

REPORTS OF REFERENCE COMMITTEES OF THE AMERICAN MEDICAL ASSOCIATION  
HOUSE OF DELEGATES 2014 ANNUAL MEETING

## REPORT OF REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS

- (1) BOARD OF TRUSTEES REPORT 2 - AMERICAN BOARD OF MEDICAL SPECIALTIES: OFFICIAL OBSERVER STATUS IN THE HOUSE OF DELEGATES

## RECOMMENDATION:

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

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

BOT Report 2 recommends that the American Board of Medical Specialties be granted official observer status in the HOD.

The Board of Trustees introduced this report and there was no further testimony. The American Board of Medical Specialties has met all of the requirements in our Bylaws to obtain official observer status and our Board of Trustees believes the ABMS would bring a welcome perspective to House of Delegates deliberations. In the capacity as official observer, they can speak and debate on the floor of the House of Delegates, but cannot introduce business or amendments, make motions, or vote. Therefore, your Reference Committee recommends that Board of Trustees Report 2 be adopted.

- (2) BOARD OF TRUSTEES REPORT 3 - NEW SPECIALTY ORGANIZATIONS REPRESENTATION IN THE HOUSE OF DELEGATES

## RECOMMENDATION:

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

**HOD ACTION: Recommendations in Board of Trustees Report 3 adopted and the remainder of the report filed.**

BOT Report 3 recommends that the American Society of Metabolic and Bariatric Surgery and the International Society for the Advancement of Spine Surgery be granted representation in our AMA HOD.

The Board of Trustees introduced this report and there was no further testimony. The Board believes that both the American Society of Metabolic and Bariatric Surgery and the International Society for the Advancement of Spine Surgery have met the criteria for representation. Therefore, your Reference Committee recommends that Board of Trustees Report 3 be adopted.

(3) BOARD OF TRUSTEES REPORT 14 - ALLIANCE FOR REGENERATIVE MEDICINE: OFFICIAL OBSERVER STATUS IN THE HOUSE OF DELEGATES

RECOMMENDATION:

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

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

Board of Trustees Report 14 asks that the Alliance for Regenerative Medicine be granted official observer status in our AMA House of Delegates

The Board of Trustees introduced this report and there was no further testimony. The Alliance for Regenerative Medicine has met all of the requirements in our Bylaws to obtain official observer status and our Board of Trustees believes the ARM would bring a welcome perspective to House of Delegates deliberations. In the capacity as official observer, they can speak and debate on the floor of the House of Delegates, but cannot introduce business or amendments, make motions, or vote. Therefore, your Reference Committee recommends that Board of Trustees Report 14 be adopted.

(4) BOARD OF TRUSTEES REPORT 26 - CONFORMING BIRTH CERTIFICATE POLICIES TO CURRENT MEDICAL STANDARDS FOR TRANSGENDER PATIENTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 26 be adopted and that the remainder of the report be filed.

**HOD ACTION: Recommendations in Board of Trustees Report 26 adopted and the remainder of the report filed.**

BOT Report 26 provides rationale to support policies that do not require sex reassignment surgery in order to change an individual's sex designation on their birth certificate, and to support medically appropriate preventive care for all individuals regardless of birth certificate sex designation.

Testimony favored the recommendations of this report. Concerns that were raised focused on the mechanisms by which sex designation on a birth certificate would be notated, which is the purview of individual states. Current best medical practice does not require sex-reassignment surgery for transgendered patients, and appropriate gender identification can be achieved via psychological and hormonal treatment alone – a decision which is made between the patient and physician. It was further noted that a birth certificate is rarely, if ever, used for the determination of medical treatment for patients; birth certificates are primarily used for legal matters, not medical. Indeed, requiring sex-reassignment surgery places a burden on an already marginalized population. Your Reference Committee believes that the recommendations of this report reflect best current medical practice and therefore recommends that Board of Trustees Report 26 be adopted.

(5) BOARD OF TRUSTEES REPORT 27 - HOSPITAL POLICIES ON INTERACTIONS WITH INDUSTRY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 27 be adopted and that the remainder of the report be filed.

**HOD ACTION: Recommendations in Board of Trustees Report 27 adopted and the remainder of the report filed.**

BOT Report 27 recommends that the AMA encourage hospitals to craft policies concerning the relationships and interactions between hospital personnel and industry representatives within the hospital setting. Hospital policies should conform to AMA policies and opinions and be developed by an interdisciplinary group, including medical staff, hospital administrators, and other stakeholders.

The Board of Trustees introduced this report, and there was no further testimony. Therefore, your Reference Committee recommends that Board of Trustees Report 27 be adopted.

(6) BOARD OF TRUSTEES REPORT 31 - 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 31 be adopted and that the remainder of the report be filed.

