a waiting period for informed consents for Medicaid patients undergoing tubal ligations and vasectomies, specifically noting potential financial costs regarding bureaucratic enforcement, unintended pregnancies, public health and ethical considerations and concomitant health care inequity/disparity issues and requesting a report back to the AMA House of Delegates at the 2014 Annual Meeting.

Testimony for this resolution favored adoption. Testimony highlighted in large part how removing the required interval between consent and these procedures would help reduce barriers to care for disadvantaged populations. The 30 day requirement was noted as arbitrary, no longer necessary, and even harmful. Compelling testimony regarding these procedures in an oncological context made clear that in some cases tubal ligation or vasectomy may be a necessary procedure, and delaying such treatment for purposes of a 30 day requirement consent interval is harmful to these patients. Limited testimony spoke about the historical nature of forced tubal ligations and vasectomies given to individuals in non-English speaking patient groups or those who suffer from mental illness. This highlights the need for informed consent, which today is enforced on a much more consistent and thorough basis than in the past. Finally, while current AMA policy may reflect the first two Resolves, the third Resolve, which asks for the AMA to study the current ramifications of the existing regulations mandating a waiting period, warrants adoption. As noted, harms to various patient populations seem to arise from this mandate, and your Reference Committee believes that an AMA report is appropriate. Therefore, your Reference Committee recommends that Resolution 001 be adopted as amended.

(8) RESOLUTION 002 - RIGHT OF CONSCIENCE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that American Medical Association Policy H-225.950 be amended by addition to read as follows:

1. Addressing Conflicts of Interest

a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.

b) Employed physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.

d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.

(i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and

(ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.

e) Assuming a title or position that may remove a physician from direct patient-physician relationships – such as medical director, vice president for medical affairs, etc. – does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. Advocacy for Patients and the Profession

a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.

b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting

a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.

b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.

c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.

d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.

e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges.

f) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.

g) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations

a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.

b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.

c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations

a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.

b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.

c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians – not lay administrators – should be ultimately responsible for all peer review of medical services provided by employed physicians.

d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.

e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity,

employee contribution to the administrative/operational activities of the employer, etc.

f) Unless specified otherwise in the employment agreement, upon termination of employment with or without cause, an employed physician should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements

a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.

b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that American Medical Association Policy H-225.950 be adopted as amended in lieu of Resolution 002.

HOD ACTION: Policy H-225.950 adopted as amended in lieu of Resolution 002.

Resolution 002 calls for the greater protections of a physician who seeks to exercise his or her conscientious objection to performing or assisting medical procedures that are in opposition to the physician's religious beliefs or moral convictions. In addition, the resolution asks that a physician be protected from discrimination in the workplace because of his or her moral or religious principles. The resolutions call for these provisions to be added to existing AMA policy.

Testimony regarding this resolution was largely supportive. Testimony agreed with the amendment that clarified this provision should apply to non-emergency situations. This is a timely issue, particularly in light of Council of Ethical and Judicial Affairs Report 1, and important to include in the Principles of Physician Employment. Further, your Reference Committee struck the term "termination of employment" due to the fact that this is redundant with the term "employment". Your Reference Committee therefore believes that the amended resolution, which amends American Medical Association Policy H-225.950, should be adopted.

(9) RESOLUTION 003 - HOSPITAL MERGERS AND REPRODUCTIVE HEALTH

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 003 be adopted:

RESOLVED, That our American Medical Association work to ensure, through appropriate state oversight agencies, that where hospital mergers and acquisitions may lead to restrictions on reproductive health care services, the merging entity shall be responsible for ensuring continuing community access to these services.

HOD ACTION: Substitute Resolution 003 adopted.

Resolution 003 asks that our American Medical Association work to ensure that hospital mergers and acquisitions do not restrict access to women's choices in the management of their reproductive medical care, while respecting an individual medical provider's religious beliefs and moral convictions.

Testimony largely favored adoption of this report, particularly with the amendments presented by the authors of the resolution. Those in favor stated that the resolution would help eliminate barriers to access to care for patients, and help to keep services available as a result of hospital mergers and acquisitions. Several testified that when their own hospitals merged with other hospitals which had restricted access to certain services, the physicians were able to work out arrangements within the community to keep those services available. Limited testimony expressed concern that economic justifications may be behind limiting certain services or merging in the first place. However, your Reference Committee found the supportive testimony favorable, and therefore recommends that Substitute Resolution 003 be adopted.

(10) RESOLUTION 004 - REPRODUCTIVE PARITY

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 004 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association support legislation and policies that require any health insurance products offering maternity services to include all choices in the management of their reproductive medical care, ~~while respecting an individual medical provider's religious beliefs or moral convictions.~~ (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 004 be adopted as amended.

HOD ACTION: Resolution 004 adopted as amended.

Resolution 004 asks that our American Medical Association support legislation and policies that require any health insurance products offering maternity services to include all choices in the management of their reproductive medical care, while respecting an individual medical provider's religious beliefs or moral convictions.

Testimony for this resolution was mixed. While the majority of testimony favored the intention of this report, there was considerable concern for the use of the words "all choices", specifically that the language implies that every and any service related to reproductive care should be covered by insurance. While your Reference Committee agrees

that this would be a burden on the health care system, it seems as though this was not the intention of the resolution. Further, after careful consideration and deliberation, your Reference Committee concludes that the Resolution is asking the AMA simply to support legislation and policies that do include all choices in the management of reproductive medical care. Finally, the amendment offered by the authors to remove the last clause in the Resolved statement was supported in testimony. For these reasons, your Reference Committee recommends that Resolution 004 be adopted as amended.

(11) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 4 -
ETHICALLY SOUND INNOVATION IN MEDICAL PRACTICE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 4 be referred.

HOD ACTION: Council on Ethical and Judicial Affairs Report 4 referred.

Council on Ethical and Judicial Affairs Report 4 examines the conditions for ethical innovations and the ethical responsibilities of physicians who participate in designing, developing, disseminating, or adopting innovative and as yet unproven modalities.

Testimony regarding Council on Ethical and Judicial Affairs Report 4 was predominately in favor of referral. Those groups speaking to the recommendations offered in this report consistently identified areas for further refinement and revision. Representatives from a variety of groups discussed the report's potential for stifling medical innovation given that innovation often begins with a single patient and does not initially consider the wider medical needs of the population. Furthermore, in certain areas of medicine, a physician might not have peers with whom to consult on potentially innovative medical practices. Another consistent theme from testimony was the problem of cost effectiveness. Testimony stated that affordability of an innovative procedure may not be easily ascertained, that the issue of cost is not the same for all patients, and that cost cannot be the only consideration in determining the provision of innovative medical practices. Numerous personal accounts about medical innovation were conveyed, elucidating the critical role innovation can play in a wide variety of medical specialties and practices. Despite reservations over the report's current status, testimony supported CEJA in its efforts to address this complex subject, and applauded the work that is being done on this report. Given the overwhelming testimony supporting referral, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 4 be referred.

(12) RESOLUTION 006 - RESTRICTIONS ON MARKETING IN HOSPITALS
AND MEDICAL CENTERS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 006 be referred.

HOD ACTION: Resolution 006 referred.

Resolution 006 asks that our American Medical Association support policies, duly adopted by a medical staff or facility governing body within its scope of authority: (1) that govern the level and content of contact between physicians and pharmaceutical, device and other medical product representatives in hospital and medical center settings in order to minimize undue external influence over medical judgment and patient care as necessary and appropriate for the particular medical staff or facility; and (2) that promote education, training, operative orientation and coaching as the focus of such contact; and that our American Medical association urge the American Hospital Association to support such policies.

Testimony on this resolution was mixed, but largely steered towards opposition. Concerns were raised about the restrictions this places on physicians, and that the resolution could revisit the complicated issue of having medical device representatives in attendance in surgical settings. Testimony noted that this resolution has the potential for

inciting significant discomfort in many physicians because of the potential problems it poses in medical practice. Because of the complex and important issues this resolution raises, your Reference Committee recommends that Resolution 006 be referred.

(13) RESOLUTION 005 - OPPOSITION TO RESTRICTIONS ON PHYSICIAN/
PATIENT FREE SPEECH

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-373.995 and H-5.989 be reaffirmed in lieu of Resolution 005.

HOD ACTION: Policies H-373.995 and H-5.989 reaffirmed in lieu of Resolution 005.

Resolution 005 asks that our American Medical Association oppose any and all attempts to restrict physician discussion with patients of any issue relevant to the patient's health and safety.

Testimony regarding this resolution was overwhelmingly supportive. Testimony uniformly regarded freedom of communication between the patient and physician to be of utmost importance, and any restrictions on such are harmful to the patient-physician relationship and patient health. Current AMA policy states this as well. Policy H-373.995 "Government Interference in Patient Counseling" "vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients". Similarly, H-5.989 "Freedom of Communication Between Physicians and Patients" "strongly condemn[s] any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient". Your Reference Committee believes that these current policies adequately address the concerns in Resolution 005, and therefore your Reference Committee recommends that Policy H-373.995 and Policy H-5.989 be reaffirmed in lieu of Resolution 005.

(14) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OPINION 1-I-13,
AMENDMENT TO E-5.055, "CONFIDENTIAL CARE FOR MINORS"

RECOMMENDATION:

Mr. 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 responds to Resolution 1-A-12, "HPV Vaccination for Minors", which asked our AMA to develop and support policy allowing emancipated minors to consent to the human papillomavirus vaccine. This opinion amends Opinion E-5.055, "Confidential Care for Minors", to clarify that minors' ability to consent to treatment for sexually transmitted disease also includes the ability to consent to measures to prevent sexually transmitted disease.

Although this opinion was extracted on the floor of the House of Delegates, no testimony was offered. This corresponding report was previously adopted by the House of Delegates at the Annual 2013 meeting. Therefore, your Reference Committee recommends that this opinion be filed.

REPORT OF REFERENCE COMMITTEE B**(1) RESOLUTION 216 – PAYMENT OF PENALTIES AND INTEREST TO PHYSICIANS FOR RAC AUDITS****RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends that Resolution 216 be adopted.

HOD ACTION: Resolution 216 adopted.

Resolution 216 asks that our American Medical Association advocate for penalties and interest to be imposed on the auditor and payable to the physician when a RAC audit or appeal for a claim has been found in favor of the physician. (New HOD Policy)

Your Reference Committee heard strong testimony in support of Resolution 216. Your Reference Committee strongly believes that Recovery Audit Contractor (RAC) auditors should be subject to penalties and interest that should be paid to a physician when a RAC audit or appeal has been found in favor of the physician. Your Reference Committee is aware that our AMA sent an August 30, 2013 letter to the Centers for Medicare and Medicaid Services (CMS) advocating for a penalty for RAC errors and a requirement that RACs reimburse physicians for the costs incurred in defending against RACs whenever an appeal against them is won, including legal fees. Your Reference Committee notes that AMA policy also supports the enactment of fines, penalties, and the recovery of costs incurred in defending against RACs whenever an appeal against them is won, in order to discourage inappropriate and illegitimate work by RACs. Your Reference Committee is also aware that our AMA submitted a June 29, 2012 white paper to the Senate Finance Committee advocating that RACs should be subject to a penalty for incorrect overpayment determinations. Your Reference Committee believes that Resolution 216 is consistent with ongoing AMA advocacy and, therefore, recommends that Resolution 216 be adopted.

(2) RESOLUTION 225 – MAINTENANCE PAYMENTS FOR ELECTRONIC HEALTH RECORDS**RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends that Resolution 225 be adopted.

HOD ACTION: Resolution 225 adopted.

Resolution 225 asks: 1. that our American Medical Association (AMA) advocate for inclusion of payment supplements in the current and proposed payment systems specifically to cover the costs of maintaining (including upgrades of) electronic health records (EHRs) at a national level by whatever means available (Directive to Take Action); and 2. that our AMA evaluate and monitor the cost to physicians and their practices of maintaining and upgrading EHRs. (Directive to Take Action)

Your Reference Committee heard unanimous testimony in support of Resolution 225. Testimony highlighted that the cost of electronic health records is not limited to purchasing the new systems but also the many upgrades, new software, and additional training required to maintain EHRs. Testimony also clarified that additional funding need not come from the federal government, and that our AMA should consider other potential sources. Your Reference Committee fully recognizes the significant costs of adopting and using EHRs and that the Meaningful Use incentives fail to cover these ongoing expenses. Your Reference Committee, therefore, agrees that additional funding is appropriate and necessary and recommends adoption of Resolution 225.

(3) RESOLUTION 205 – ALLEVIATING THE FINANCIAL BURDENS ASSOCIATED WITH ICD-10 IMPLEMENTATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 205 be adopted.

HOD ACTION: Resolution 205 adopted.

Resolution 205 states that our American Medical Association seek federal legislative and regulatory reform to require funding assistance be provided to physician practices to alleviate the financial burdens associated with the implementation costs, upgrades and staff training necessitated as part of the transition to ICD-10. (Directive to Take Action).

Your Reference Committee heard strong support for Resolutions 205. Those in support testified that implementation of ICD-10 coding will create significant financial burdens and workflow disruptions for physicians, especially at a time when physicians are in various stages of trying to implement electronic health records and comply with other quality reporting programs. Your Reference Committee also heard concern over the lack of testing of the new code set prior to its implementation and the need for a transition period if the code set is ever adopted. Testimony also strongly encouraged that our AMA and its members support and encourage co-sponsors for H.R. 1701, the “Cutting Costly Codes Act,” and the companion bill S. 972, which would halt implementation of the ICD-10 code set and require the Government Accountability Office (GAO) to recommend a less disruptive replacement for ICD-9.

Your Reference Committee strongly agrees with the testimony heard and recognizes the substantial financial and administrative burdens ICD-10 would place on physicians. Your Reference Committee, therefore, recommends adoption of Resolution 205, which would help cover the costs of implementation, upgrades, and staff training.

(4) BOARD OF TRUSTEES REPORT 2 – NON-PHYSICIAN PRACTITIONERS CERTIFYING MEDICARE PATIENTS’ NEED FOR THERAPEUTIC SHOES AND INSERTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 3 of Board of Trustees Report 2 be amended by addition to read as follows:

3. That our AMA officially adopt the following definition of “physician-led collaboration,” in the context of physician-led, team-based health care: A set of communication and decision-making processes and actions carried out over time by and among members of a physician-led health care team related to the treatment and care of patients, including: (i) formal, often structured and multi-directional, communication of information about the treatment and care of patients, including clinical observations and assessments; (ii) development of appropriate plans of care, including decisions regarding the health care to be provided, accessing and assessment of appropriate additional resources or expertise, and arrangement of appropriate referrals, testing, or studies; and (iii) coordinating the actions and responsibilities necessary to carry out these plans effectively, taking into account the proven skills, knowledge, and capabilities of each member of the physician-led health care team. (New HOD Policy)

RECOMMENDATION B:

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

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Board of Trustees Report 2 be changed to read as follows:

DEFINITIONS OF PHYSICIAN-LED SUPERVISION AND
COLLABORATION

HOD ACTION: Board of Trustees Report 2 referred with report back at A-14.

Board of Trustees Report 2 recommends that our AMA officially adopt the following definition of “physician-led,” in the context of team-based health care: The consistent use by a physician of the leadership knowledge, skills and expertise necessary to identify, engage and elicit from each team member the unique set of contributions needed to help each patient achieve their care goals; (New HOD Policy) Board of Trustees Report 2 also recommends that our AMA officially adopt the following definition of “supervision,” in the context of team-based health care: (i) General supervision means the health care is furnished under the physician’s overall direction and control, but the physician’s presence is not required during the delivery of care. Under general supervision, the ongoing training of the non-physician personnel who perform the health care and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician. (ii) Direct supervision in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the delivery of care. It does not mean that the physician must be present in the room when the care is being delivered. (iii) Personal supervision means a physician must be in attendance in the room during the delivery of care. (New HOD Policy) Board of Trustees Report 2 also recommends that our AMA officially adopt the following definition of “collaboration,” in the context of team-based health care: A set of communication and decision-making processes and actions carried out over time by and among members of a team related to the treatment and care of patients, including: (i) formal, often structured and multi-directional, communication of information about the treatment and care of patients, including clinical observations and assessments; (ii) development of appropriate plans of care, including decisions regarding the health care to be provided, accessing and assessment of appropriate additional resources or expertise, and arrangement of appropriate referrals, testing, or studies; and (iii) coordinating the actions and responsibilities necessary to carry out these plans effectively, taking into account the proven skills, knowledge, and capabilities of each member of the health care team. (New HOD Policy)

Your Reference Committee heard mixed testimony on Board of Trustees Report 2. Your Reference Committee commends our AMA Board of Trustees for its efforts in the challenging task of defining the terms “supervision,” “collaboration,” and “physician-led.” Your Reference Committee heard that our AMA must ensure that the physician remain the leader of any collaboration within the physician-led health care team. Your Reference Committee also heard strong support of physician-led health care teams. Your Reference Committee, therefore, proposes amendments to the definition of collaboration based on this testimony that reflect our AMA’s strong commitment to physician-led health care teams.

Your Reference Committee heard limited testimony in support of the underlying Resolution behind Board of Trustees Report 2, (Resolution 213-I-12), which asked our AMA to support authorization of physician assistants and nurse practitioners under the supervision of an MD or DO to certify Medicare beneficiaries’ need for therapeutic shoes and/or inserts. Your Reference Committee notes that the House of Delegates referred Resolution 213-I-12 with the clear directive to address our lack of policy defining such terms as supervision and collaboration. While your Reference Committee recognizes the importance of the issues raised, the directive to the Board did not encompass these issues. Therefore, your Reference Committee recognizes the issues raised, in the original resolution, and encourages the authors of Resolution 213-I-12 to bring a resolution to our House of Delegates during the 2014 Annual Meeting.

Your Reference Committee agrees with testimony that the title of Board of Trustees Report 2 does not accurately reflect the report’s recommendations. Therefore, your Reference Committee recommends that the recommendations of Board of Trustees Report 2 be adopted as amended and that the remainder of the report be filed.

(5) RESOLUTION 206 – FDA TO EXTEND REGULATORY JURISDICTION OVER ALL NON-PHARMACEUTICAL TOBACCO PRODUCTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 206 be adopted.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 206 be changed to read as follows:

FDA TO EXTEND REGULATORY JURISDICTION OVER ALL NON-PHARMACEUTICAL NICOTINE AND TOBACCO PRODUCTS

HOD ACTION: Resolution 206 adopted with a title change.

Resolution 206 asks that our American Medical Association urge the US Food and Drug Administration (FDA) to immediately implement the deeming authority written into the FDA tobacco law to extend FDA regulation of tobacco products to pipes, cigars, hookah e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the FDA tobacco law. (New HOD Policy).

Your Reference Committee heard overwhelmingly supportive testimony on Resolution 206. Testimony clarified that electronic cigarettes are not tobacco but are nicotine products and therefore, urged that this be reflected in the Resolution's title. Your Reference Committee agrees with the testimony heard and strongly believes that the FDA should exercise the authority it was given by Congress to regulate all tobacco and nicotine products. Accordingly, your Reference Committee recommends that Resolution 206 be adopted with a change in the title.

(6) RESOLUTION 212 – AMA ADVOCATE IN SGR REFORM THAT HIGH-PERFORMING HEALTH SYSTEMS™ ARE CREDIBLE MODELS FOR PROVIDING OPTIMALLY COORDINATED, COMPREHENSIVE, ACCOUNTABLE, COST-EFFECTIVE, PATIENT-CENTERED CARE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 212 be adopted.

PHYSICIAN-LED, SINGLE AND MULTI-SPECIALTY, ORGANIZED GROUP PRACTICE MODELS

RESOLVED, That our American Medical Association recognize that physician-led, single and multi-specialty group practices, integrated delivery systems, and other organized systems of care demonstrating the following attributes: (i) efficient provision of services, (ii) organized system of care, (iii) quality measurement and improvement activities, (iv) care coordination, (v) use of it and evidence-based medicine, (vi) compensation practices that promote all aforementioned attributes, and (vii) accountability, are credible models for providing coordinated, comprehensive, accountable, cost-effective, patient-centered care. (New HOD Policy)

HOD ACTION: Substitute Resolution 212 adopted.

Resolution 212 asks that our American Medical Association advocate in SGR reform that multi-specialty, physician-led group practices, integrated delivery systems, and other organized systems of care that meet the AMGA definition

of “High-Performing Health System”™ are credible models for providing optimally coordinated, comprehensive, accountable, cost effective, patient-centered care. (New HOD Policy).

Your Reference Committee heard mixed testimony on Resolution 212. Testimony included reservations regarding the propriety of singling out specific practice models for AMA advocacy as well as their relevance to SGR reform. Recognizing these concerns, the sponsor of Resolution 212 recommended an amendment to reflect that the intent of Resolution 212 was not to promote a single delivery model and that advocacy could be separated from efforts to repeal SGR. Additional testimony highlighted the need to recognize not only multi-specialty but single specialty practices. Your Reference Committee understands that longstanding AMA policy supports the ability of physicians to practice medicine in the practice model of their choice, and many continue to practice as solo practitioners or in single specialty groups. Your Reference Committee further acknowledges that our AMA advocacy supports the ability of physicians to develop, implement, and select from alternative payment and delivery models. Consequently, your Reference Committee recommends that substitute Resolution 212 be adopted in lieu of original Resolution 212. Your Reference Committee also recommends a change in the title to reflect the general subject matter of the substitute resolution.

(7) RESOLUTION 217 – PRIMARY CARE PHYSICIAN SUPPLY IN STATES THAT ALLOW INDEPENDENT UNSUPERVISED MEDICAL PRACTICE BY NURSE PRACTITIONERS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 217 be adopted.

PRIMARY CARE PHYSICIAN SUPPLY

RESOLVED, That our AMA continue to work with interested stakeholders to gather and disseminate data regarding the primary care physician supply. (Directive to Take Action)

HOD ACTION: Substitute Resolution 217 adopted

Resolution 217 asks that our AMA gather data regarding primary care physician supply in all states especially those states that allow unsupervised and independent medical practice by nurse practitioners since the date that independent practice by nurse practitioners was allowed in those states. (Directive to Take Action) Resolution 217 also asks that our AMA determine if primary care physician supply per capita has declined in states that allow independent unsupervised medical practice by nurse practitioners. (Directive to Take Action)

Your Reference Committee heard testimony generally in support of Resolution 217. Testimony reflected the fact that our AMA already closely monitors, on a state-by-state basis, the practice locations of primary care physicians and nurse practitioners. Testimony also reflected the fact that our AMA’s Geographic Mapping Initiative demonstrates the practice locations of multiple specialties of physician and non-physician health care professionals, and that this data is regularly disseminated to the Federation as part of our AMA’s ongoing advocacy in partnership with national specialty and state medical associations. Your Reference Committee also heard that our AMA is currently updating and modernizing the Geographic Mapping Initiative. Testimony also suggested that the American Academy of Family Physicians’ Robert Graham Center’s Primary Care Physician Mapper has the capacity to demonstrate the primary physician supply per capita. Your Reference Committee believes the issues addressed in original Resolution 217 are timely, and in consideration of testimony heard, has offered a substitute resolution. In addition, your Reference Committee believes that the title of Resolution 217 should be changed to better reflect the substitute resolution.

(8) RESOLUTION 218 – FDA REGULATION OF OFF-LABEL DRUG PROMOTION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 218 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association support the Food and Drug Administration's authority to prohibit medication off-label ~~detailing~~ marketing and promotion.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 218 be adopted as amended.

HOD ACTION: Resolution 218 referred.

Resolution 218 asks that our AMA support the Food and Drug Administration's authority to prohibit medication off-label detailing. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 218. Your Reference Committee strongly believes the FDA should have the authority to safeguard the safety and efficacy of drugs and medical devices. However, your Reference Committee also heard testimony that the ability to prescribe off-label constitutes the practice of medicine and that sharing information developed by an independent third party (other than a manufacturer) should not be restrained. Your Reference Committee heard testimony generally in support of a proposed amendment to Resolution 218 that would address medication off-label marketing and promotion. Your Reference Committee believes that Resolution 218, as amended, supplements AMA policy protecting physician access to reliable information. Your Reference Committee, therefore, recommends that Resolution 218 be adopted as amended.

(9) RESOLUTION 219 – DRUG ENFORCEMENT AGENCY LICENSURE FEES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 219 be amended by addition and deletion to read as follows:

~~RESOLVED, That our American Medical Association work through appropriate channels with the Drug Enforcement Agency (DEA) and other stakeholders to limit licensure fee increases to no more than that of inflation, allow physicians in one practice to share a common DEA number, and decrease the disproportionate amount that physicians practitioners have to pay for renewal. (Directive to Take Action)~~

RESOLVED, That our AMA work through appropriate channels to freeze DEA licensure fees for physicians. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 219 be adopted as amended.

HOD ACTION: Resolution 219 adopted as amended.

Resolution 219 asks that our American Medical Association work through appropriate channels with the Drug Enforcement Agency (DEA) to limit licensure fee increases to no more than that of inflation, allow physicians in one practice to share a common DEA number, and decrease the disproportionate amount that physician practitioners have to pay for renewal. (Directive to Take Action)

Your Reference Committee heard generally supportive testimony on Resolution 219. Testimony expressed that existing licensure fees are likely to rise, increasing the financial burdens on physicians. Testimony, however, also highlighted potential fraud and abuse concerns if physicians in one practice shared a single DEA number. Your Reference Committee strongly believes the fees collected to support the Diversion Control Program should reflect the risk and attendant costs to combat diversion at various points in the chain of supply and distribution. Your Reference Committee further believes that fee increases may not accurately reflect the actual costs of administering the Diversion Control Program, as evidenced by the surplus the DEA earned on the previous DEA registration fee. Although the DEA has the legal authority to modify the fees, it has declined to do in the past. Accordingly, your Reference Committee suggests broadening the resolution to include advocacy to other relevant stakeholders. Your Reference Committee also fully understands the concerns of allowing a common DEA number and supports removing this provision from the Resolution. Therefore, your Reference Committee recommends that Resolution 219 be adopted as amended.

(10) RESOLUTION 223 – MEDICARE’S TWO MIDNIGHT RULE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 223 be amended by deletion to read as follows:

~~RESOLVED, That our AMA immediately seek an opinion and guidance from CMS regarding how physicians should demonstrate “medical necessity” to best prevent unnecessary audit recoupment.~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the Resolution 223 be adopted as amended.

HOD ACTION: Resolution 223 adopted as amended.

Resolution 223 asks: 1. that our American Medical Association petition the Centers for Medicare & Medicaid Services to repeal the August 19 rules regarding Hospital Inpatient Admission Order and Certification (Directive to Take Action); 2. that our AMA immediately seek an opinion and guidance from CMS regarding how physicians should demonstrate “medical necessity” to best prevent unnecessary audit recoupment (Directive to Take Action); and 3. that our AMA reaffirm Section 5 of AMA Policy D-320.991 Creating a Fair and Balanced Medicare and Medicaid RAC Program, which states: “Our AMA, in coordination with other stakeholders such as the American Hospital Association, will seek to influence Congress to eliminate the current RAC system and ask CMS to consolidate its audit systems into a more balanced, transparent, and fair system, which does not increase administrative burdens on physicians.” (Reaffirm HOD Policy)

Your Reference Committee heard generally supportive testimony on Resolution 223. Your Reference Committee agrees that CMS’ new two-midnight stay benchmark to determine hospital inpatient status may have adverse consequences for physicians and patients. Your Reference Committee believes it is important to commend our AMA

for strongly opposing the new policy in its June 25, 2013 formal regulatory comment letter regarding the CMS' 2014 Inpatient Prospective Payment System proposed rule and for continuing its advocacy to urge CMS to repeal the flawed policy. Your Reference Committee also agrees with testimony urging our AMA to exercise great caution in seeking CMS guidance on how physicians should demonstrate "medical necessity" to best prevent unnecessary audit recoupment. Your Reference Committee, therefore, recommends that Resolution 223 be adopted as amended.

(11) RESOLUTION 226 – SUSTAINABLE GROWTH RATE REPEAL

RECOMMENDATION:

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

RESOLVED, That our American Medical Association (AMA) reaffirm AMA policy D-450.981, Protecting Patients Rights, and continue to strongly advocate for the repeal of the flawed sustainable growth rate (SGR) formula and for our AMA's principles for pay-for-performance (Reaffirm Policy); and be it further

RESOLVED, That our AMA reaffirm AMA policy H- 450.947, Pay-for-Performance Principles and Guidelines (Reaffirm Policy); and be it further

RESOLVED, That our AMA support SGR repeal and continue to strongly advocate for the AMA's Pay-for-Performance Principles and Guidelines (AMA policy H-450.947) (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate with CMS and Congress for alternative payment models, developed in concert with specialty and state medical organizations, including private contracting as an option (Directive to Take Action).

RESOLVED. That our AMA will continue to advocate for future positive updates in the Medicare physician fee schedule.

HOD ACTION: Substitute Resolution 226 adopted as amended.

Resolution 226 asks that our AMA reaffirm Policy D-450.981, Protecting Patients Rights, which states in part that our AMA will "continue to advocate for the repeal of the flawed sustainable growth rate (SGR) formula without compromising our AMA's principles for pay-for-performance" (Reaffirm HOD Policy); that our AMA reaffirm Policy H-450.947, Pay-for-Performance Principles and Guidelines (Reaffirm HOD Policy); that our AMA support SGR repeal proposals that are coupled with physician payment reforms consistent with the AMA's Pay-for-Performance Principles and Guidelines (AMA Policy H-450.947) (Directive to Take Action); and our AMA advise Congress that any repeal or reform of SGR should include an option for private contracting by Medicare patients. (Directive to Take Action).

Your Reference Committee heard virtually unanimous testimony in strong support of the language in the amendment to Resolution 226. Testimony highlighted a fervent desire that physicians convey a focused and unified message in our advocacy efforts to seek repeal of the Sustainable Growth Rate (SGR). There were also many positive comments on how the amended resolution demonstrates significant cooperation among diverse physician sections and delegations. Your Reference Committee commends these efforts to work together. Your Reference Committee also agrees with the sentiment that "together we are stronger," and believes that adoption of Substitute Resolution 226 would reflect this spirit.

(12) BOARD OF TRUSTEES REPORT 1 – PHARMACIST ADMINISTRATION OF IMMUNIZATIONS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 1 be referred.

HOD ACTION: Board of Trustees Report 1 referred for report back at A-14.

The Board recommends that the following be adopted as AMA policy: 1. Pharmacists are essential members of physician-led teams, including the patient-centered medical home, with a potential role in increasing immunization rates in this country. (New HOD Policy); 2. Pharmacist administration of immunizations is only proper when any of the following criteria are satisfied: (a) the pharmacist has an order or prescription from a physician licensed to practice medicine in the state where the immunization is to be administered; (b) the pharmacist has a protocol or collaborative agreement with a physician licensed to practice in the state where the immunization is to be administered; or (c) the state where the immunization is to be administered has designated a state of emergency which necessitates the rapid immunization of the population in order to respond to the public health state of emergency, during which administration by pharmacists should be limited to the specific vaccine required to respond to the emergency, for the duration of the emergency declaration. The American Medical Association opposes any state or federal law that allows pharmacists to administer immunizations without any of the above requirements, and will work with interested state and national specialty medical associations to ensure pharmacist immunization laws are consistent with the above criteria. These criteria do not apply to administration of the influenza vaccine, if authorized by state law. (New HOD Policy); 3. A state's educational requirements for pharmacists who administer immunizations should be developed from input by both the state boards of medicine and pharmacy. (New HOD Policy)

Your Reference Committee heard mixed testimony on Board of Trustees Report 1. Your Reference Committee heard considerable testimony in support of the timeliness of Board of Trustees Report 1 and the importance of strong AMA policy governing pharmacist administration of immunizations. Your Reference Committee heard that complex patient safety issues arise with immunization of the pediatric population, an issue not addressed in Board of Trustees Report 1 and well developed in stakeholder policy. Your Reference Committee also heard testimony that pharmacist administration of immunizations involves a multiplicity of issues, including the safety of live vaccines, the appropriateness of pharmacist immunization of at-risk populations, the need to ensure communication with the treating physician, parity in requirements for reporting to immunization registries, and handling of adverse events. Your Reference Committee agrees that these issues warrant further study and therefore, recommends that Board of Trustees Report 1 be referred.

(13) RESOLUTION 204 - IMPROVING THE AFFORDABLE CARE ACT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 204 be referred.

HOD ACTION: Resolution 204 referred for report back at A-14.

Resolution 204 asks that our American Medical Association consider the following recommendations related to the ACA: 1. Replace the individual mandate with a refundable tax credit that could only be used to purchase health insurance; 2. Repeal the employer mandate. Businesses, as well as individuals, should be allowed to purchase health insurance with pretax dollars; 3. Allow health insurance to be sold across state lines. Health-insurance should be portable and should follow the individual from job to job and state to state; 4. Allow small businesses to self-insure or purchase insurance through small business health plans or association health plans. Currently, this option is available only to large businesses; 5. Improve health-related savings accounts and consumer-driven health care plans by allowing higher deductibles and higher savings account contributions; 6. Allow and encourage states to develop alternatives to Medicaid by using federal funds granted by the Health and Human Services Secretary under

provisions of the ACA; 7. Restore funds cut from traditional Medicare; 8. Avoid reducing Medicare Advantage funding. This insurance is highly popular with seniors; 9. Eliminate the unaccountable and unpopular Independent Payment Advisory Board; 10. Eliminate involvement in the ACA by the Internal Revenue Service; 11. Maintain the guaranteed insurability, full coverage of preventative services and elimination of lifetime benefit caps under the ACA; 12. Continue the family insurance coverage of children living in a household until age 26; 13. Eliminate the taxes on medical devices and pharmaceuticals and health insurance companies since this added expense would only be passed on to our patients; 14. Repeal and replace the sustainable growth rate formula; 15. Enact meaningful medical liability reform; 16. Expand the funding of medical schools and residency programs in order to increase the number of physician providers; 17. Cancel all current ACA waivers, exemptions, subsidies and discounts except for those based on patient income under provisions of the ACA. Prohibit any of these in the future unless they are based on income of the patient; 18. Prohibit any future insurance plans that are alternatives to the ACA for all federal employees, members of Congress, federal judges and the president, as well as their dependents; 19. Due to the complexity of improving the ACA, its implementation should be delayed at least one year; 20. Finally, Congress should be asked to appoint a committee with a majority membership of health care providers and AMA leadership with a mandate to revise Medicare and to produce a plan that would allow its long-term viability and adequate health benefits for seniors and the disabled. The same committee would also work to identify the changes that would effectively improve the ACA and allow for its long-term vitality. (Directive to Take Action)

Your Reference Committee appreciates the deeply-held sentiments expressed by those testifying both in favor of and against Resolution 204. Those who spoke in favor of adopting Resolution 204 strongly urged our AMA to acknowledge the problems that implementation of the Affordable Care Act (ACA) is creating for physicians and for patients' access to care. Others who testified in support of Resolution 204 stated that it was critical for our AMA to come out of the Interim Meeting with a strong statement in support of repealing and replacing the ACA, or substantially amending it. Some who spoke against adoption of the resolution argued that existing AMA policy and advocacy activities already cover the vast majority of the items our AMA is being asked to consider, and that current AMA policy should be reaffirmed in lieu of adoption of Resolution 204. Also, your Reference Committee heard testimony arguing that adoption of Resolution 204 would be premature given that other government programs, such as Medicare and Medicaid, had numerous problems in the early stages of their implementation, and that our AMA should let implementation of the ACA proceed before advocating to change it. Further, some who testified argued that the resolution was overly complex, included conflicting language, and should be referred for a report summarizing existing AMA policy covered by the resolution and AMA advocacy activities to improve the ACA.

Your Reference Committee reviewed a document submitted by the Council on Legislation that highlights current AMA policy and advocacy activities, and agrees with those who testified that a significant majority of the items listed in Resolution 204 are extensively covered by existing policy. Your Reference Committee also considered that current AMA policy (D-165.938) directs our AMA to report on its advocacy activities to improve the ACA, and this directive has resulted in informational Board of Trustees Report 6, which is being considered by your Reference Committee and is included in this report under Item 21. Further, your Reference Committee considered that the HOD adopted policy at the 2013 Annual Meeting that directs our AMA to submit a report at the 2013 Interim Meeting assessing the progress of implementation of the ACA based on AMA policy, and that this informational report is available on the HOD website as Council on Medical Service Report 5-I-13. While these reports have provided important information on certain aspects of the ACA, they do not address the full range of the issues included in Resolution 204. Taking this into consideration, as well as the divergent sentiments reflected in the testimony, your Reference Committee recommends that Resolution 204 be referred. In making this recommendation, your Reference Committee notes that the resolution asks for "consideration" of the 20 elements that make up the one resolve. Your Reference Committee believes that in recommending referral, the objective of the resolution is essentially accomplished, but in a manner that allows for a more comprehensive consideration of each item.

(14) RESOLUTION 227 – HOSPITAL INPATIENT ADMISSION ORDER AND CERTIFICATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 227 be referred for decision.

RESOLVED, That our American Medical Association support the rescission of the requirement that a physician certify the estimated time the patient will need to remain in the hospital as a condition for payment for inpatient services (New HOD Policy); and be it further

RESOLVED, That our AMA adopt as policy that upon admission of any patient to a hospital for inpatient services, the admitting/attending physician should be furnished by the hospital with appropriate information – for example the Geometric Mean Length of Stay (GMLOS) – to help the physician plan appropriately for the services that will be required to care for that particular patient (New HOD Policy); and be it further

RESOLVED, That our AMA inform the Centers for Medicare and Medicaid Services as soon as possible of the AMA's policy calling for the rescission of the requirement that a physician certify the estimated time the patient will need to remain in the hospital, and take appropriate action to enact this policy. (Directive to Take Action)

HOD ACTION: Resolution 227 with resolved clauses 1 and 3 adopted and resolved clause 2 referred for decision.

Resolution 227 asks: 1. that our American Medical Association support the rescission of the requirement that a physician certify the estimated time the patient will need to remain in the hospital as a condition for payment for inpatient services (New HOD Policy); 2. that our AMA adopt as policy that upon admission of any patient to a hospital for inpatient services, the admitting/attending physician should be furnished by the hospital with appropriate information – for example the Geometric Mean Length of Stay (GMLOS) – to help the physician plan appropriately for the services that will be required to care for that particular patient (New HOD Policy); and 3. that our AMA inform the Centers for Medicare and Medicaid Services as soon as possible of the AMA's policy calling for the rescission of the requirement that a physician certify the estimated time the patient will need to remain in the hospital, and take appropriate action to enact this policy. (Directive to Take Action)

Your Reference Committee heard testimony supportive of the intent of Resolution 227. Your Reference Committee agrees that, while the issues raised by the testimony are timely, they are also very complex, especially given the newness of the regulation. In order to ensure that our AMA is best positioned to advocate on the issues raised in Resolution 227, your Reference Committee recommends that Resolution 227 be referred for decision.

(15) RESOLUTION 201 – REPEAL OF MCCARRAN-FERGUSON ACT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 201 not be adopted.

HOD ACTION: Resolution 201 not adopted.