**HOD ACTION: Recommendations in Board of Trustees Report 31 adopted and the remainder of the report filed.**

Board of Trustees Report 31 recommends that the American Academy of Cosmetic Surgery, American Academy of Hospice and Palliative Medicine, American Association for Thoracic Surgery, American Association of Gynecologic Laparoscopists, American Association of Plastic Surgeons, American Association of Public Health Physicians, American College of Allergy, Asthma and Immunology, American Society for Aesthetic Plastic Surgery, Inc., American Society of Interventional Pain Physicians, Association of University Radiologists, Infectious Diseases Society of America and the Society of Laparoendoscopic Surgeons retain representation in the American Medical Association House of Delegates. Board of Trustees Report 31 further recommends that the American Society of Hematology be given a grace period of one year to meet the membership requirements to retain their position in the AMA House of Delegates, and that the American College of Physician Executives representation in the AMA House of Delegates be terminated per the organization's request.

The Board of Trustees introduced this report and there was no further testimony. Your Reference Committee recommends that Board of Trustees Report 31 be adopted.

(7) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 1 - BYLAW CHANGES FOR THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

RECOMMENDATION:

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

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

Council on Constitution & Bylaws Report 1 responds to CLRPD Report 1-I-13, which asked 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 AMA section.

Limited testimony favored the adoption of this report. The Council on Long Range Planning and Development spoke to the work of the Council on Constitution and Bylaws on this report, and thanked CCB for this proposed change to the bylaws of CLRPD. Therefore, your Reference Committee Recommends that Council on Constitution and Bylaws Report 1 be adopted.

(8) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 2 -  
ETHICALLY SOUND INNOVATION IN MEDICAL PRACTICE

RECOMMENDATION:

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

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

CEJA Report 2 examines the conditions for ethical innovations and the ethical responsibilities of physicians who participate in designing, developing, disseminating, or adopting innovative modalities.

Testimony generally favored adoption of this report. Your Reference Committee agrees with the Council on Ethical and Judicial Affairs that this report addresses a significant gap in the existing *Code of Medical Ethics*. Testimony was heard regarding the first use of an innovative technique (in an emergency, for example) and the impracticalities of following the guidance provided during those times.

The objective of this report, however, is to provide ethical guidelines for physicians who design, develop, disseminate and adopt innovative medical practices. Based on this objective, your Reference Committee believes that this report provides useful rationale for the recommendations, which are an appropriate and useful roadmap for the physicians to which the recommendations speak. Therefore, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 2 be adopted.

(9) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 3 -  
RESTRICTIVE COVENANTS

RECOMMENDATION:

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

**HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs  
Report 3 adopted and the remainder of the report filed.**

Council on Ethical and Judicial Report 3 recommends that Opinions E-9.02 Restrictive Covenants in the Practice of Medicine, E-9.021 Covenants Not-to-Compete for Physicians in Training, and E-6.11 Competition be amended by substitution with language that states competition among physicians is ethically justifiable when based on factors such as quality of services, skill, experience, conveniences offered to patients, fees or credit terms. This report also recommends amendments providing that covenants not-to-compete restrict competition, can disrupt continuity of

care and may limit access to care. Finally, the report recommends guidelines for instances when physicians should not enter into covenants.

Testimony presented largely spoke in favor of adoption of this report. While limited testimony called for strengthening the recommendations, the majority of testimony noted how the report provides a nuanced approach to addressing an increasingly complicated and relevant issue in law and ethics. Furthermore, this report presents a consolidation of existing policy pertaining to restrictive covenants in physician employment and education. Therefore, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 3 be adopted.

(10) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 8 - CEJA  
SUNSET REPORT OF 2004 HOUSE POLICIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 8 be adopted and the remainder of the report be filed.

**HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs  
Report 8 adopted and the remainder of the report filed.**

Council on Ethical and Judicial Affairs Report 8 recommends that the House of Delegates policies that are listed in the Appendix to Council on Ethical and Judicial Affairs Report 8 be acted upon in the manner indicated and the remainder of the report be filed.

No testimony was heard other than the introduction of this report. Therefore, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 8 be adopted.

(11) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 4 -  
MORATORIUM ON AMA AFFILIATE MEMBERS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first Recommendation of Council on Constitution & Bylaws Report 4 be amended by deletion to read as follows:

1. That our American Medical Association (AMA) Board of Trustees ~~constitute a taskforce to~~ study the issue of affiliate membership in our AMA and address the rationale for affiliate memberships (Directive to Take Action).

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws Report 4 be adopted as amended and the remainder of the report be filed.

**HOD ACTION: recommendations in Council on Constitution and Bylaws  
Report 4 adopted as amended and the remainder of the report filed.**

Council on Constitution and Bylaws Report 4 recommends that our AMA BOT form a taskforce to examine affiliate membership in our AMA, and that there be a moratorium on the consideration of any new affiliate members until the HOD acts on the findings of the task force.

Limited testimony favored the adoption of this report. Testimony noted that affiliate membership of the American Medical Association, while at one time popular, has become a confusing membership category within the AMA. Affiliate memberships are non-fee paying members of the AMA, their membership statistics are not tracked, and affiliate members have no say in the policy determinations of the organization. An amendment by the Council on Constitution and Bylaws was introduced to alter the recommendations of the report striking “constitute a taskforce to” from recommendation one. Therefore, your Reference Committee recommends that Council on Constitution and Bylaws Report 4 be adopted as amended.