Resolution 201 asks that our American Medical Association work legislatively to repeal the McCarran-Ferguson Act of 1945. (Directive to Take Action)

Your Reference Committee heard mixed testimony regarding Resolution 201. In particular, your Reference Committee heard testimony and received information that our AMA has considered the repeal issue on at least three recent occasions. Each time, our AMA decided not to support repeal. For example, at the 2011 Annual Meeting, the House of Delegates (HOD) voted not to adopt Resolution 230, which called for our AMA to encourage federal legislation that would modify and/or repeal the antitrust exemption afforded to insurers by the Act. And, during the 2012 Interim Meeting, the HOD referred a similar resolution to our AMA Board of Trustees (the Board) for decision. In its report, the Board determined that there is strong evidence that repeal of the McCarran-Ferguson Act would do little to make the health insurance market more competitive. The report cited a 2009 study by the

Congressional Budget Office which concluded that enacting a repeal of the antitrust exemption would have no significant effect on the premiums that private insurers would charge for health insurance. The report also stated that some experts have expressed concern that repeal might even lead to higher premiums—not just for health insurers, but also for medical liability insurance companies—by exposing insurers to new types of litigation. Further, the report stated that our AMA has repeatedly chosen not to support repeal because to do so would divert advocacy resources from our long-standing, focused antitrust advocacy strategy.

In light of evidence that repealing the McCarran-Ferguson Act's antitrust exemptions for health insurers will not bring about the relief necessary for physicians to effectively negotiate with health insurance companies, and would divert our focus away from existing antitrust advocacy efforts, your Reference Committee recommends that Resolution 201 not be adopted.

(16) RESOLUTION 202 - DECREASING MEDICARE PAYMENT RECOVERY PERIOD

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-70.926 be reaffirmed in lieu of Resolution 202.

HOD ACTION: Policy H-70.926 reaffirmed in lieu of Resolution 202.

Resolution 202 asks that our American Medical Association work to decrease the payment recovery period of Medicare and all insurers to six months after submission. (Directive to Take Action)

Testimony received by your Reference Committee was generally supportive of Resolution 202. Many emphasized that, based on a principle of equity, time periods for recoupment should be similar to the deadlines required for submission of a claim. Testimony clarified that, consistent with existing AMA policy, deadlines for claim submission can extend to one year, and not six months as stated in the original resolution. Your Reference Committee also heard compelling testimony pointing out that our AMA has submitted a formal request to the Centers for Medicare and Medicaid Services (CMS) to limit audits to one year from the payment of claims and is awaiting CMS decision on this issue. Given the clarification provided by testimony and that adoption of contrary policy may confuse and disrupt this advocacy, your Reference Committee recommends Policy H-70.926 be reaffirmed in lieu of Resolution 202.

Policy to be reaffirmed:

H-70.926 Reasonable Time Limitations on Post-Payment Audits and Recoupments by Third Party Payers

Our AMA policy is that post-payment audits, post-payment downcodes and other similar requests for recoupment by third party payers be made within one year of the date the claim is submitted or within the same amount of time permitted for submission of the claim, whichever is less. (Res. 815, A-01; Reaffirmation I-04; Reaffirmation A-08)

(17) RESOLUTION 220 – DELAY OR CANCELING OF ICD-10

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy D-70.952 be reaffirmed in lieu of Resolution 220.

RESOLVED, That our American Medical Association support delaying or canceling the implementation of ICD-10. (New HOD Policy)

HOD ACTION: Original Resolution 220 adopted.

Resolution 220 asks that our American Medical Association support delaying or canceling the implementation of ICD-10. (New HOD Policy)

Your Reference Committee heard strong support for Resolutions 220. Those in support testified that implementation of ICD-10 coding will create significant financial burdens and workflow disruptions for physicians and therefore, should be delayed or canceled.

Your Reference Committee strongly agrees with the testimony heard but notes that existing AMA policy already explicitly addresses the resolves of Resolution 220. In particular, your Reference Committee acknowledges that current policy asks that our AMA “vigorously work to stop the implementation of ICD-10 and to reduce its unnecessary and significant burdens on the practice of medicine.” Your Reference Committee recognizes that, based on this existing policy, our AMA has issued strong letters of support for the pending ICD-10 legislation that would halt implementation; held numerous meetings with government officials seeking repeal of ICD-10; and have secured numerous victories in the past delaying the code set. Therefore, since Resolution 220 is reflected in existing AMA policy and substantial AMA advocacy efforts, your Reference Committee recommends that Policy D-70.952 be reaffirmed in lieu of Resolution 220.

Policy to be reaffirmed:

D-70.952 Stop the Implementation of ICD-10

1. Our AMA will: (A) vigorously work to stop the implementation of ICD-10 and to reduce its unnecessary and significant burdens on the practice of medicine; (B) do everything possible to let the physicians of America know that our AMA is fighting to repeal the onerous ICD-10 requirements on their behalf; (C) work with other national and state medical and informatics associations to assess an appropriate replacement for ICD-9; and (D) evaluate the feasibility of moving from ICD-9 to ICD-11 as an alternative to ICD-10 and report back to the House of Delegates.

2. In order to alleviate the increasing bureaucratic and financial burden on physicians, our AMA will vigorously advocate that the Centers for Medicare & Medicaid Services eliminate the implementation of ICD-10.

3. Our AMA will immediately reiterate to the Centers for Medicare & Medicaid Services that the burdens imposed by ICD-10 will force many physicians in small practices out of business. This communication will be sent to all in Congress and displayed prominently on our AMA website.

4. Our AMA: (A) will educate US physicians on the burdens of ICD-10 and how our AMA is fighting to repeal the onerous ICD-10 requirements on their behalf; (B) supports federal legislation to stop the implementation of ICD-10 and remain with ICD-9 until ICD-11 can be properly evaluated; and (C) supports federal legislation to mandate a two-year “implementation” period by all payers, including CMS, if ICD-10 or ICD-11 is implemented. During this time, payers will not be allowed to deny payment based on specificity of ICD-10/11 diagnosis. However, they will be required to provide feedback for incorrect diagnosis. In addition, no payer will be allowed to ask for “takebacks” due to lack of ICD-10/11 diagnosis code specificity for the aforementioned two-year implementation period. (Sub. Res. 216, I-11; Appended: Res. 236, A-12; Appended: Res. 209, I-12; Appended: Res. 236, A-13)

(18) RESOLUTION 211 – PATIENT’S CHOICE OF MANAGEMENT OF END OF LIFE CARE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-140.966 be reaffirmed in lieu of Resolution 211.

HOD ACTION: Policy H-140.966 reaffirmed in lieu of Resolution 211.

Resolution 211 asks that our American Medical Association support creating model state legislation to ensure that no insurance policy sold in the state be allowed to block a patient’s choice regarding health care during the end of life (Directive to Take Action); and that our AMA craft this model legislation keeping the Right of Conscience intact for physicians. (Directive to Take Action)

Your Reference Committee heard limited testimony that largely focused on patient choice in the management of end of life care. Your Reference Committee, however, does not believe that the language of this resolution is sufficiently clear to guide our AMA in the drafting of effective model state legislation. We believe that our AMA's existing policy supports the underlying intent of this resolution, which is patient autonomy in making end of life decisions. Therefore, your Reference Committee recommends that Policy H-140.966 be reaffirmed in lieu of Resolution 211.

Policy to be reaffirmed:

H-140.966 Decisions Near the End of Life

Our AMA believes that: (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration. (2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment. (3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide. (4) Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time. (5) Our AMA supports continued research into and education concerning pain management. (CEJA Rep. B, A-91; Reaffirmed by BOT Rep. 59, A-96; Reaffirmation A-97; Appended: Sub. Res. 514, I-00; Reaffirmed: CEJA Rep. 6, A-10)

- (19) RESOLUTION 214 – MEANINGFUL USE NO LONGER MEANINGFUL
RESOLUTION 221 – ELIMINATING PROPOSED PEANLITES FOR NOT
ACHIEVING MEANINGFUL USE
RESOLUTION 222 – SAFETY OF EHR

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-478.991 be reaffirmed in lieu of Resolutions 214, 221, and 222.

HOD ACTION: Policy H-478.991 reaffirmed in lieu of Resolutions 214, 221, and 222.

Resolution 214 states: 1. that our American Medical Association advocate for suspension of the Meaningful Use component of the HITECH Act (New HOD Policy); and 2. that our AMA advocate for elimination of the Medicare payment penalties, provided for in the HITECH Act, for not meeting Meaningful Use requirements. (New HOD Policy). Resolution 221 asks that our American Medical Association seek the termination of the "meaningful use" standards of the Centers for Medicare & Medicaid Services from medical practice and that the proposed penalties beginning in 2015 should be eliminated immediately and an effort made to gradually integrate tomorrow's technological advances into health care in a safer, more efficient manner. (Directive to Take Action) Resolution 222 asks that our American Medical Association advocate for physicians to have the option to choose either EHR or paper charts without penalty (New HOD Policy); and that our AMA, through appropriate channels, influence national policy to remove the penalties for not using an EHR system. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolutions 214, 221, and 222. The majority of testimony supported removal of the Meaningful Use penalties and highlighted the significant costs of trying to comply with the program's requirements. Testimony also emphasized how certain physicians, including those in small practices, nearing retirement, and specialists, face additional challenges in achieving Meaningful Use. Others cautioned that full scale repeal of the Meaningful Use program would have the unintended consequence of eliminating incentive

payments for physicians who have complied with the program requirements and are anticipating funding to offset the costs of adopting and using EHRs. Testimony also highlighted some of the restrictions when using paper charts as opposed to electronic records. Your Reference Committee agrees with the intent of these Resolutions to mitigate the EHR penalties but acknowledges that our AMA has incorporated these concerns into existing AMA policy. Specifically, current AMA policy asks that our AMA “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.” Because AMA policy already addresses the Resolutions’ concerns while retaining key incentive payments, your Reference Committee recommends that Policy H-478.991 be reaffirmed in lieu of Resolutions 214, 221, and 222.

Policy to be reaffirmed:

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. (Sub. Res. 202, A-09; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed in lieu of Res. 237, A-12; Reaffirmed in lieu of Res. 218, I-12; Reaffirmed in lieu of Res. 219, I-12; Reaffirmed in lieu of Res. 226, I-12; Reaffirmed in lieu of Res. 228, I-12; Reaffirmed in lieu of Res. 725, A-13; Appended: Res. 205, A-13)

(20) RESOLUTION 228 – EHR STARK EXEMPTION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy D-478.994 be reaffirmed in lieu of Resolution 228.

HOD ACTION: Policy D-478.994 reaffirmed in lieu of Resolution 228.

Resolution 228 asks that our American Medical Association petition both the Centers for Medicare & Medicaid Services and the Office of the Inspector General to extend the EHR Stark Exemption and Anti-Kickback Safe Harbor to December 31, 2016. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 228, which highlighted how these waivers are necessary to offset the significant expense of adopting and maintaining EHRs. Testimony also noted concern that certain providers, including clinical laboratories and pathologists, should be excluded from the EHR safe harbors due to potential fraud and abuse violations. Your Reference Committee acknowledges those entities seeking a carve-out, but recognizes the more general intent of the Resolution to expand, rather than narrow, the law’s current EHR waivers. Further, your Reference Committee recognizes that existing AMA Policy D-478.994 supports an even stronger position by seeking an indefinite extension of the Stark Law and Anti-Kickback Statute safe harbors. Given the intent of Resolution 228 is to secure ongoing and continuous support for EHR services and products, your Reference Committee recommends that Policy D-478.994 be reaffirmed in lieu of Resolution 228.

Policy to be reaffirmed:

D-478.994 Health Information Technology

Our AMA will: (1) support legislation and other appropriate initiatives that provide positive incentives for physicians to acquire health information technology (HIT); (2) pursue legislative and regulatory changes to obtain an exception to any and all laws that would otherwise prohibit financial assistance to physicians purchasing HIT; (3) support initiatives to ensure interoperability among all HIT systems;

and (4) support the indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of Electronic Health Record (EHR) products and services, and will advocate for federal regulatory reform that will allow for indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of EHR products and services. (Res. 723, A-05; Reaffirmation A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed: Res. 726, A-08; Reaffirmation I-08; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed: Res. 205, A-11; Appended: Res. 220, A-12; Reaffirmed in lieu of Res. 218, I-12; Reaffirmed in lieu of Res. 219, I-12; Reaffirmed in lieu of Res. 226, I-12; Reaffirmed in lieu of Res. 228, I-12)

(21) BOARD OF TRUSTEES REPORT 6 – REDEFINING THE AMA’S POSITION ON ACA AND HEALTHCARE REFORM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 6 be filed.

HOD ACTION: Board of Trustees Report 6 filed.

Board of Trustees Report 6 outlines in a clear and brief manner the broad range of policies that have been adopted by the House of Delegates on the Affordable Care Act as well as current AMA activities on each item.

Your Reference Committee heard testimony generally in support of Board of Trustees Report 6. Your Reference Committee heard limited concern that language in Board of Trustees Report 6 regarding the U.S. Preventive Services Task Force (USPSTF) may be interpreted as tacit support of all future USPSTF-recommended preventive services. However, your Reference Committee notes that the language regarding USPSTF-recommended preventive services is from current AMA Policy H-330.896. Your Reference Committee did not hear sufficient testimony to support amending current AMA Policy H-330.896, and therefore recommends that Board of Trustees Report 6 be filed.

REPORT OF REFERENCE COMMITTEE F

(1) BOARD OF TRUSTEES REPORT 8 - ABUSE OF CPT DESCRIPTORS RELATED TO SURGERY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 8 be adopted and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 8 adopted and the remainder of the Report filed.

Board of Trustees Report 8 comes in response to Resolution 601-I-12, which sought to address the misuse of the CPT nomenclature to circumvent state licensing rules by a small group of professionals who used one or more non-surgical procedure codes in the Surgery Section of the code set to inappropriately suggest that they perform surgery. This issue also impacted some beneficiaries whose plans denied coverage due to misinterpretation of a service as “surgery” simply because the code is part of the surgery section of CPT where the service would have been covered had it not been listed under the surgery heading.

Board of Trustees Report 8 highlights that a code change application was submitted, considered, and approved by the CPT Editorial Panel. This is the proper independent resource to address such matters, as detailed in Policy H-70.919, “Use of CPT Editorial Panel Process.” Therefore, the Board of Trustees recommends that Resolution 601-I-12 not be adopted.

Your Reference Committee received no testimony in response to the report, and is fully supportive of the Board of Trustees’ recommendation. Furthermore, your Reference Committee encourages those with CPT-related issues in the future to avail themselves of the CPT Editorial Panel’s process, as described by our AMA policy.

(2) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 1 - ONLINE MEMBER FORUMS AND COMPATIBILITY WITH AMA BYLAWS

RECOMMENDATION:

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

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

Council on Constitution and Bylaws Report 1 responds to Policy G-600.045, “Virtual Reference Committees in the House of Delegates,” which calls for a review of the virtual reference committee pilots to ensure compatibility with the AMA Bylaws.

The Council on Constitution and Bylaws notes in their report that the virtual reference committees have since been rebranded as online member forums to allay any confusion or misperceptions. Further, The Council believes no amendments to the AMA Bylaws are necessary and that Policy G-600.045(2) can be rescinded, as the review has been accomplished and the results reported to our AMA House of Delegates.

Your Reference Committee extends its appreciation to the Council on Constitution and Bylaws for its work to clarify the matter of virtual reference committees. Having received no testimony, your Reference Committee favors adoption of the Council’s report.

(3) COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT 1 - ESTABLISHMENT OF NEW SECTIONS: MODIFICATION OF EXISTING POLICY AND BYLAWS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in 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 seeks to amend Policy G-615.001, "Establishment and Function of Sections" so the Council on Long Range Planning and Development will be tasked with evaluating only current or potential sections, and not advisory and ad hoc committees, which are both structurally and functionally different from sections. To this end, the Council on Long Range Planning and Development recommends the following:

1. That Policy G-615.001, Establishment and Function of Sections, be amended by addition and deletion to read as follows:
 1. Our American Medical Association adopts the following criteria in consideration of requests for establishing new sections... 2. Our AMA will consider requests for establishing new sections a change in status for existing groups or formation of new groups by letter of application to the CLRPD, which will make recommendations to the BOT and HOD for further action, or by submission of a resolution.
 2. That AMA Bylaw 6.615 be modified to reflect that CLRPD evaluates and makes recommendations to the HOD, through the BOT, only with respect to the formation and/or change in status of any section.

Your Reference Committee received no testimony in response to the Council's report. Your Reference Committee is supportive of the Council's desire to clarify its ongoing role with regard to the evaluation of AMA Sections.

(4) BOARD OF TRUSTEES REPORT 4 - DESIGNATION OF SPECIALTY SOCIETIES FOR REPRESENTATION IN THE HOUSE OF DELEGATES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 4 be amended by addition and deletion on page 3, lines 23-45, to read as follows.

1. That ~~the current specialty delegation allocation system (ballot and formula) be discontinued and that~~ specialty society delegate allocation in the House of Delegates be determined in the same manner as state medical society delegate allocation based on membership numbers allowing one delegate per 1,000 AMA members or fraction thereof, ~~starting with the 2015 delegate apportionment~~.
2. That specialty society membership data be submitted annually by all societies with more than one delegate or societies seeking to obtain an additional delegate or delegates to determine delegate allocation as part of a two-year pilot program with a report back at the 2016 Annual Meeting of our AMA House of Delegates.

3. That the current specialty delegation allocation system (ballot and formula) be continued until the pilot program is completed and the 2016 Annual Meeting report is acted upon by the House of Delegates.
- ~~43. That this system be implemented tested with all specialty societies with more than one delegate seated in the House of Delegates being required to submit membership data in 2014 and as required for their scheduled five-year review.~~
- ~~54. That organizations that would lose or gain one or more a delegates through this pilot delegate allocation system based on declining membership be assist our AMA with documenting the impact. However, no actual changes to delegation allocation other than those which occur through the five-year review and balloting system will be implemented until the data are collected and presented for acceptance to our AMA House of Delegates at the 2016 Annual Meeting. allowed a one year grace period to increase their AMA membership and that their delegation remain unchanged until the end of the grace period.~~
- ~~65. That in the future any system of delegate allocation continues to be monitored and evaluated for improvements.~~
- ~~6. That the Council on Constitution and Bylaws investigate the need to amend any bylaws~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 4 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 4 adopted as amended and the remainder of the Report filed.

Board of Trustees Report 4 outlines the continuing difficulties by which specialty society representation in the House of Delegates is determined, and the report provides a series of recommendations in an attempt to improve the process.

Your Reference Committee recognizes this is a complex matter that has a long history in our AMA House of Delegates. Your Reference Committee agrees with the positive sentiments expressed on behalf of the efforts put forth by our AMA Board of Trustees to suggest a possible solution.

Your Reference Committee noted that the current process is flawed. The recommendations of the Board of Trustees have merit, but raise concerns about unintended consequences for specialty society delegations, including a shift away from the “one member, one specialty vote” practice. Therefore, your Reference Committee favors the testimony suggesting a two-year pilot that would allow our AMA House of Delegates to collect data, weigh the impact of potential changes, determine the administrative burden, and refine the process before committing to delegate reapportionment.

(5) BOARD OF TRUSTEES REPORT 5 - CONFLICT OF INTEREST DISCLOSURE FOR CANDIDATES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 5 be amended by substitution to read as follows:

1. That our AMA amend its current process for implementation of the Board of Trustees Conflicts of Interest Policy to require completion of Disclosure of Affiliation forms by all candidates for election to our AMA Board of Trustees and Councils prior to their election.
2. That our AMA expand accessibility to completed Disclosure of Affiliation information by posting such information on the “Members Only” section of the AMA website before election by the House of Delegates.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 5 be adopted as substituted and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 5 adopted as substituted and the remainder of the report filed.

Board of Trustees Report 5 comes in response to Resolution 606-A-13, which called upon our AMA to develop a conflict of interest disclosure form to be completed annually by elected officers and those appointed to office or running as candidates, and that the disclosures be available for review by members, especially members of our AMA House of Delegates.

Board of Trustees Report 5 examines the content of the current AMA Conflict of Interest disclosure form, the administrative process for completing and reviewing the disclosure form, identifies who is required to complete the disclosure, and addresses why candidates are not asked to complete a conflict of interest disclosure form in advance of election or appointment. The Board of Trustees recommends that the following statements be adopted in lieu of Resolution 606-A-13:

1. That our AMA maintain its current process for implementation of the BOT Conflict of Interest Policy, including completion of Disclosure of Affiliation forms; and
2. That our AMA expand accessibility to completed Disclosure of Affiliation forms by posting such forms on the “Members Only” section of the AMA web site.

Your Reference Committee heard testimony on the importance of the House of Delegates having advance access to conflict of interest disclosures for those seeking elected offices. While it may not be possible for our AMA to verify information that is provided immediately preceding an election, your Reference Committee believes it is incumbent upon candidates to provide accurate information in the first place. The proposed substitute language does not preclude AMA verification of submitted information at the earliest opportunity. Therefore, your Reference Committee favors adoption of the substitute recommendations reflected above, which were proffered during testimony and edited to reflect that the policy shall impact only elected positions for our Board of Trustees and our AMA Councils and does not apply to appointed positions or committees. Your Reference Committee believes these amendments create equity for those candidates nominated from the floor of our AMA House of Delegates and those candidates announced in advance of the election.

(6) COMMITTEE ON RULES AND CREDENTIALS REPORT 1 - POLICY ON CAMPAIGN ANNOUNCEMENTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendation in Committee on Rules and Credentials Report 1 be amended by substitution, to read as follows:

...

(4) An announcement of candidacy includes only the candidate's name, photograph, email address, URL, the office sought, and a list of endorsing societies.

...

(11) ~~Publication of candidate interviews in *AMNews* will be featured prior to AMA elections.~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendation in Committee on Rules and Credentials Report 1 be adopted as substituted and the remainder of the Report be filed.

HOD ACTION: Committee on Rules and Credentials Report 1 adopted as substituted and the remainder of the Report filed.

Committee on Rules and Credentials Report 1 notes that upon reviewing Policy G-610.020, "Election Campaigns," the Committee has become aware of elements of current policy that merit change to be less proscriptive and to avoid imposing a potential technical violation of the rules when announcing a candidacy. Additionally, the Committee wishes to remove from policy a reference to *AMNews* given that it is no longer published.

While your Reference Committee appreciates the intent of the Committee on Rules and Credentials to simplify our AMA policy on election campaigns, your Reference Committee agreed with testimony indicating that the proposed changes create ambiguity and specific direction is preferred. Your Reference Committee believes the substituted language brings policy in line with current practice.

(7) RESOLUTION 601 - REGULATIONS IN TIMES OF ARMED CONFLICT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-520.998 be reaffirmed in lieu of Resolution 601.

HOD ACTION: Policy H-520.998 reaffirmed in lieu of Resolution 601.

Resolution 601 calls upon our AMA to endorse the World Medical Association's policy on medical neutrality entitled, "Regulations in Times of Armed Conflict," and requests that the United States use its voice in international affairs to protect medical neutrality.

Your Reference Committee heard testimony opposing this resolution because of concerns that another organization's policy may not always be compatible with or supportive of AMA policy. It would also be ill advised to support another organization's policy as policy modifications might be made in the future without our knowledge or input. Testimony also expressed concern about how adoption of this resolution might affect members of the United States military.

Your Reference Committee notes that our AMA has existing policy supporting the concept of medical neutrality, which reads as follows:

Policy to be reaffirmed:

H-520.998 Medical Neutrality

Our AMA supports medical neutrality, under the principles of the Geneva Convention, for all health care workers and the sick and wounded in all countries. (Sub. Res. 72, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11)

Your Reference Committee wishes to thank the Medical Student Section for its attention to this important issue.

(8) RESOLUTION 605 - CRIMINALIZATION OF ERRORS IN MEDICAL DOCUMENTATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-160.954 be reaffirmed in lieu of Resolution 605.

HOD ACTION: Policy H-160.954 reaffirmed in lieu of Resolution 605.

Resolution 605 calls upon our AMA to submit an amicus curiae brief supporting the petition for certiorari of John Natale, MD seeking review of the ruling in US v. Natale, 719 F.3d 719.

Your Reference Committee heard mixed testimony on this resolution. While testimony generally supported the idea of further examining the issue of criminalization of medical documentation errors, the resolution asks our AMA to support a specific court case whose ruling is currently under review. Testimony presented explained that our AMA's practice is to evaluate the merits of the case once it is accepted for review by the appropriate appellate body and all facts of the case are made available. In this case, the appellate body is the Supreme Court of the United States, which has not yet accepted this case for review.

Your Reference Committee notes that our AMA has existing policy on the issue of criminalization of medical documentation errors, which reads as follows:

Policy to be reaffirmed:

H-160.954 Criminalization of Medical Judgment

Our AMA continues to take all reasonable and necessary steps to insure that errors in medical decision-making and medical records documentation, exercised in good faith, do not become a violation of criminal law. (2) Henceforth our AMA opposes any future legislation which gives the federal government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties. (Sub. Res. 223, I-93; Reaffirmed: Res. 227, I-98; Reaffirmed: Res. 237, A-99; Reaffirmed and Appended: Sub. Res. 215, I-99; Reaffirmation A-09; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation: I-12; Modified: Sub. Res. 716, A-13)

Your Reference Committee noted that our AMA is not precluded from advocating for this case in the future.

(9) BOARD OF TRUSTEES REPORT 9 - PUBLIC HEALTH AND PRIMARY PREVENTION IN AMA'S STRATEGIC PLAN

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 9 be filed.

HOD ACTION: Board of Trustees Report 6 filed.

Board of Trustees Report 9 is an informational report that was extracted for consideration in Reference Committee F. The report is in response to Policy G-625.020, which calls upon "our AMA Board of Trustees to consider whether our American Medical Association's strategic plan adequately addresses public health and primary prevention and report back to the House of Delegates at the 2013 Interim Meeting."

Your Reference Committee appreciates the Board's informative report and in light of the fact that no action was requested from the limited testimony that was heard, your Reference Committee recommends that the report be filed.

REPORT OF REFERENCE COMMITTEE J

- (1) COUNCIL ON MEDICAL SERVICE REPORT 3 - HOSPITAL-BASED PHYSICIANS AND THE VALUE-BASED PAYMENT MODIFIER

RECOMMENDATION:

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

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

Council on Medical Service Report 3 recommends that our AMA continue to advocate for repeal or modification of the Value-Based Payment Modifier (VBM) program, and encourage national medical specialty societies to pursue the development of relevant performance measures that demonstrate improved quality and lower costs, which could be incorporated into quality measurement and improvement programs.

There was supportive testimony on this report. In particular, speakers appreciated the report's emphasis on the need for our AMA to continue to advocate for repeal or significant modification of the VBM program, and on the importance of direct involvement by medical specialties in the development of performance measures that are relevant to practicing physicians. Your Reference Committee commends the Council on a strong report, and recommends its adoption.

- (2) COUNCIL ON MEDICAL SERVICE REPORT 4 - INTEGRATED ELECTRONIC PATIENT CARE REPORTS FOR PREHOSPITAL PROVIDERS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the Recommendations in Council on Medical Service Report 4 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 4 adopted and the remainder of the report filed.

Council on Medical Service Report 4 recommends reaffirming policies that guide our AMA's work on HIT and HIE-related issues.

There was supportive testimony on this report. Your Reference Committee believes that this report provides useful information to the House regarding health information technology and exchanges, and recommends its adoption.

- (3) RESOLUTION 811 - REVIEW OF SELF-ADMINISTERED DRUG LIST ALTERATIONS UNDER MEDICARE PART B

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 811 be adopted.

HOD ACTION: Resolution 811 adopted.

Resolution 811 asks that our AMA seek to require that any alterations to Self-Administered Drug Lists be subject to review by Carrier Advisory Committees.

There was supportive testimony on this resolution. Your Reference Committee appreciated testimony highlighting the fact that moving drugs to the self-administered drug list, per se, is not inappropriate, and agrees that active involvement by Carrier Advisory Committees would help ensure that drugs are appropriately classified and that the appropriate therapeutic options are accessible to patients. Accordingly, your Reference Committee recommends that Resolution 811 be adopted.

(4) RESOLUTION 816 - INAPPROPRIATE INTERFERENCE WITH HOSPITAL ADMISSIONS BY PATIENT MANAGEMENT CONTACTORS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 816 be adopted.

HOD ACTION: Resolution 816 adopted.

Resolution 816 asks that our AMA study whether contracted patient management personnel are making medical management decisions about hospital admissions, and make recommendations for new policy to address this issue.

There was supportive testimony on this resolution, and speakers expressed concern and confusion regarding the complexity of the inpatient/observation status designations of Medicare patients who are treated in the hospital setting. Your Reference Committee accordingly recommends that Resolution 816 be adopted.

(5) RESOLUTION 817 – RANDOM DRUG SCREENING

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 817 be adopted.

HOD ACTION: Resolution 817 adopted.

Resolution 817 asks that our AMA develop model medical staff bylaws addressing random drug testing of medical staffs, and reaffirm Policy H-95.984, which addresses the use of drug testing by employers.

Your Reference Committee heard supportive testimony on Resolution 817. Your Reference Committee agrees that model medical staff bylaws are needed that address random drug screening of medical staff members, and accordingly recommends adoption of Resolution 817.

(6) RESOLUTION 821 - QUALIFICATIONS, SELECTION AND ROLE OF HOSPITAL MEDICAL DIRECTORS AND OTHERS PROVIDING MEDICAL MANAGEMENT SERVICES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 821 be adopted.

HOD ACTION: Resolution 821 referred.

Resolution 821 asks that our AMA amend Policy H-235.981 so that it includes language to address the medical staff's overall responsibility to the governing body for the quality of care provided to patients by the hospital.

Testimony on Resolution 821 was limited to its sponsor. Your Reference Committee agrees that Policy H-235.981 should include language addressing the medical staff's overall responsibility to the governing body for the quality care provided to patients by the hospital. Accordingly, your Reference Committee recommends that Resolution 821 be adopted.

Note that Resolution 821 as submitted details the extensive amendments to Policy H-235.981 that are necessary to effectively address the issues presented in this resolution. In the interest of streamlining this report, your Reference Committee urges members of the House to refer to the resolution directly to see the amended language.

(7) COUNCIL ON MEDICAL SERVICE REPORT 1 - PAYMENT MECHANISMS FOR TEAM-BASED HEALTH CARE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 in Council on Medical Service Report 1 be amended by addition and deletion on lines 19 – 21 to read as follows:

1. That our AMA advocate that physicians who lead team-based care in their practices ~~team-based physician leaders~~ receive the payments for health care services provided by the team and establish payment disbursement mechanisms that foster physician-led team-based care. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 2 in Council on Medical Service Report 1 be amended by deletion on lines 23 and 29 to read as follows:

2. That our AMA advocate that physicians ~~who are team-based innovators~~ make decisions about payment disbursement in consideration of team member contributions, including but not limited to:

- a. Volume of services provided;
- b. Intensity of services provided;
- c. Profession of the team member;
- d. Training and experience of the ~~physician~~ team member; and
- e. Quality of care provided. (New HOD Policy)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Recommendation 3 in Council on Medical Service Report 1 be amended by addition on line 32 to read as follows:

3. That our AMA advocate that an effective payment system for physician-led team-based care should:

- a. Reflect the value provided by the team and that any savings accrued by this value should be shared by the team;
- b. Reflect the time, effort and intellectual capital provided by individual team members;
- c. Be adequate to attract team members with the appropriate skills and training to maximize the success of the team; and
- d. Be sufficient to sustain the team over the time frame that it is needed. (New HOD Policy)

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Council on Medical Service Report 1 be amended by addition of a fifth recommendation to read as follows:

5. That our AMA advocate that payment models for physician-led team-based care should be determined by physicians working collaboratively with hospital and payer partners to design models best suited for their particular circumstances. (New HOD Policy)

RECOMMENDATION E:

Mr. Speaker, your Reference Committee recommends that Council on Medical Service Report 1 be amended by addition of a sixth recommendation to read as follows:

6. That our AMA develop educational programs to assist members wishing to develop and implement physician-led team based care payment methodologies at the individual team, practice, accountable care organization, hospital and health system levels. (Directive to Take Action).

7. That our AMA report back to the House on issues, developments and AMA activity on "Payment Mechanisms for Team-Based Health Care" by the I-15 meeting.

RECOMMENDATION F:

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

RECOMMENDATION G:

Mr. Speaker, your Reference Committee recommends that the title of Council on Medical Service Report 1 be changed to read as follows:

PAYMENT MECHANISMS FOR PHYSICIAN-LED TEAM-BASED HEALTH CARE

HOD ACTION Council on Medical Service Report 1 adopted as amended and the remainder of the report filed with a title change.

Council on Medical Service Report 1 makes recommendations related to the design of payment systems and the distribution of payments associated with team-based care.

Your Reference Committee heard generally supportive testimony on this report. Although some speakers expressed concern that the report did not provide adequate detail with respect to how payment models should be designed or implemented, your Reference Committee agrees with other speakers who noted that the recommendations provide an important foundation for future policy developments in this area. Based on testimony received, your Reference Committee proposes several amendments that help strengthen and clarify the Council's policy recommendations. In particular, your Reference Committee agrees with testimony suggesting that the words "physician-led" be added throughout the recommendations, in order to emphasize the important concept of physician leadership in team-based care models. There was also some concern that Recommendation 2 as written could inappropriately limit payments to certain physicians and create tension among physician team members. Your Reference Committee believes that the amended language addresses these concerns. Your Reference Committee also concurs with the clarifying

language proposed by a member of the Council on Medical Service, which acknowledges the differences associated with managing payments for physician-led team-based care within an individual physician practice and in a more integrated practice setting. Finally, your Reference Committee also agrees that it would be helpful for our AMA to provide assistance in the form of educational materials that physicians could use to develop and implement physician-led team based payment methodologies. Your Reference Committee recommends that the recommendations in Council on Medical Service Report 1 be adopted as amended and the remainder of the report filed.

(8) COUNCIL ON MEDICAL SERVICE REPORT 6 - THE CORPORATE PRACTICE OF MEDICINE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 of Council on Medical Service Report 6 be amended by addition and deletion to read as follows:

1. That our American Medical Association (AMA) amend Policy H-215.981 and its title by addition and deletion to read as follows:

H-215.981 ~~Hospital-Employed Physicians~~ Corporate Practice of Medicine

(1) Our AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine. (2) At the request of state medical associations, our AMA will provide guidance, and consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs. (3) Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues. (Modify HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the Recommendations in Council on Medical Service Report 6 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 6 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 6 recommends modifying and reaffirming policies in order to balance concerns related to barriers to clinical integration and the need to protect the independent medical judgment of physicians and patient-physician relationships.

There was generally supportive testimony on this report. However, some testimony on the online member forum raised concerns with the third recommendation of the report, which calls for Policy D-215.993 to be rescinded. In response, a member of the Council on Medical Service offered an amendment to the first recommendation of the report, which directly addresses the need for the AMA to provide model legislation on this issue - which has already been developed - to state medical associations. Your Reference Committee believes that this amendment sufficiently responds to the testimony given in the online member forum, and accordingly recommends that Council on Medical Service Report 6 be adopted as amended.

(9) COUNCIL ON MEDICAL SERVICE REPORT 7 - STRENGTHENING MEDICARE THROUGH COMPETITIVE BIDDING

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 of Council on Medical Service Report 7 be amended by addition on lines 34 - 35 to read as follows:

1. That our American Medical Association support the following principles to guide the use of competitive bidding among health insurers in the Medicare program..:

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that subparagraph (f) of Recommendation 1 be amended by addition and deletion on lines 4 – 6 to read as follows:

- f. All contracting entities should be required to offer beneficiaries a plan that includes only the standardized benefit package. Expanded ~~Richer~~ benefit options could also be offered for beneficiaries willing to pay higher premiums.

RECOMMENDATION C:

Mr. 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 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 support several principles to help ensure that a competitive bidding process works efficiently and fairly, including requirements for bidding entities, criteria for bids, and the availability of resources for beneficiary education and support for choosing among alternate plans. The report also recommends that our AMA support using a competitive bidding process to determine federal payments to Medicare Advantage plans.

There was generally supportive testimony on this report. A concern was raised that a competitive bidding system is not appropriate for all services, and there should be exceptions to the use of a competitive bidding process for certain individual services. A member of the Council on Medical Service testified that the intent of the report was to outline principles for competitive bidding among health insurers competing to provide a defined set of Medicare benefits to beneficiaries. Your Reference Committee recommends the amended language to clarify this intent. Another speaker expressed support for ensuring the availability of chronic care services as part of a basic benefit package. Your Reference Committee notes that the principles outlined in the report are intended to guide the development of a bidding process, rather than define specific details of what should be included in a bid. However, Recommendation 1(c) ensures that patients would not lose access to any services provided through the current Medicare program. In Recommendation 1(f), your Reference Committee believes that it is more descriptive to refer to “expanded” benefits, rather than “richer” benefits. Your Reference Committee believes that the principles outlined in the report provide a solid foundation for exploring additional opportunities to use competitive bidding in the Medicare program, and recommends that the recommendations be adopted.

(10) COUNCIL ON MEDICAL SERVICE REPORT 8 - LONG-TERM CARE RESIDENTS WITH CRIMINAL HISTORIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 in Council on Medical Service Report 8 be amended by addition to read as follows:

1. That our American Medical Association (AMA) encourage the long-term care provider and correctional care communities, including the American Medical Directors Association, the Society of Correctional Physicians, the National Commission on Correctional Health Care, the American Psychiatric Association, long-term care advocacy groups and offender advocacy groups, to work together to develop national best practices on how best to provide care to, and develop appropriate care plans for, individuals with violent criminal backgrounds or violent tendencies in long-term care facilities while ensuring the safety of all residents of the facilities. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 2 in Council on Medical Service Report 8 be amended by addition and deletion to read as follows:

2. That our AMA encourage more research on how to best care for residents of long-term care facilities with criminal ~~histories~~ backgrounds, which should include how to vary approaches to care planning and risk management based on age of offense, length of incarceration, violent tendencies, and medical and psychiatric history. (New HOD Policy)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Recommendation 3 in Council on Medical Service Report 8 be amended by addition and deletion to read as follows:

3. That our AMA encourage research to identify and appropriately address possible liabilities for medical directors, attending physicians, and other providers in long-term care facilities caring for residents with criminal ~~backgrounds~~ histories. (New HOD Policy)

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Council on Medical Service Report 8 be amended by addition of a fifth recommendation to read as follows:

5. That our AMA urge the Society of Correctional Physicians and the National Commission on Correctional Health Care to work to develop policies and guidelines on how to transition to long-term care facilities for individuals recently released from incarceration, with consideration to length of incarceration, violent tendencies, and medical and psychiatric history. (New HOD Policy)

RECOMMENDATION E:

Mr. Speaker, your Reference Committee recommends that the Recommendations in Council on Medical Service Report 8 be adopted as amended and the remainder of the report be filed.

RECOMMENDATION F:

Mr. Speaker, your Reference Committee recommends that the title of Council on Medical Service Report 8 be changed to read as follows:

LONG-TERM CARE RESIDENTS WITH CRIMINAL BACKGROUNDS

HOD ACTION: Council on Medical Service Report 8 adopted as amended and the remainder of the report filed with a title change.

Council on Medical Service Report 8 recommends that our AMA encourage the long-term care provider and correctional care communities work together to develop national best practices on how best to provide care to individuals with violent criminal backgrounds or violent tendencies in long-term care facilities while ensuring the safety of all residents of the facilities.

There was mixed testimony on this report. Speakers raised concerns that the recommendations of the report would stigmatize the long-term care resident population with criminal backgrounds, as many individuals in this population do not have violent tendencies. Testimony also noted that most incidents of violence and aggression in long-term care facilities are committed by residents with cognitive impairments and mental illness, not residents with criminal backgrounds. A speaker also stated that the recommendations of the report should refer to residents with criminal “backgrounds” instead of “histories,” a change which your Reference Committee incorporated into the recommendations and title of this report.

However, other speakers testified in support of the report’s recommendations, citing a need for more data and research addressing the long-term care resident population with criminal backgrounds. Specifically, testimony cited the need for the recommendations of the report to address juvenile offenders, which your Reference Committee addressed in its amendment to the second recommendation of the report. Testimony also highlighted the importance of organizations with expertise on this issue working together to develop best practices on how to best care for individuals with violent criminal backgrounds or violent tendencies, as they are currently insufficient. Your Reference Committee agrees with a suggestion made in testimony that the American Psychiatric Association be included in the list of organizations outlined in the first recommendation.

In addition, a member of the Council on Medical Service noted that the Council was specifically instructed to study the issue of long-term care residents with criminal backgrounds. The member also cited that the recommendations of the report focus on the segment of the population with violent tendencies, realizing that many residents with criminal backgrounds do not have violent tendencies and are not likely to reoffend. Your Reference Committee believes that the recommendations of the report fill a void that currently exists with respect to best practices and research on this topic. Additional research and best practices addressing how to best care for residents of long-term care facilities with criminal backgrounds will only help to ensure that the aims of care planning and risk management efforts are appropriate for and prevent the stigmatization of this population. The development of best practices and clear guidelines will also help to assure that individuals with criminal backgrounds are able to access the long-term care they need, as long-term care facilities will have guidance on how to best care for this population, and understand the liabilities they may face in doing so.

In its report, the Council noted that the medical records of residents with criminal histories are oftentimes not transferred from correctional institutions, making continuity of care difficult. As such, your Reference Committee accepts an amendment offered that urges the Society of Correctional Physicians and the National Commission on Correctional Health Care to work to develop policies and guidelines on how to transition to long-term care facilities for individuals recently released from incarceration. Your Reference Committee believes that the recommendations of the report provide a strong foundation for future work to improve the long-term care provided to residents with

criminal backgrounds, with the ultimate goal to ensure the safety of all residents of long-term care facilities. Accordingly, your Reference Committee recommends that the recommendations of Council on Medical Service Report 8 be adopted as amended.

(11) RESOLUTION 802 - UPDATING AMA HOD POLICY ON REQUIREMENTS FOR AND PRESCRIPTION OF DURABLE MEDICAL EQUIPMENT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy H-330.945 be amended by addition and deletion to read as follows:

H-330.945 Durable Medical Equipment Requirements

The AMA will: (1) continue to seek legislation to prohibit unsolicited contacts by durable medical equipment suppliers that recommend medically unnecessary durable medical equipment to Medicare beneficiaries; (2) affirm the concept that members of a physician-led interprofessional health care team be enabled to perform delegated medical duties, including ordering durable medical equipment, that they are capable of performing according to their education, training and licensure and at the discretion of the physician team leader; and (23) advocate that the initiators of orders for durable medical equipment should be a physician, or a nurse practitioner or physician assistant operating in collaboration with or supervised by a physician within their care team, consistent with state scope of practice laws and; (4) reaffirm the concept that physicians are ultimately solely responsible for the medical needs of their patients, and should be the initiators of orders for durable medical equipment.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Policy H-330.955 be amended by addition and deletion to read as follows:

H-330.955 Prescription of Durable Medical Equipment

(1) The AMA continues to voice its objection to CMS regarding its onerous requirement that physicians initiate and complete the entire certification of medical necessity form for durable medical equipment. (2) The AMA advocate that additional members of a physician-led health care team be permitted to complete the certification of medical necessity form for durable medical equipment, according to their education, training and licensure and at the discretion of the physician team leader, but require that the final signature authorizing the prescription for the durable medical equipment be the responsibility of the physician. (23) The AMA calls for CMS to revise its interpretation of the law to permit that the physician's prescription be the only certification of medical necessity needed to initiate an order for and to secure Medicare payment for durable medical equipment. (34) The AMA calls on physicians to be aware of the abuses caused by product-specific advertising by manufacturers and suppliers of durable medical equipment, the impact on the consumers of inappropriate promotion, and the contribution such promotion makes to unnecessary health care expenditures.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Amended Policies H-330.945 and H-330.995 be adopted in lieu of Resolution 802.

HOD ACTION: Amended Policies H-330.945 and H-330.995 adopted in lieu of Resolution 802.

Resolution 802 asks that our AMA review and update Policies H-330.945 and H-330.955 so they are consistent with the current practice of medicine and emerging patient care models. The resolution highlights specific issues to consider, including the role of nurse practitioners or physicians assistants working in collaboration with and supervised by a physician and the certificate of need process.

Your Reference Committee heard mixed testimony on Resolution 802. Some speakers raised a concern that this resolution represents a slippery slope, as it calls for nurse practitioners and physician assistants to have the ability to complete the certificate of medical necessity for durable medical equipment (DME). Testimony also cited that the potential for fraud arises associated with allowing additional members of the health care team to initiate orders for DME.

Testimony in favor of this resolution stressed that the concepts outlined in the resolution align with AMA's policy and advocacy efforts addressing physician-led health care teams. As such, a member of the Council on Medical Service recommended that the Reference Committee propose the necessary amendments to Policies H-330.945 and H-330.955 instead of recommending adoption of original Resolution 812, which recommended study of the need for such amendments. Therefore, your Reference Committee has proposed amendments to both policies, which not only complement AMA policy on physician-led health care teams, but underscore that it is up to individual physician leaders of health care teams whether to allow nurse practitioners and physician assistants to initiate orders for DME. Importantly, the amendment to Policy H-330.955 proposed by the Reference Committee stresses that the final signature authorizing the prescription for DME be the responsibility of the physician. Your Reference Committee recommends adoption of the amended policies in lieu of Resolution 802.

(12) RESOLUTION 805 - PHYSICIAN SATISFACTION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 805 be amended by deletion to read as follows:

RESOLVED, That our AMA ~~help:~~ (1) study current tools and develop metrics to measure physician professional satisfaction; and (2) ~~encourage the Joint Commission to require a national standardized measure of physician satisfaction to use as a standard for hospital accreditation~~ (Directive to Take Action).

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 805 be adopted as amended.

HOD ACTION: Resolution 805 adopted as amended.

Resolution 805 asks that our AMA study current tools and develop metrics to measure physician satisfaction; and encourage the Joint Commission to require a national standardized measure of physician satisfaction to use as a standard for hospital accreditation.

Your Reference Committee heard supportive testimony on the first part of this resolution asking our AMA to study and develop metrics to measure physician satisfaction. Your Reference Committee notes that this is consistent with the work of our AMA's new strategic focus on enhancing practice sustainability and physician satisfaction. However, several speakers expressed concern about the second part of the resolution, which asks the Joint Commission to require a standardized measure of physician satisfaction. Speakers were reluctant to have the Joint Commission take the lead in developing a metric that might not accurately measure physician satisfaction, and that could end up being an additional administrative burden on physicians. Your Reference Committee agrees with

testimony that our AMA should take a leadership role in developing ways to measure physician satisfaction, and recommends that Resolution 805 be adopted as amended.

(13) RESOLUTION 806 - SUSPEND HCAHPS RATING SYSTEM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 806 be adopted.

IMPROVING THE HCAHPS RATING SYSTEM

RESOLVED, That our AMA urge the Centers for Medicare and Medicaid Services to modify the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scoring system so that it assigns a unique value for each rating option available to patients (Directive to Take Action); and be it further

RESOLVED, That our AMA reaffirm Policies H-406.991 and D-385.958, which emphasize that patient satisfaction surveys should be used to help improve patient care and not for the purpose of determining physician payment (Reaffirm HOD Policy)

HOD ACTION: Substitute Resolution 806 adopted.

Resolution 806 asks that our AMA urge the Centers for Medicare and Medicaid Services to suspend the HCAHPS rating until a valid scoring system can be adopted.

There was mixed testimony on this resolution. There was strong support for the need to improve the scoring system used by the HCAHPS program, however, most speakers did not believe that calling for a suspension of the HCAHPS was a realistic or desirable way of addressing the problem. Several speakers noted that the HCAHPS is a carefully developed and validated system that provides important and valuable information about the patient experience. Accordingly, your Reference Committee concurs with testimony that our AMA should work with CMS to modify the HCAHPS scoring system so that it reflects the full range of rating options available to patients. Your Reference Committee heard testimony suggesting that the resolution be expanded to include outpatient assessment tools (i.e., the Clinician and Group Consumer Assessment of Healthcare Providers and Systems [CGCHAPS]), however, your Committee felt that this was beyond the scope of the resolution, as the two assessment tools are currently being used and scored in different ways.

Several speakers also expressed concern about linking patient satisfaction ratings to physician payment. Your Reference Committee notes that our AMA has policies that support the use of physician satisfaction surveys as a tool to improve the quality of care provided to patients, and not as a way of determining physician payment. Your Reference Committee recommends that the following important policies be reaffirmed.

Policy to be reaffirmed:

H-406.991 Work of the Task Force on the Release of Physician Data (relevant section excerpted)

...7. Patient Satisfaction Measurement Requirements - Until the relationship between patient satisfaction and other outcomes is better understood, data collected on patient satisfaction is best used by physicians to better meet patient needs particularly as they relate to favorable patient outcomes and other criteria of high quality care - Because of the difficulty in determining whether responses to patient satisfaction surveys are a result of the performance of a physician or physician office, or the result of the demands or restrictions of health insurers or other factors out of the control of the physician, the use of patient satisfaction data is not appropriate for incentive or tiering mechanisms. - As in physician profiling programs, it is important that programs that publicly rate physicians on patient satisfaction notify physicians of their rating and provide a chance for the physician to appeal that rating prior to its publication. (BOT Rep. 18, A-09; Reaffirmation A-10; Reaffirmed: BOT action

in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10; Reaffirmation I-10; Reaffirmed in lieu of Res. 808, I-10; Reaffirmed in lieu of Res. 824, I-10; Reaffirmation A-11; Reaffirmed: BOT Rep. 17, A-13)

D-385.958 Patient Satisfaction Surveys and Quality Parameters as Criteria for Physician Payment
Our AMA will work with the Centers for Medicare & Medicaid Services (CMS) and non-government payers to ensure that (1) subjective criteria, such as patient satisfaction surveys, be used only as an adjunctive and not a determinative measure of physician quality for the purpose of physician payment; and (2) physician payment determination, when incorporating quality parameters, only consider measures that are under the direct control of the physician. (Res. 102, A-13)

(14) RESOLUTION 813 - HEALTH INSURANCE EXCHANGE AND 90 DAY GRACE PERIOD

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 813 be adopted.

RESOLVED, That our American Medical Association reaffirm Policy H-165.838, which states that insurance coverage options offered in a health insurance exchange should not require provider participation (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA reaffirm Policies H-165.839 and D-185.999, which support standards to provide physicians with accurate and real time verification of patient eligibility, co-payment due, deductible payable information, and claims processing (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA reaffirm Policy 185.981, which supports a standardized, national health benefits verification system that includes an obligation on the part of the insurer or managed care plan to pay physicians for any services rendered to patients whose eligibility for benefits have been verified erroneously (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA oppose the preemption of state law by federal laws relating to the federal grace period for subsidized health benefit exchange enrollees (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that health plans be required to notify physicians that a patient is in the federal grace period for subsidized health benefit exchange enrollees upon an eligibility verification check by the physician. The notification must specify which month of the grace period a patient is in. Failure to notify physicians of patient grace period status would result in a binding eligibility determination upon the insurer. (New HOD Policy)

HOD ACTION: Substitute Resolution 813 adopted.

Resolution 813 asks that our AMA oppose efforts to mandate physician participation in health insurance exchange products; support insurance identification cards that contain contact information to verifying eligibility and coverage; support that authorization of eligibility and coverage will be a guarantee of payment for services rendered; oppose the preemption of state law by federal laws relating to the federal grace period for subsidized health benefit exchange enrollees; and support the suspension of coverage in months two and three of the federal grace period for subsidized health benefit exchange enrollees who fail to pay premiums.

Your Reference Committee heard generally supportive testimony of the spirit of Resolution 813. A member of the Council on Medical Service noted that existing policies already address the intent of some of the resolves of the resolution. The majority of the testimony focused on the last resolve, suggesting different solutions to minimize the impact of insurers pending claims during the second and third months of the grace period, including allowing physicians to collect deposits from patients for services rendered during this time period. A member of the Council on Legislation recommended substituting the fifth resolve with language that would require health insurers to notify physicians that a patient has entered the grace period upon an eligibility check by the physician. And, importantly, failure to notify physicians as required would result in a binding eligibility determination upon the insurer. Your Reference Committee believes that this notification would allow physicians the opportunity to inform the patient of his/her status and provide education to the patient on the importance of paying premiums. As such, your Reference Committee recommends that Substitute Resolution 813 be adopted.

(15) RESOLUTION 814 - RETRO-AUTHORIZATION FOR TESTS/
PROCEDURES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 814 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support a requirement ~~requiring~~ that payors provide a retro-authorization process, with reasonable ~~requirements as to the~~ timeframes for submission and consideration and with reasonable procedural standards for all tests, procedures, treatments, medications and evaluations requiring authorization- (New HOD Policy); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 814 be amended by addition of a second resolve to read as follows:

RESOLVED, That our AMA reaffirm Policy H-285.940, which opposes health plans refusing to pay for the provision of covered services for the sole reason that required notification of these services was not reported in a timely manner (Reaffirm HOD Policy); and be it further

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 814 be amended by addition of a third resolve to read as follows:

RESOLVED, that our AMA reaffirm Policy H-285.931, which states that physicians and patients of a health plan should have access to a timely, expeditious internal appeals process. (Reaffirm HOD Policy)

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Resolution 814 be adopted as amended.

HOD ACTION: Resolution 814 adopted as amended.

Resolution 814 asks that our AMA support requiring payers to provide a retro-authorization process for all services requiring authorization.

Your Reference Committee heard generally supportive testimony on Resolution 814. Your Reference Committee agreed with suggestions raised in testimony to broaden the focus of the first resolve. In addition, your Reference Committee believes that reaffirming Policies H-285.940 and H-285.931 would reinforce the importance of this issue. Your Reference Committee recommends adoption of Resolution 814 as amended.

(16) RESOLUTION 818 - CLAIMS BASED DATA AS A FLAWED QUALITY OF CARE MEASURE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 818 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association strongly urge insurance companies to not use claims or other administrative based data as the sole determinant of quality of care rendered or physician payment and furthermore, ~~that insurance companies do not financially penalize physicians for patient non-compliance.~~ (Directive to Take Action); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 818 be amended by addition of a second resolve to read as follows:

RESOLVED, That our AMA reaffirm Policies H-450.942 and D-450.965, which address patient adherence to treatment plans (Reaffirm HOD Policy).

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 818 be adopted as amended.

HOD ACTION: Resolution 818 adopted as amended.

Resolution 818 asks that our AMA discourage insurance companies from using claims data as the sole determinant of quality of care rendered, and from financially penalizing physicians for patient non-compliance.

Several speakers, including the sponsor of Resolution 818, suggested that the resolution should be divided into two resolves, one related to the use of claims data for quality measurement, and the other related to the practice of financially penalizing physicians for patient non-adherence. There was strong support for the concept of discouraging insurance companies from using claims or other administrative data as the sole determinant of quality of care. Your Reference Committee concurs with testimony that administrative data should also not be used as the sole determinant of physician payment, and proposes amended language to include this concept.

Testimony on the second part of the resolution regarding patient adherence was more mixed. Several speakers noted that physicians have a responsibility to work with their patients to help them understand the importance of treatment adherence, and cited examples where lack of patient compliance could potentially indicate quality of care issues. Your Reference Committee notes that our AMA has policies that address the importance of patient responsibility and adherence to treatment plans, and support the development of resources to support patient compliance. Accordingly, your Reference Committee recommends adding a second resolve that would reaffirm the following policies.

Policy to be reaffirmed:

H-450.942 Patient Adherence to Treatment Plans

It is AMA policy that patient adherence to any medical treatment program is necessary in order to achieve high quality and cost-effective health care. (Res. 505, A-06; Reaffirmed: BOT Rep. 8, I-11)

D-450.965 Patients' Responsibilities for Health Care Outcomes

Our AMA will: (1) continue to support the development of resources for patients and physicians to promote adherence through its partnerships with the National Council on Patient Information and Education and National Consumer League National Medication Adherence Campaign; (2) publicize existing resources for physicians to help patients adhere to treatment through its website; and (3) examine issues of patient adherence as part of its strategic initiative on Improving Health Outcomes and, if appropriate, will develop with others targeted education and resources to support patient adherence. (BOT Rep. 8, I-11; Modified: BOT Rep. 3, I-12)

- (17) RESOLUTION 819 - HEALTH INSURANCE CARRIERS CANCELING COVERAGE FOR HUNDREDS OF THOUSANDS OF PATIENTS ACROSS THE COUNTRY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 819 be adopted.

HEALTH INSURANCE CANCELLATIONS

RESOLVED, That our AMA support urgent efforts to maintain coverage while facilitateing a smooth transition to alternative new coverage options which offer “meaningful coverage” as defined in Policy H-165.848 for individuals who have received cancellation notices from their health insurance companies as a result of the Affordable Care Act. (New HOD Policy).

HOD ACTION: Substitute Resolution 819 adopted as amended. Amendment J-9 referred for decision to 12/15/13.

Resolution 819 asks that our AMA work with the President, legislators and CMS to ensure that patients can renew or extend existing insurance contracts until alternatives are available through Exchanges or the private market.

Your Reference Committee heard mixed testimony on Resolution 819. Most testimony highlighted the critical nature of this issue, and stressed that the individuals affected by the recent health plan cancellations should not be left without any health insurance coverage. While testimony raised the concern that some individuals affected by insurance cancellations may face higher premiums in health insurance exchanges, other speakers noted that some individuals would be eligible for premium credits and cost-sharing subsidies, or could enroll in the catastrophic health plans offered in health insurance exchanges. Your Reference Committee notes that catastrophic health plans in exchanges are available to individuals up to age 30, as well as individuals who are exempt from the individual mandate, including those who meet the definitions for financial hardship, as well as those for whom the lowest cost plan option exceeds 8 percent of an individual's income.

Many speakers cited issues with Resolution 819 as written. Some speakers noted that supporting Resolution 819 would allow for the continuation of policies that are not allowed under the Affordable Care Act, a law that the AMA supported. In addition, a member of the Council on Medical Service noted that many of the policies that were canceled do not meet the definition of “meaningful coverage” outlined in Policies H-165.848, H-165.865 and H-165.846. Additional testimony cited that the policies that are being canceled may charge different premiums based on an individual's health status or gender, and may not provide coverage for pre-existing conditions. Ultimately, a member of the Council on Medical Service proposed substitute language, to ensure that AMA efforts on this issue focus on facilitating a smooth transition to new coverage options for individuals who have received cancellation notices from their health insurance companies. Several speakers rose in support of the Council's substitute language, and the sponsor of Resolution 819 stated that it was acceptable. As such, your Reference Committee recommends adoption of Substitute Resolution 819.

(18) RESOLUTION 801 - PRIVACY ISSUES FOR MINORS REGARDING INSURANCE COMPANY EXPLANATION OF BENEFITS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 801 be referred.

HOD ACTION: Resolution 801 referred.

Resolution 801 asks that our AMA advocate for maintaining privacy regarding the doctor patient relationship by advocating against insurance companies sending EOBs to anyone other than the patient or their health care provider.

There was mixed testimony on this resolution. While testimony was supportive of the intent of the resolution – to protect the privacy rights of adult dependents and minors – several speakers highlighted concerns with the last two resolved clauses, as Explanation of Benefits forms enable policyholders to understand their cost-sharing obligations, as well as ensure that all services billed are valid. Testimony also cited that not all minors are competent to make health care decisions and understand the cost-sharing obligations of their health plan. Your Reference Committee agrees that the resolution may have unintended consequences, which was evidenced by several calls for referral. Accordingly, your Reference Committee recommends referral of Resolution 801.

(19) RESOLUTION 808 - REFERENCE PRICING

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 808 be referred.

HOD ACTION: Resolution 808 referred.

Resolution 808 asks that the term “Reference Pricing” be substituted for the term “Benefit Payment Schedule” in AMA policy, and that the AMA advocate for inclusion of the option of “Reference Pricing” in a pluralistic approach to Health System Reform.

There was mixed testimony on this resolution, with several speakers expressing interest in the concept of reference pricing, but citing the need for additional information about forms of reference pricing, how it is being used by insurers, and the possible implications of its use for patients and physicians. Your Reference Committee agrees with testimony that additional information is necessary in order to appropriately respond to this issue, and accordingly recommends that Resolution 808 be referred.

(20) RESOLUTION 804 - REIMBURSEMENT FOR EATING DISORDERS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-185.974, H-345.981 and D-345.997 be reaffirmed in lieu of Resolution 804.

HOD ACTION: Policies H-185.974, H-345.981 and D-345.997 reaffirmed in lieu of Resolution 804.

Resolution 804 asks that our AMA seek federal legislation requiring full insurance coverage for ALL eating disorders, including inpatient and outpatient care, as well as maintenance care.

There was mixed testimony on Resolution 804. Many speakers supported the intent of the resolution, but highlighted concerns with calling for legislation mandating insurance coverage for all eating disorders. Your Reference Committee notes that Policy H-165.856 states that benefit mandates should be minimized to allow markets to

determine benefit packages and permit a wide choice of coverage options. In addition, Policy H-185.964 opposes new health benefit mandates unrelated to patient protections, which jeopardize coverage to currently insured population.

Anorexia nervosa, bulimia and binge eating are recognized as DSM-5 diagnoses, and thus qualify for mental health treatment. A speaker noted that improved coverage of mental health services is provided for in the Affordable Care Act, through its inclusion as a category of essential health benefits. Testimony highlighted that coverage for eating disorders should align with AMA's support for mental health parity of coverage for mental illness, alcoholism and substance abuse. Your Reference Committee agrees, and also believes that barriers should be eliminated to access to treatment for mental illness, including eating disorders. As such, your Reference Committee recommends that Policies H-185.974, H-345.981 and D-345.997 be reaffirmed in lieu of Resolution 804.

Policy to be reaffirmed:

H-185.974 Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs
Our AMA supports parity of coverage for mental illness, alcoholism and substance use. (Res. 212, A-96; Reaffirmation A-97; Reaffirmed: Res. 215, I-98; Reaffirmation A-99; Reaffirmed: BOT Action in response to referred for decision Res. 612, I-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 9, A-01; Reaffirmation A-02; Reaffirmation I-03; Modified: CMS Rep. 2, A-08; Reaffirmed: CMS Rep. 5, I-12)

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)

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; (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. (CMS Rep. 9, A-01; Reaffirmed: CMS Rep. 7, A-11)

(21) RESOLUTION 807 - ROLE OF CRITICAL ACCESS HOSPITALS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-465.990 be reaffirmed in lieu of Resolution 807.

HOD ACTION: Policy H-465.990 reaffirmed in lieu of Resolution 807.

Resolution 807 asks that our AMA work to modify federal laws, rules, and regulations to reimburse all hospital billed physician services and their facilities at equal rates.

Strong concerns were raised about this resolution and the negative effect it could have on critical access hospitals and their ability to continue providing necessary and effective care for their rural patients. Your Reference Committee is sympathetic to the concerns raised in this resolution regarding the potential for critical access hospitals to place other rural hospitals at a disadvantage and, consequently, interfering with their ability to continue to provide

quality care to the patients they serve. Your Reference Committee notes our AMA has existing policy that supports reducing financial constraints on small rural hospitals, and recommends reaffirming this policy in lieu of Resolution 807.

Policy to be reaffirmed:

H-465.990 Closing of Small Rural Hospitals

Our AMA encourages legislation to reduce the financial constraints on small rural hospitals in order to improve access to health care. (Res. 145, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)

(22) RESOLUTION 812 - HEALTH EXCHANGE BENEFIT DESIGNS AND TAX DEDUCTIBILITY OF OUT-OF-POCKET EXPENSES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-165.846 and H-165.839 be reaffirmed in lieu of Resolution 812.

HOD ACTION: Policies H-165.846 and H-165.839 reaffirmed in lieu of Resolution 812.

Resolution 812 asks that our AMA support efforts to develop benefit designs in the health insurance exchanges that appeal to young and healthy people, and support legislation allowing full tax deductibility of all out of pocket health care expenses.

Your Reference Committee heard mixed testimony on Resolution 812. Several speakers raised concerns with the second resolved clause of the resolution. Importantly, testimony stressed that allowing for full federal and state income tax deductibility of all out-of-pocket health care expenses would not only be very costly, in this era in which lawmakers are aiming to achieve budgetary savings, but also would lack appropriate safeguards as to what would be defined as a “health care expense.” Your Reference Committee agrees that the second resolved clause would be costly, not politically feasible, and would likely have unintended consequences.

Many individuals spoke in favor of the first resolve. However, your Reference Committee notes that existing Policies H-165.839 and H-165.846 address the intent of the first resolve, and state that health insurance exchanges and other similar structures should maximize health plan choice for individuals and families purchase coverage. Policy also states that health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features. As such, your Reference Committee recommends that Policies H-165.839 and H-165.846 be reaffirmed in lieu of Resolution 812.

Policy to be reaffirmed:

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)

H-165.846 Adequacy of Health Insurance Coverage Options

Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options: A. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose. B. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage. C. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations. D. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services. 2. Our AMA 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. (CMS Rep. 7, A-07; Reaffirmation I-07; Reaffirmation A-09; Reaffirmed: Res. 103, A-09; Reaffirmation I-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: CMS Rep. 2, A-11; Appended: CMS Rep. 2, A-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed: CMS Rep. 3, A-13)

(23) RESOLUTION 815 - VULNERABLE PATIENT ACCESS AND PROTECTION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-373.999, H-285.911, D-165.989, D-285.972, and H-160.952 be reaffirmed in lieu of Resolution 815.

HOD ACTION: Policies H-373.999, H-285.911, D-165.989, D-285.972, and H-160.952 reaffirmed in lieu of Resolution 815.

Resolution 815 asks that our AMA promote access to appropriate care for all patients, promote special access for vulnerable patients if appropriate care cannot be provided within a patient's insurance provider network, and oppose any health care delivery model, public or private, that restricts patient access to physicians adequately experienced in their disease.

There was supportive testimony on this resolution, and the need to ensure that patients have access to appropriate care regardless of their source of health care coverage or the health care delivery model, including accountable care organizations, used to provide care to the patient. Your Reference Committee appreciates testimony highlighting several AMA policies that support adequate insurance provider networks and efforts to address patient care and access problems that might be created by new care delivery models. Your Reference Committee believes that the following policies address the important concerns raised in Resolution 815, and recommends that they be reaffirmed:

H-373.999 Patient Advocacy/Protection Activities

The AMA will continue to aggressively pursue legislative, regulatory, communications and advocacy opportunities to identify and correct patient care and access problems created by new health care delivery mechanisms. (BOT Rep. 55, A-96; Reaf: I-97; Renumbered: CMS Rep. 7, I-05)

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)

D-165.989 Managed Care Organization Reimbursement Formulas

Our AMA will continue to assist states medical associations in their efforts to enact meaningful legislation that protects patients and patient access through network adequacy provisions. (CMS Rep. 6, A-00; Reaf: CMS Rep. 6, A-10)

D-285.972 Tiered, Narrow, or Restricted Physician Networks

Our AMA will: (1) seek to have third party payers disclose, in plain language, the criteria by which the carrier creates a tiered, narrow or restricted network; (2) monitor the development of tiered, narrow or restricted networks to ensure that they are not inappropriately driven by economic criteria by the plans and that patients are not caused health care access problems based on the potential for a limited number of specialists in the resulting network(s); and (3) seek legislation or regulation which prohibits the formation of networks based solely on economic criteria and ensures that, before health plans can establish new panel networks, physicians are informed of the criteria for participating in those networks, with sufficient advance time to permit them to satisfy the criteria. (Res. 806, I-06; Reaffirmed in lieu of Res. 729, A-08; Reaffirmation I-10)

H-160.952 Access to Specialty Care

The AMA: (1) continues to encourage primary care and other medical specialty organizations to collaborate in developing guidelines to delineate the clinical circumstances under which treatment by primary care physicians, referral for initial or ongoing specialist care, and direct patient self-referral to other specialists are appropriate, timely, and cost-effective; (2) encourages the medical specialty organizations that develop referral guidelines to document the impact of the guidelines on the quality, accessibility, timeliness, and cost-effectiveness of care; and (3) urges all health plans that control access to services through a primary care case manager to cover direct access to and services by a specialist other than the case manager without financial penalty when that access is in conformance with such collaboratively developed guidelines. (CMS Rep. 1, A-94; Reaffirmed and Modified: CMS Rep. 7, A-05; Reaffirmation A-09)

(24) RESOLUTION 822 - PREPAYMENT REVIEW BY THIRD PARTY PAYERS**RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends that Policies H-190.991 and H-190.972 be reaffirmed in lieu of Resolution 822.

HOD ACTION: Original Resolution 822 adopted.

Resolution 822 asks that our AMA work with all payers to ensure that they stop the practice of delaying payments by asking for documentation to review prior to payment and establish rules to continue to allow the payer to conduct prepayment documentation review if the payer has performed a post payment documentation review and proven that the provider has been submitting incorrect claims. The resolution also asks that if efforts to work with payers to end the practice of delaying payments without reasonable justification fail, our AMA should seek legislation that would accomplish this.

There was limited yet supportive testimony on Resolution 822. However, your Reference Committee believes that Policies H-190.991 and H-190.972 address the intent of Resolution 822, and accordingly recommends that they be reaffirmed in lieu of the resolution.

Policy to be reaffirmed:

H-190.991 Excessive Requests for Information from Insurance Carriers and Delays in Processing Insurance Claims

It is the policy of our AMA (1) to continue to oppose excessive and unnecessary requests for additional information and unexplained delays in processing and payment by third party insurance carriers where a completed standard claim form for reimbursement has been submitted, and (2) that state medical societies should pursue existing AMA model legislation to require the payment of claims with interest where clean claims are not paid on a timely basis. (Sub. Res. 69, A-91; Modified: Sunset Report, I-01; Reaffirmation I-04; Reaffirmation A-09)

H-190.972 Strategy for Eliminating Delayed Payments to Physicians by Third Party Payers

It is the policy of our AMA that delayed payments to physicians and hospitals without justification by third party payers should be prohibited by law. (BOT Rep. 13, I-97; Reaffirmation I-04)

REPORT OF REFERENCE COMMITTEE K

- (1) COUNCIL ON MEDICAL EDUCATION REPORT 1 - UPDATE ON EXPANDING ACCESS TO CLINICAL TRAINING SITES FOR MEDICAL STUDENTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 1 be adopted and the remainder of the report filed.

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

Council on Medical Education Report 1 studies the issue of limiting international medical student clerkship rotations to a maximum of 12 weeks. It recommends that our AMA:

(1) reaffirm Policy H-255.988, "Foreign Medical Graduates," which supports the concept that the core curriculum of a foreign medical school should be provided by that school and that U.S. hospitals should not provide substitute core clinical experience for students attending a foreign medical school, and which states that the AMA does support US teaching hospitals and foreign medical educational institutions entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of US core clinical clerkships;

(2) reaffirm Policy D-295.931(1), "Update on the Availability of Clinical Training Sites for Medical Student Education," which directs the AMA to work with appropriate stakeholders to (a) study options to require that students from international medical schools who desire to take clerkships in U.S. hospitals come from medical schools that are approved by an independent or private organization, such as the Liaison Committee on Medical Education (LCME), using principles consistent with those used to accredit US medical schools; (b) advocate for regulations that will assure that international students taking clinical clerkships in U.S. medical schools come from approved medical schools that assure educational quality that promotes patient safety; and (c) advocate that any institution that accepts students for clinical placements be required to assure that all such students are trained in programs that meet requirements for curriculum, clinical experiences and attending supervision as expected for LCME and American Osteopathic Association accredited programs;

(3) reaffirm Policies D-295.931(4), "Update on the Availability of Clinical Training Sites for Medical Student Education," and D-295.320(4), "Factors Affecting the Availability of Clinical Training Sites for Medical Student Education," which direct the AMA to oppose any arrangements of U.S. medical schools or their affiliated hospitals that allow the presence of visiting students to disadvantage their own students educationally or financially, and to advocate for federal and state legislation or regulations to oppose any extraordinary compensation for clinical clerkship sites by medical schools or other clinical programs that would result in displacement or otherwise limit the training opportunities of U.S. LCME/Commission on Osteopathic College Accreditation (COCA) students in clinical rotations;

(4) reaffirm Policy D-295.320(2), "Factors Affecting the Availability of Clinical Training Sites for Medical Student Education," which directs the AMA to encourage medical schools and the rest of the medical community within states or geographic regions to engage in collaborative planning to create additional clinical education resources for their students;

and (5) rescind Policy D-295.320(6), "Factors Affecting the Availability of Clinical Training Sites for Medical Student Education," since that has been accomplished through this report.

Your Reference Committee heard testimony in favor of this report. The availability of clinical teaching sites and faculty to support the educational needs of medical students is a matter of ongoing and serious concern, especially as

the number of U.S. medical school graduates continues to rise. Some non-U.S. medical schools pay U.S. hospitals to provide clinical training for their students; these monies are particularly attractive to financially distressed teaching hospitals. The educational experience of U.S. students, however, may be compromised by their having to compete for faculty attention and access to patients with students from non-U.S. schools. The report's recommendations support the AMA's continuing work to ensure appropriate availability of clinical resources for medical students. Some concern was expressed that the report reaffirms current AMA policy but does not address some deeper systemic issues. Therefore, future AMA reports on this issue should consider a number of concerns that were raised in the testimony, including transparency of payments by non-U.S. schools to U.S. teaching hospitals, availability of federal funding for U.S. citizens attending non-U.S. schools, the quality of non-U.S. versus that of U.S. medical schools, and attrition and graduation rates of non-U.S. students and their success rate in matching to U.S. residency programs and ultimately practicing in medicine.

(2) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 2 - A
CONTEMPORARY VIEW OF NATIONAL DRUG CONTROL POLICY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 2 be adopted and the remainder of the report filed.

HOD ACTION: Council on Science and Public Health Report 2 adopted and the remainder of the report filed.

Council on Science and Public Health Report 2 evaluates individual, societal, and public health related issues around federal drug control policies, the so-called "war on drugs," state-based cannabis activities, drug decriminalization/legalization, and the intersection of illicit and prescription drug abuse. It recommends:

(1) that Policies H-95.995 and H-95.977 be amended by addition and deletion to read as follows:

H-95.995 ~~Health Aspects of Cannabis Marijuana Use~~

Our AMA (1) discourages cannabis marijuana use, especially by persons vulnerable to the drug's effects and in high-risk situations; (2) supports the determination of the consequences of long-term cannabis marijuana use through concentrated research, especially among youth and adolescents; and (3) supports the modification of state and federal laws to emphasize public health based strategies to address and reduce cannabis use ~~reduce the severity of penalties for possession of marijuana;~~ (4) urges that educational efforts on the harms of cannabis use be extended to all segment of the population.

H-95.997 ~~Marijuana Cannabis~~ Intoxication as a Criminal Defense

Our AMA: (1) ~~recommends personal possession of insignificant amounts of that substance be considered a misdemeanor with commensurate penalties applied;~~ (2) believes a plea of cannabis intoxication not be a defense in any criminal proceedings; ~~and (3) urges that educational efforts be expanded to all segments of the population.~~ (BOT Rep. J, A-72; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10);

(2) that Policy H-95.981 be amended by addition and deletion to read as follows:

H-95.981 ~~Federal Drug Policy Drug Abuse in the United States - A Policy Report~~

The AMA, in an effort to reduce personal and public health risks of drug abuse, urges the formulation of a comprehensive national policy on drug abuse, specifically advising that the federal government and the nation should: (1) ~~encourage recognition that acknowledge that federal efforts to address illicit drug use via~~ at supply reduction and enforcement have been ineffective should be accompanied by increased efforts to reduce the demand for illicit drugs; (2) ~~renew and expand federal leadership to reduce the demand for illicit drugs;~~ (3) expand the availability and reduce the cost of treatment programs for substance use disorders, including addiction, including treatment on demand for intravenous drug abusers; (4) lead a coordinated approach to adolescent drug education; (5) develop community-based prevention programs for youth at risk; (6) continue to fund the Office of National Drug Control Policy appoint a high ranking official of the Executive Branch to coordinate federal drug policy; (7) ~~encourage a variety of private initiatives and carefully evaluate the use of~~

~~limited workplace drug testing; (86)~~ extend greater protection against discrimination in the employment and provision of services to drug abusers; ~~(97)~~ make a long-term commitment to expanded research and data collection; ~~(408)~~ broaden the focus of national and local policy from drug abuse to substance abuse; and ~~(410)~~ recognize the complexity of the problem of substance abuse and oppose drug legalization. (BOT Rep. NNN, A-88; Reaffirmed: CLRPD 1, I-98; Reaffirmed: CSAPH Rep. 2, A-08);

- (3) that Policy H-95.954 be amended by addition and deletion to read as follows:

H-95.954 The Reduction of Medical and Public Health Consequences of Drug Abuse

Our AMA: (1) encourages national policy-makers to pursue an approach to the problem of drug abuse aimed at preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use; (2) encourages policy-makers to recognize the importance of screening for alcohol and other drug use in a variety of settings, and to broaden their concept of addiction treatment to embrace a continuum of modalities and goals, including appropriate measures of harm reduction, which can be made available and accessible to enhance positive treatment outcomes for patients and society; (3) encourages the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable. Training must be available so that an adequate number of physicians are prepared to provide treatment. Program regulations should be strengthened so that treatment is driven by patient needs, medical judgment, and drug rehabilitation concerns. Treatment goals should acknowledge the benefits of abstinence from drug use, or degrees of relative drug use reduction; (4) encourages the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such programs and modification of laws and regulations is urgent, considering the contribution of injection drug use to the epidemic of HIV infection; (5) encourages a the undertaking of comprehensive review of the risks and benefits of U.S. state-based drug legalization initiatives, research into the potential effects, both positive and adverse, of relaxing existing drug prohibitions and controls and, that, until the findings of such reviews such research can be adequately assessed, the AMA reaffirm its opposition to drug legalization; (6) strongly supports the ability of physicians to prescribe syringes and needles to patients with injection drug addiction in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases; and (7) encourages state medical associations to work with state regulators to remove any remaining barriers to permit physicians to prescribe needles for patients. (CSA Rep. 8, A-97; Reaffirmed: CSA Rep. 12, A-99; Appended: Res. 416, A-00; Reaffirmation I-00; Reaffirmed: CSAPH Rep. 1, A-10);

- (4) that Policy H-95.998 be amended by addition and deletion to read as follows:

H-95.998 AMA Policy Statement on Cannabis (~~Marijuana~~)

Our AMA believes that (1) cannabis is a dangerous drug and as such is a public health concern; (2) sale ~~and possession of marijuana~~ cannabis should not be legalized; (3) public health based strategies, rather than incarceration, should be utilized in the handling of individuals possessing cannabis for personal use~~handling of offenders should be individualized~~; and (4) additional research should be encouraged. (BOT Rep. K, I-69; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed in lieu of Res. 202, I-12);

- and (5) that Policy H-95.952, “Cannabis for Medicinal Use,” be reaffirmed.

Testimony on Council on Science and Public Health Report 2 reflected the complex individual, societal, and public health issues around federal drug control policies, the potential legalization of cannabis, and state-based cannabis activities. Support was offered for the philosophical position that addressing illicit drug use, especially for cannabis, is best achieved by employing a public-health based approach that reduces individual harm from drug use while preserving the state’s interest in protecting the public from the adverse consequences of individual drug use. Other testimony supported the view that the Council had not gone far enough, and that policy should at least be neutral on the issue of cannabis legalization given the shifts in state-based policies and public attitudes. Additionally, the term “criminal penalties” was offered as a substitute for “incarceration” in Recommendation 4, a change supportive of decriminalization. Your Reference Committee supports the general approach advocated by the Council on Science and Public Health and recommends adoption.

(3) RESOLUTION 916 - SUPPORT STRICTER OSHA SILICA PERMISSIBLE EXPOSURE LIMIT STANDARD

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 916 be adopted.

HOD ACTION: Resolution 916 adopted.

Resolution 916 asks that our American Medical Association (1) support the Department of Labor's Occupational Safety and Health Administration's (OSHA's) proposed rule to establish a stricter permissible exposure limit (PEL) for respirable crystalline silica; (2) support OSHA's proposed rule to establish a stricter standard of exposure assessment and medical surveillance requirements to identify adverse health effects in exposed populations of workers; and (3) submit comments, in collaboration with respiratory and occupational health medical societies, in support of a stricter silica PEL.

Testimony urged that the AMA formally support OSHA's proposed rule to reduce exposure to respirable crystalline silica in an effort to protect the health of workers. Your Reference Committee believes the health of workers is an important public health priority, and therefore supports adoption.

(4) RESOLUTION 922 - EXAMINING THE CHANGING NATURE OF U.S. MEDICAL RESIDENCIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 922 be adopted.

HOD ACTION: Resolution 922 adopted.

Resolution 922 asks that our AMA continue to study the effect of ever increasing match participants and the stagnant growth of U.S. residency positions with a report back at 2014 Annual Meeting. (Directive to Take Action)

Your Reference Committee heard testimony in support of this resolution and was informed that the Council on Medical Education is currently working on a report for A-14 regarding GME financing, which will also address this issue. Therefore, your Reference Committee recommends adoption so that this issue can be considered in the Council's A-14 report.

(5) BOARD OF TRUSTEES REPORT 3 - A MORE UNIFORM APPROACH TO ASSESSING PATIENTS FOR CONTROLLED SUBSTANCES FOR PAIN RELIEF

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 in Board of Trustees Report 3 be amended by addition on line 7, to read as follows:

1. That our AMA consult with relevant Federation partners and consider developing by consensus a set of best practices to help inform the appropriate clinical use of opioid analgesics, including risk assessment and monitoring for substance use disorders, in the management of persistent pain.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 3 be adopted as amended and the remainder of the report filed.

HOD ACTION: Board of Trustees Report 3 adopted as amended and the remainder of the report filed.

Board of Trustees Report 3 reviews recent trends in patient harms attributed to prescription opioid analgesics, briefly addresses the issue of opioid associated overdoses and deaths, and reviews relevant American Medical Association (AMA) policy. It recommends (1) that our AMA consult with relevant Federation partners and consider developing by consensus a set of best practices to help inform the appropriate clinical use of opioid analgesics in the management of persistent pain; (2) that our AMA urge the Centers for Disease Control and Prevention to take the lead in promoting a standard approach to documenting and assessing unintentional poisonings and deaths involving prescription opioids, including obtaining more complete information on other contributing factors in such individuals, in order to develop the most appropriate solutions to prevent these incidents; and (3) that Policy H-120.960 be reaffirmed.

Testimony favored the recommendations in the report, noting the importance of efforts to develop best practices for the management of persistent pain, including conducting risk assessments for substance use disorders, including addiction. Additionally, it is essential that a public health-based approach be used to improve the management of patients with persistent pain in order to assure their safety and provide appropriate access to controlled substances while minimizing diversion and misuse. The Centers for Disease Control and Prevention is the chief reporting agency for data on unintentional doses and deaths attributable to opioid analgesics. A standard approach to documentation and assessment of presumed opioid-related poisonings and deaths is needed in order to craft solutions. Many contributory factors exist, including concomitant use of anxiolytics, sedative-hypnotics, drugs that influence cardiac conduction, etc. Your Reference Committee believes the Board's recommendations are a step in the right direction, and recommends adoption as amended.

(6) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 1 - INCLUSION OF SUPPLEMENT PURCHASES IN NUTRITIONAL ASSISTANCE PROGRAMS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 1 be amended by the addition of second and third recommendations, to read as follows:

1. That our American Medical Association support improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity. (New HOD Policy)

2. That our AMA reaffirm Policy D-150.985, which urges fortification of all grain products, including those that are corn-based, as a means to increase folic acid intake in all women of child-bearing age. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-440.898, which encourages education of women on the need to achieve adequate folic acid intake. (Reaffirm HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 1 be adopted as amended and the remainder of the report filed.

HOD ACTION: Council on Science and Public Health Report 1 adopted as amended and the remainder of the report filed.

Council on Science and Public Health Report 1 examines the potential inclusion of vitamin and mineral supplements as eligible items under the Supplemental Nutrition Assistance Program and the Special Supplemental Nutrition Program for Women, Infants, and Children. It recommends that our American Medical Association support improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity.

Testimony was mostly supportive of the Council's recommendation, though testimony strongly underscored the importance of folic acid intake and the need to ensure that low-income women of child-bearing age are consuming the recommended daily dosage. The Council noted that the SNAP program has experienced recent funding cuts and that emphasis should be placed on maintaining the program's essential benefits for those who need them. The Council also stated that recent evidence suggests that fortification programs appear to be more effective than supplementation in increasing folic acid levels, and that current AMA policy, adopted as a result of its 2006 report, urges fortification of all grains products, including those that are corn-based. Existing AMA policy also supports education of women on the need to achieve adequate folate intake. Your Reference Committee supports the Council's current recommendation as well as an additional recommendation reaffirming policy urging fortification of all grain products.

Policies recommended for reaffirmation:

D-150.985 Folic Acid Fortification of Grain Products

Our AMA will: (1) urge the Food and Drug Administration to recommend folic acid fortification of all grains marketed for human consumption, including grains not carrying the "enriched" label; and (2) write letters to domestic and international producers of corn grain products, including masa, nixtamal, maize, and pozole, to advocate for folic acid fortification of such products. (CSAPH Rep. 6, A-06)

H-440.898 Recommendations on Folic Acid Supplementation

Our AMA will: (1) encourage the Centers for Disease Control and Prevention (CDC) to continue to conduct surveys to monitor nutritional intake and the incidence of neural tube defects (NTD); (2) continue to encourage broad-based public educational programs about the need for women of child-bearing potential to consume adequate folic acid through nutrition, food fortification, and vitamin supplementation to reduce the risk of NTD; (3) encourage the CDC and the National Institutes of Health to fund basic and epidemiological studies and clinical trials to determine causal and metabolic relationships among homocysteine, vitamins B12 and B6, and folic acid, so as to reduce the risks for and incidence of associated diseases and deficiency states; (4) encourage research efforts to identify and monitor those populations potentially at risk for masking vitamin B12 deficiency through routine folic acid supplementation of enriched food products; (5) urge the Food and Drug Administration to increase folic acid fortification to 350 µg per 100 g of enriched cereal grain; and (6) encourage the FDA to require food, food supplement, and vitamin labeling to specify milligram content, as well as RDA levels, for critical nutrients, which vary by age, gender, and hormonal status (including anticipated pregnancy); and (7) encourage the FDA to recommend the folic acid fortification of all refined grains marketed for human consumption, including grains not carrying the "enriched" label. (CSA Rep. 8, A-99; Modified: CSAPH Rep. 6, A-06)

(7) RESOLUTION 903 - GUN SAFETY COUNSELING IN UNDERGRADUATE MEDICAL EDUCATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 903 be amended by addition and deletion on lines 16-33, to read as follows:

(1) amend Policy H-145.976 by insertion as follows:

H-145.976 Censorship of Physician Discussion of Firearm Risk

Our AMA: (1) will oppose any restrictions on physicians' and other members of the physician-led health care team's and medical students ~~being able~~ ability to inquire and talk about firearm safety issues and risks with their patients; and (2) will oppose any law restricting physicians' and other members of the physician-led health care team's and medical students' discussions with patients and their families about ~~guns~~ firearms as an intrusion into medical privacy (Modify current HOD Policy); and be it further

~~RESOLVED, That our AMA advocate for the inclusion of strategies for counseling patients on safe gun use and storage in undergraduate medical education (New HOD Policy); and be it further~~

~~RESOLVED, That our AMA encourage dissemination of advocate that the Association of American Medical Colleges, Agency for Health, Research and Quality, and other relevant professional medical societies develop gun educational materials related to firearm safety counseling modules to be used in undergraduate medical education. (New HOD Policy)~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 903 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 903 be changed to read as follows:

FIREARM SAFETY COUNSELING IN PHYSICIAN-LED HEALTH CARE TEAMS

HOD ACTION: Resolution 903 adopted as amended with a title change.

Resolution 903 asks that our American Medical Association

(1) amend Policy H-145.976 by insertion as follows:

H-145.976 Censorship of Physician Discussion of Firearm Risk

Our AMA: (1) will oppose any restrictions on physicians and medical students being able to inquire and talk about firearm safety issues and risks with their patients; and (2) will oppose any law restricting physicians' and medical students' discussions with patients and their families about guns as an intrusion into medical privacy (Modify current HOD Policy);

(2) advocate for the inclusion of strategies for counseling patients on safe gun use and storage in undergraduate medical education; and (3) advocate that the Association of American Medical Colleges, Agency for Health, Research and Quality, and other relevant professional medical societies develop gun safety counseling modules to be used in undergraduate medical education.

Your Reference Committee heard extensive testimony on Resolution 903 generally in favor of Resolve 1 but with concerns about the second and third Resolves. Our AMA has been a strong supporter of the right of physicians to discuss gun safety with their patients (as contained in Policy H-145.976), and our AMA would be opposed to any legislation that would restrict a physician's ability to inquire about firearm risk factors or to initiate a discussion about appropriate gun safety precautions with a patient. Testimony noted that it would be more inclusive, and more reflective of actual practice, to add language to this policy encompassing all members of the health care team versus solely medical students. As for Resolve 2, our AMA is reluctant to specify content that must be included in the medical curriculum. Testimony also raised questions about the practicality and advisability of adding this element to an already packed medical school curriculum. Related to Resolve 3, it was noted that the proposed language would be more flexible by not specifying particular organizations and advocating instead for dissemination of gun safety educational materials by the appropriate organizations. For these reasons, your Reference Committee recommends adoption of Resolution 903 as amended.

(8) RESOLUTION 904 - EVALUATIONS OF STANDARDIZED CLINICAL SKILLS EXAMS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolve 1 of Resolution 904 be amended by addition on lines 21-23, to read as follows:

RESOLVED, That our American Medical Association evaluate the cost/value equation, benefits, and consequences of the implementation of standardized clinical exams as a step for licensure, along with the barriers to more meaningful examination feedback for both examinees and U.S. medical schools, and provide recommendations based on these findings (Directive to Take Action); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolve 2 of Resolution 904 be amended by addition on line 26, to read as follows:

RESOLVED, That our American Medical Association evaluate the consequences of the January 2013 changes to the USMLE Step II Clinical Skills exam and their implications for U.S. medical students and international medical graduates. (Directive to Take Action)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 904 be adopted as amended.

HOD ACTION: Resolution 904 adopted as amended.

Resolution 904 asks that our American Medical Association (1) evaluate the benefits and consequences of the implementation of standardized clinical exams as a step for licensure and provide recommendations based on these findings; and (2) evaluate the consequences of the January 2013 changes to the USMLE Step II Clinical Skills exam and their implications for US medical students.

Your Reference Committee heard extensive testimony on Resolution 904. Supporters of the resolution noted concerns about costs of the clinical skills examination, which include travel to one of only five testing centers nationwide. They also cited the exam's questionable utility as a filter for student preparedness for practice, given that approximately 98 percent of U.S. medical school students pass on their first attempt. It was expressed that the examination is essentially a poor value proposition, with a low return on investment. In addition, examinees obtain

little feedback on their exam performance, other than a pass/fail grade. Your Reference Committee therefore asks that Resolution 904 be adopted as amended.

(9) RESOLUTION 905 - ATHLETE CONCUSSION MANAGEMENT AND CHRONIC TRAUMATIC ENCEPHALOPATHY PREVENTION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 905 be amended by addition and deletion on line 29, to read as follows:

RESOLVED, that our American Medical Association support ~~collegiate and professional athletic organizations adopting~~ the adoption of evidence-based guidelines for the evaluation and management of concussions by all athletic organizations (New HOD Policy); and be it further

RESOLVED, That our American Medical Association encourage further research in the diagnosis, treatment, and prevention of chronic traumatic encephalopathy. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 905 be adopted as amended.

HOD ACTION: Resolution 905 adopted as amended.

Resolution 905 asks that our American Medical Association (1) support collegiate and professional athletic organizations adopting evidence-based guidelines for the evaluation and management of concussions; and (2) encourage further research in the diagnosis, treatment, and prevention of chronic traumatic encephalopathy.

Testimony overwhelmingly underscored the serious problems of concussions and other repetitive brain injuries that can result in chronic traumatic encephalopathy, as well as the impact on both males and females at all age levels to include K-12. Support was strongly voiced for more rigorous actions to prevent such injuries and for research into the causes and prevention. Concern about the need for certified athletic trainers was also raised (see Policy H-470.995). Your Reference Committee recommends adopting the resolution as amended.

(10) RESOLUTION 906 - INCREASING HEALTHCARE ACCESS FOR THE UNDERSERVED

RECOMMENDATION

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 906 be adopted.

EXPLORING THE FEASIBILITY OF CLINIC-BASED RESIDENCY PROGRAMS

RESOLVED, That our American Medical Association advocate that key stakeholders, such as the Accreditation Council for Graduate Medical Education, explore the feasibility of extending residency programs through a pilot study placing medical graduates in integrated physician-led practices in order to expand training positions and increase the number of physicians providing healthcare access. (Directive to Take Action).

RESOLVED, That our AMA encourage that pilot studies of clinic-based residency program expansion be funded by private sources. (New HOD Policy)

HOD ACTION: Substitute Resolution 906 adopted with a title change.

Resolution 906 asks that our American Medical Association advocate to key stakeholders to establish and fund pilot clinic-based residency programs at diverse underserved sites, employing medical graduates in integrated physician-led practices to expand training positions utilizing dedicated funding and increase the number of physicians providing healthcare access to those with the greatest medical need.

Your Reference Committee heard testimony noting concerns with the wording of the original resolution and potential issues with program accreditation and medical licensure. The majority of testimony, however, was in favor of the spirit of the resolution and the need to explore any and all possible sources for expanded residency program slots. The revised language proffered by the authors emphasizes the exploratory nature of the request, and was supported by most of those providing testimony. Accordingly, your Reference Committee recommends that Substitute Resolution 906 be adopted.

(11) RESOLUTION 907 - MODERN CHEMICAL CONTROLS POLICY

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy D-135.976 be amended to read as follows:

D-135.976 Modernization of the Federal Toxic Substances Control Act (TSCA) of 1976

Our AMA will: (1) support collaborate with relevant stakeholders to advocate for modernizing the Toxic Substances Control Act (TSCA) to require chemical manufacturers to provide adequate safety information on all chemicals and give federal regulatory agencies reasonable authority to regulate hazardous chemicals in order to protect the health of all individuals, especially vulnerable populations; (2) support the public disclosure of chemical use, exposure and hazard data in forms that are appropriate for use by medical practitioners, workers, and the public; and (3) work with members of the Federation to promote a reformed TSCA that is consistent with goals of Registration, Evaluation, Authorisation, and Restriction of Chemicals (REACH). (Res. 515, A-12)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Policy D-135.976 be adopted as amended in lieu of Resolution 907.

HOD ACTION: Policy D-135.976 be adopted as amended in lieu of Resolution 907.

Resolution 907 asks that our American Medical Association (AMA) (1) lobby Congress to amend the Toxic Substances Control Act of 1976 to require protecting the health of vulnerable populations and communities; (2) work with the National Medical Association and the Safer Chemicals Healthy Families Campaign to advocate for health protective chemical policy on a federal and state level; and (3) reaffirm our commitment to AMA Policy D-135.976, Modernization of the Federal Toxic Substances Control Act (TSCA) of 1976.”

Your Reference Committee received mostly supportive testimony on this resolution. While the special risks among vulnerable populations to toxic chemicals were emphasized, others noted that all populations should be protected. Testimony also supported working with relevant stakeholders to more actively advocate for changes to TSCA that

would protect vulnerable populations. Your Reference Committee believes that current AMA policy could be amended to achieve the requests of the resolution.

(12) RESOLUTION 911 - PROMOTING HEALTH AWARENESS AND PREVENTIVE SCREENINGS IN INDIVIDUALS WITH DISABILITIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 911 be amended by addition and deletion on lines 23-26, to read as follows:

RESOLVED, That our American Medical Association ~~continue to work~~ closely with relevant stakeholders ~~with the National Council on Disability, the US Department of Health and Human Services, the World Health Organization, and related agencies~~ to advocate for equitable access to health promotion and preventive screenings for individuals with disabilities. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 911 be adopted as amended.

HOD ACTION: Resolution 911 adopted as amended.

Resolution 911 asks that our American Medical Association continue to work closely with the National Council on Disability, the US Department of Health and Human Services, the World Health Organization, and related agencies to advocate for equitable access to health promotion and preventive screenings for individuals with disabilities.

Your Reference Committee received supportive testimony on this item. Several commenters underscored the disparities in health promotion and preventive screenings experienced by individuals with disabilities, citing specific examples. Online testimony expressed concern that it may not be appropriate to encourage physicians of every specialty to perform such screenings, nor would it be appropriate for every individual patient with a disability to undergo them. Your Reference Committee favors modification of the resolution so that it is supportive of access to health promotion and prevention activities for disabled individuals who need them without being prescriptive as to which organization should be carrying out such activities.

(13) RESOLUTION 912 - CRISIS IN MEDICATION SHORTAGES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy H-100.956(6) be amended by addition and deletion, to read as follows:

6. The Council on Science and Public Health shall continue to evaluate the drug shortage issue and report back at least annually to the House of Delegates on progress made in addressing drug shortages ~~as appropriate~~.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Policy H-100.956 be adopted as amended in lieu of Resolution 912.

HOD ACTION: Policy H-100.956 adopted as amended in lieu of Resolution 912.

Resolution 912 asks that our American Medical Association (AMA) adopt the policy that the Council on Science and Public Health will render a report at each and every Annual and Interim Meeting of the AMA on the “Crisis in Medication Shortages” until the House of Delegates deems otherwise.

Drug shortages continue to be a critical issue affecting patient management. The Council on Science and Public Health has generated three reports on drug shortages and will be providing another update at A-14. These reports have reviewed existing trends and progress in addressing drug shortages, pertinent emerging or existing legislation, and recommendations to address drug shortages that have emerged from relevant stakeholders. Current policy allows the Council to determine if and when additional reports on drug shortages will provide added value. Your Reference Committee believes that a report should be offered at least annually for the foreseeable future.

(14) RESOLUTION 915 - ASK THE JOINT COMMISSION TO REEVALUATE THE PAIN SCALE OF PATIENTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 915 be adopted.

JOINT COMMISSION ACCREDITATION STANDARD FOR PAIN ASSESSMENT

RESOLVED, That our American Medical Association urge The Joint Commission to reevaluate its accreditation standard for pain assessment, including evidence on whether the standard improves pain management practices, in order to ensure that the standard supports physician’s abilities to select the most appropriate treatment options for their patients. (Directive to Take Action)

RESOLVED, That Policy H-220.931, which asks that standards and performance measures set forth by The Joint Commission be supported by the best available evidence, be reaffirmed. (Reaffirm HOD Policy)

HOD ACTION: Substitute Resolution 915 adopted.

Resolution 915 asks that our American Medical Association ask the Joint Commission to reevaluate the mandate for pain assessment and subsequent implied treatment of all patients with opioids based on a subjective pain scale reported by the patient; and that the Joint Commission desist in referring to pain assessment scores as “the fifth vital sign.”

Testimony reflected continuing concern about The Joint Commission (TJC) standard on pain assessment, as well as patient satisfaction surveys that include pain management as a metric. These are two important but separate issues, and the use of patient satisfaction surveys was discussed in Board of Trustees Report 9-A-13. Some testimony reflected the belief that existing TJC standards for pain assessment and the use of patient satisfaction surveys are driving a trend toward overuse of opioid analgesics. The pain assessment process is often performed at the same time a patient’s vital signs are taken. Because of this, pain is sometimes called “the fifth vital sign.” This is not a term that was created by TJC, and it does not require or advocate that pain be the “fifth vital sign.” Testimony also noted that TJC has evolved into an organization that has an educational function as well as an accrediting function. Accordingly, some sentiment was expressed for referral of this resolution. Your Reference Committee is aware that TJC is currently in the process of updating its pain standards. The substitute resolution appropriately emphasizes the need to adopt an evidence-based approach to this and other standards-setting processes.

Policy recommended for reaffirmation

H-220.931 Evidence-Based Value of Joint Commission Standards and Measures

Our AMA asks The Joint Commission that all present and future standards and performance measures set forth by The Joint Commission be supported by the best available evidence.

(15) RESOLUTION 917 - CULTURALLY, LINGUISTICALLY COMPETENT MENTAL HEALTH CARE AND OUTREACH FOR AT-RISK COMMUNITIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolve 1 of Resolution 917 be amended by addition and deletion on line 17 to read as follows:

RESOLVED, That our American Medical Association support adequate attention and funds being ~~appropriated~~ directed towards culturally and linguistically competent mental health direct services for the diverse, multi-ethnic communities at greatest risk (New HOD Policy); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolve 2 of Resolution 917 be amended by addition and deletion on lines 21-24 to read as follows:

RESOLVED, That our AMA encourage greater cultural and linguistic-competent outreach to ethnic communities ~~that goes beyond in-language print materials to include~~ including partnerships with ethnic community-based ~~ethnic~~ organizations, health care advocates, and respected ~~ethnic~~ media outlets (~~e.g., print, radio, television and social media~~) that are well-respected and utilized by the members of these respective ethnic communities. (New HOD Policy)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 917 be adopted as amended.

HOD ACTION: Resolution 917 adopted as amended.

Resolution 917 asks that our American Medical Association (1) support adequate attention and funds being appropriated towards culturally and linguistically competent mental health direct services for the diverse, multi-ethnic communities at greatest risk; and (2) encourage greater cultural and linguistic-competent outreach to ethnic communities that goes beyond in-language print materials to include partnerships with community-based ethnic organizations, health care advocates, and ethnic media outlets (e.g. print, radio, television and social media) that are well-respected and utilized by the members of these respective ethnic communities.

Supportive testimony was received for this item, underscoring the need for increased attention to mental health services and the disparity in access to services among some communities. It was noted that increased attention to cultural and linguistic factors can result in better communication between health care providers and patients, and concomitantly, better mental health care. Some concern was expressed about the focus of Resolve 2, so your Reference Committee recommends amending it so that it retains the same meaning but is simplified.

(16) RESOLUTION 921 - GUN VIOLENCE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 921 be amended by addition and deletion on line 21, to read as follows:

RESOLVED, That our American Medical Association strongly urge U.S. legislators to ~~fund support~~ further research into the epidemiology of risks related to gun violence on a national level. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 921 be adopted as amended.

HOD ACTION: Resolution 921 adopted as amended.

Resolution 921 asks that our American Medical Association strongly urge U.S. legislators to support further research into the epidemiology of risks related to gun violence on a national level.

Supportive testimony emphasized the importance of research into the epidemiology of gun violence, especially for the development of programs that could reduce its prevalence. Your Reference Committee points out that a Presidential Executive Order has re-established the ability of researchers to investigate gun violence, and that funding is needed in order to conduct such research. The Reference Committee therefore recommends adopting the resolution with an amendment to include such language.

(17) RESOLUTION 913 – PRE-MEDICAL SCHOOL SHADOWING

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 913 be referred.

HOD ACTION: Resolution 913 referred.

Resolution 913 asks that our American Medical Association (1) promote the development of programs that assist physicians in providing pre-medical shadowing opportunities; and (2) communicate to the Association of American Medical Colleges that for medical schools which have the pre-medical shadowing requirement, aiding these underprivileged students in getting their shadowing is an obligation of the medical school.

Your Reference Committee heard testimony on Resolution 913 in support of the availability of appropriate guidelines for providing pre-medical school shadowing opportunities. It was also noted that increased opportunities for shadowing can help increase diversity in medicine (through the AMA Doctors Back to School program, for example) and make the dream of a career in medicine a reality. Further testimony noted that shadowing should be available to all interested in a medical career, especially underprivileged individuals. In addition, questions were raised as to the responsibility of medical schools to offer shadowing opportunities. Such programs may contribute to improved matriculation and lower attrition rates. Guidelines recently released by the Association of American Medical Colleges offer recommended practices for clinical shadowing, as requested by Resolve 1. In addition, the Council on Medical Education will review the AAMC guidelines in a report on shadowing scheduled for the A-14 Meeting. Your Reference Committee believes that the planned Council report would be the best method in which to fully examine shadowing and ensure effective AMA policy on this critical issue to the future of medicine.

(18) RESOLUTION 914 - CHANGE RURAL AND OFF SITE RURAL TRAINING TRACK REQUIREMENTS IN ORDER TO PRESERVE AND ENCOURAGE INTEREST IN RURAL RESIDENCY PROGRAMS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 914 be referred.

HOD ACTION: Resolution 914 referred.

Resolution 914 asks that our American Medical Association (1) work with the Centers for Medicare and Medicaid Services to allow for up to one month in the second post graduate year and one month in the third post graduate year of an ABMS/AOA approved Family Medicine, General Internal Medicine or General Pediatric residency to occur in the office of a primary care physician who is listed and meets the qualifications for adjunct faculty of the sponsoring institution; and (2) work with the Accreditation Council of Graduate Medical Education Residency Review Committee for Family Medicine and other specialties to adjust GME program requirements so that the patient encounters during this experience may count toward the continuity requirements for the completion of a residency.

Your Reference Committee heard testimony in favor of Resolution 914 as a mechanism to encourage interest in rural residency programs. Our AMA is supportive of efforts to improve the viability of rural training opportunities, which help increase the likelihood of physician practice in underserved rural areas. Testimony noted, however, that the resolution had some issues with language and terminology—for example, the first Resolve refers to the ABMS as the accreditor of residency programs, rather than the Accreditation Council of Graduate Medical Education. More substantively, several individuals providing testimony asked for the resolution to be expanded to cover other fields of medicine, including general surgery, psychiatry, and obstetrics-gynecology. The Council on Medical Education is developing a report on GME funding and workforce issues for the A-14 meeting; the details of this resolution can be further explored and delineated in the planned report. Accordingly, your Reference Committee urges referral.

(19) RESOLUTION 923 - CMS DEFINITION OF “RESIDENT PHYSICIAN”

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 923 be referred with report back to the House of Delegates at the 2014 Annual Meeting.

HOD ACTION: Resolution 923 referred with report back to the House of Delegates at the 2014 Annual Meeting.

Resolution 923 asks that our AMA advocate, in conjunction with appropriate stakeholders, that the Centers for Medicare & Medical Services use our AMA definition of Resident when formulating rules and regulations. (New HOD Policy)

Your Reference Committee heard testimony urging referral of this item. It was noted that this resolution is more complex than it appears and could have unforeseen consequences. In particular, if physicians in fellowships are defined as residents, this could compromise their ability to bill for services. Timely exploration of this issue is critical due to the requirements of the Sunshine Act; therefore, your Reference Committee urges referral with a report back at A-14.

(20) RESOLUTION 902 - MEDICAL ETHICS GUIDELINES FOR UNDERGRADUATE MEDICAL EDUCATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-295.961 be reaffirmed in lieu of Resolution 902.

HOD ACTION: Policy H-295.961 reaffirmed in lieu of Resolution 902.

Resolution 902 asks that our American Medical Association (AMA) (1) recognize the importance of addressing the disparity between current outcomes and the ideal status of undergraduate medical education in bioethics and humanities; (2) in partnership with the AMA Medical Student Section, leverage its internal resources and its relationships with professional society stakeholders to create suggested guidelines for undergraduate medical education of bioethics and humanities guided by LCME requirements and the American Society for Bioethics and Humanities Task Force; and (3) advocate for the national adoption of a set of suggested guidelines for undergraduate medical education in bioethics and humanities by allopathic and osteopathic medical schools.

Your Reference Committee heard extensive testimony on Resolution 902. It was noted by the resolution's authors that medical school accreditation requirements for developing professionalism among students lack specificity, which has led to significant variability of medical school curricula in ethics, as stated in the first Resolve. In its virtual testimony, the Council on Medical Education, however, points to data from an annual questionnaire of all graduating medical students showing that the great majority of respondents believe that their instruction in ethical decision making, bioethics, and professionalism was adequate. Our AMA is addressing ethical issues from the perspective of medical students and residents/fellows, through its Virtual Mentor online journal, for example, and encourages education related to ethics, but does not believe in mandating medical curriculum; this is better left to the faculty of medical schools. Finally, existing AMA policy reflects the intent of this resolution. Policy H-295.961, for example, calls for "attention to subject matter related to ethics and to the doctor-patient relationship at all levels of medical education." For these reasons, your Reference Committee recommends reaffirmation of Policy H-295.961 in lieu of this resolution.

Policy recommended for reaffirmation:

H-295.961 Medicolegal, Political, Ethical and Economic Medical School Course

(1) The AMA urge every medical school and residency program to teach the legal, political, ethical and economic issues which will affect physicians. (2) The AMA will work with state and county medical societies to identify and provide speakers, information sources, etc., to assist with the courses. (3) An assessment of professional and ethical behavior, such as exemplified in the AMA Principles of Medical Ethics, should be included in internal evaluations during medical school and residency training, and also in evaluations utilized for licensure and certification. (4) The Speaker of the HOD shall determine the most appropriate way for assembled physicians at the opening sessions of the AMA House of Delegates Annual and Interim Meetings to renew their commitment to the standards of conduct which define the essentials of honorable behavior for the physician, by reaffirming or reciting the seven Principles of Medical Ethics which constitute current AMA policy. (5) There should be attention to subject matter related to ethics and to the doctor-patient relationship at all levels of medical education: undergraduate, graduate, and continuing. Role modeling should be a key element in helping medical students and resident physicians to develop and maintain professionalism and high ethical standards. (6) There should be exploration of the feasibility of improving an assessment of ethical qualities in the admissions process to medical school. (7) Our AMA pledges support to the concept that professional attitudes, values, and behaviors should form an integral part of medical education across the continuum of undergraduate, graduate, and continuing medical education. (Res. 189, A-90; Modified by CME Rep. 1, I-95; Appended: Res. 318, I-98; Reaffirmed: CME Rep. 2, A-08)

(21) RESOLUTION 919 - HIGH COST OF RECERTIFICATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies D-275.971, D-275.969, H-275.923, and H-275.924 be reaffirmed in lieu of Resolution 919.

HOD ACTION: Policies D-275.971, D-275.969, H-275.923, and H-275.924 reaffirmed in lieu of Resolution 919.

Resolution 919 asks that our American Medical Association request an investigation into the high cost of recertification and, if such investigation warrants reduction of recertification fees, that our AMA urge/advocate for a reduction by the ABMS of recertification fees.

Your Reference Committee heard limited but supportive testimony on this issue. Our AMA continues to closely monitor the development of maintenance of certification (MOC), including MOC fees, and the Council on Medical Education has written several reports on this topic, and will report again on this issue at the A-14 Meeting. As stated in extensive AMA policy on this topic, our AMA advocates for balancing the requirements of MOC with a sensitivity to physicians' valuable time and resources, ensuring physician input into the ongoing development of MOC, and making this process as efficient, effective, and evidence-based as possible. Your Reference Committee

therefore recommends reaffirmation of Policies D-275.971, D-275.969 (4), H-275.923 (3), and H-275.924 (4) in lieu of Resolution 919.

Policy recommended for reaffirmation:

D-275.971 American Board of Medical Specialties - Standardization of Maintenance of Certification Requirements

1. Our AMA will work with the American Board of Medical Specialties to streamline Maintenance of Certification (MOC) to reduce the cost, inconvenience, and the disruption of practice due to MOC requirements for all of their member boards, including subspecialty requirements. 2. Our AMA will actively work to enforce existing policies to reduce current costs and effort required for the maintenance of certification and to work to control future charges and expenses. (Sub. Res. 313, A-06; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Appended: Res. 319, A-12; Reaffirmed in lieu of Res. 313, A-12)

D-275.969 Specialty Board Certification and Recertification

1. Our AMA will continue to monitor the progress by the ABMS and its member boards on implementation of Maintenance of Certification (MOC) and encourage ABMS to report its research findings on the issues surrounding certification, recertification and MOC on a periodic basis. 2. An update report will be prepared for the AMA House of Delegates no later than 2010. 3. Our AMA will encourage dialogue between the ABMS and its respective specialty societies to work on development, implementation, and monitoring of MOC that meets the needs of practicing physicians and improves patient care. 4. Our AMA will exercise its full influence to protect physicians from undue burden and expense in the Maintenance of Certification process. (CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09)

H-275.923 Maintenance of Certification / Maintenance of Licensure

Our AMA will: 1. Continue to work with the Federation of State Medical Boards (FSMB) to establish and assess maintenance of licensure (MOL) principles with the AMA to assess the impact of MOC and MOL on the practicing physician and the FSMB to study the impact on licensing boards. 2. Recommend that the American Board of Medical Specialties (ABMS) not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety. 3. Encourage rigorous evaluation of the impact on physicians of future proposed changes to the MOC and MOL processes including cost, staffing, and time. 4. Review all AMA policies regarding medical licensure; determine if each policy should be reaffirmed, expanded, consolidated or is no longer relevant; and in collaboration with other stakeholders, update the policies with the view of developing AMA Principles of Maintenance of Licensure in a report to the HOD at the 2010 Annual Meeting. 5. Urge the National Alliance for Physician Competence (NAPC) to include a broader range of practicing physicians and additional stakeholders to participate in discussions of definitions and assessments of physician competence. 6. Continue to participate in the NAPC forums. 7. Encourage members of our House of Delegates to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups. 8. Continue to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major CME credit systems that comprise the foundation for post graduate medical education in the US, including the Performance Improvement CME (PICME) format; and continue to develop relationships and agreements that may lead to standards, accepted by all US licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician CME. 9. Collaborate with the American Osteopathic Association and its eighteen specialty boards in implementation of the recommendations in CME Report 16-A-09, Maintenance of Certification / Maintenance of Licensure. 10. Continue to support the AMA Principles of Maintenance of Certification (MOC). 11. Monitor MOL as being led by the Federation of State Medical Boards (FSMB), and work with FSMB and other stakeholders to develop a coherent set of principles for MOL. 12. Our AMA will 1) advocate that if state medical boards move forward with the more intense MOL program, each state medical board be required to accept evidence of successful ongoing participation in the American Board of Medical Specialties Maintenance of Certification and American Osteopathic Association-Bureau of Osteopathic Specialists Osteopathic Continuous Certification to have fulfilled all three components of the MOL if performed, and 2) also advocate to require state medical boards accept programs created by specialty societies as evidence

that the physician is participating in continuous lifelong learning and allow physicians choices in what programs they participate to fulfill their MOL criteria. (CME Rep. 16, A-09; Appended: CME Rep. 3, A-10; Reaffirmed: CME Rep. 3, A-10; Appended: Res. 322, A-11; Reaffirmed: CME Rep. 10, A-12; Reaffirmed in lieu of Res. 313, A-12; Reaffirmed: CME Rep. 4, A-13)

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 each 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 permit 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 would not be 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. The AMA affirms the current language regarding continuing medical education (CME): “By 2011, each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part 2. 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 Physician’s Recognition Award (PRA) Category 1, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and or American Osteopathic Association Category 1A).” 10. MOC is an essential but not sufficient component to promote patient-care safety and quality. Health care is a team effort and changes to MOC should not create an unrealistic expectation that failures in patient safety are primarily failures of individual physicians. (CME Rep. 16, A-09; Reaffirmed: CME Rep. 11, A-12; Reaffirmed: CME Rep. 10, A-12; Reaffirmed in lieu of Res. 313, A-12; Reaffirmed: CME Rep. 4, A-13)

(22) RESOLUTION 920 - TELEMEDICINE LICENSURE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-480.969 and D-480.999 be reaffirmed in lieu of Resolution 920.

HOD ACTION: Policies H-480.969 and D-480.999 reaffirmed in lieu of Resolution 920.

Resolution 920 asks that our American Medical Association support the continuation of telemedicine licensure by individual states and opposes efforts to change such to federal licensure of telemedicine.

Your Reference Committee heard mixed testimony on this resolution which raised concern for the evolving issue of telemedicine. Our AMA examined the issues related to telemedicine at its A-13 HOD Meeting with BOT Report 22-A-13, which included a review of extensive existing AMA policy on telemedicine and licensure. AMA policy (H-480.969) supports telemedicine licensure at the state level, and opposes federal regulation of telemedicine licensure

(D-480.999). Your Reference Committee recommends reaffirmation of Policies H-480.969 and D-480.999 in lieu of Resolution 920.

Policy recommended for reaffirmation:

H-480.969 The Promotion of Quality Telemedicine

(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles: (a) application to situations where there is a telemedical transmission of individual patient data from the patient's state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board's state; (b) exemption from such a licensure requirement for traditional informal physician-to-physician consultations ("curbside consultations") that are provided without expectation of compensation; (c) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and (d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices. (2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the interstate telemedicine approach adopted must accommodate these essential quality-related functions. (3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties). (CME/CMS Rep., A-96; Amended: CME Rep. 7, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 6, A-10; Reaffirmed: CME Rep. 6, A-12; Reaffirmed in lieu of Res. 805, I-12; Reaffirmed: BOT Rep. 22, A-13)

D-480.999 State Authority and Flexibility in Medical Licensure for Telemedicine

Our AMA will continue its opposition to a single national federalized system of medical licensure. (CME Rep. 7, A-99; Reaffirmed and Modified: CME Rep. 2, A-09)