(12) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 4 - HEALTH PROMOTION AND PREVENTIVE CARE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first introductory paragraph of the recommendations in Council on Ethical and Judicial Affairs Report 4 be amended by deletion to read as follows:

Medicine and public health share an ethical foundation stemming from the essential and direct role that health plays in human flourishing. ~~While a physician's role tends to focus on diagnosing and treating illness once it occurs,~~ physicians also have a professional commitment to prevent disease and promote health and well-being for their patients and the community.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 4 be adopted as amended and the remainder of the report be filed.

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

Council on Ethical and Judicial Affairs Report 4 provides ethical guidelines for physicians regarding physicians' active role in health promotion and disease prevention within therapeutic relationships with individual patients. The medical profession can enhance disease prevention and health promotion at the population level by advocating for initiatives and policies which will lead to healthier communities.

Testimony overwhelmingly supported adoption of this report. The Council on Ethical and Judicial Affairs offered the above amendment, which deletes the non-substantive line at the beginning of the recommendations which states “while a physician's role tends to focus on diagnosing and treating illness once it occurs” in light of the fact that physicians in certain specialties do not have a primarily curative or palliative role. Testimony supported this amendment. Your Reference Committee agrees with the favorable testimony and CEJA's own amendment, and therefore recommends that Council on Ethical and Judicial Affairs Report 4 be adopted as amended.

(13) RESOLUTION 1 - OPT-OUT ORGAN DONATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 1 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~study~~ reevaluate the ethical considerations of presumed consent and other potential models for increasing the United States organ donor pool. (Directive to Take Action)

## RECOMMENDATION B:

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

## RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 1 be changed to read as follows:

## ORGAN DONATION

**HOD ACTION: Resolution 1 be adopted as amended with change in title.**

Resolution 1 asks that our AMA reconsider the ethical implications of a presumed consent model in organ donation and other avenues for increasing the number of registered organ donors in the US.

Testimony favored adoption of this report. The authors of the report provided an amendment which deleted “presumed consent” as a model of increasing the organ donor pool to specifically be studied. Eliminating this term allows for study of all models of increasing the organ donor pool. The recommended change in title reflects the deletion of the “presumed consent” term. Testimony also specifically mentioned the importance of pilot studies of financial incentives, which your Reference Committee believes would fall under the array of models to be studied and does not need to be specifically included in the Resolved. Your Reference Committee also agrees with testimony suggesting deletion of the word “ethical” as a specific consideration to study; doing so will allow the study to look not only at the ethical considerations, but the economic as well. Your Reference Committee recommends that Resolution 1 be adopted as amended.

## (14) RESOLUTION 2 - MODERNIZATION OF HIV SPECIFIC CRIMINAL LAWS

## RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the following Substitute Resolution 2 be adopted:

RESOLVED, That AMA Policy H-20.914 be amended by addition as follows:  
 H-20.914 Discrimination and Criminalization Based on HIV Seropositivity  
 Our AMA: (1) Remains cognizant of and concerned about society's perception of, and discrimination against, HIV-positive people; (2) Condemns any act, and opposes any legislation of categorical discrimination based on an individual's actual or imagined disease, including HIV infection; this includes Congressional mandates calling for the discharge of otherwise qualified individuals from the armed services solely because of their HIV seropositivity; (3) Encourages vigorous enforcement of existing anti-discrimination statutes; incorporation of HIV in future federal legislation that addresses discrimination; and enactment and enforcement of state and local laws, ordinances, and regulations to penalize those who illegally discriminate against persons based on disease; ~~and~~ (4) Encourages medical staff to work closely with hospital administration and governing bodies to establish appropriate policies regarding HIV-positive patients; (5) Supports consistency of federal and/or state laws with current medical and scientific knowledge including avoidance of any imposition of punishment based on health and disability status; and (6) Encourages public education and understanding of the stigma created by HIV criminalization statutes and subsequent negative clinical and public health consequences.  
 (Modify Current HOD Policy)



**HOD ACTION: Substitute Resolution 2 adopted.**

Resolution 2 asks that our AMA amend H-20.914 to include criminalization based on HIV seropositivity. The resolution also supports consistency of federal and state laws with current medical and scientific knowledge and accepted human rights-based approaches to disease control and prevention, in concordance with current AMA Policy condemning any act and opposing any legislation of categorical discrimination based on an individual's actual or imagined HIV infection.

Testimony largely favored adoption of this resolution. Those providing testimony for the resolution noted that it provides an important dimension to House policy and that it is consistent with the policies of other organizations that focus on issues of infectious disease and HIV. Testimony speaking against the resolution discussed the inconsistencies in states on the issue of HIV-specific criminal laws, and that the phrases "human rights-based approaches" and "unwarranted punishment" are vague. Your Reference Committee therefore clarified the language recommended in Resolution 2, and recommends that Substitute Resolution 2 be adopted.

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

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 1 be referred.

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

Council on Ethical and Judicial Report 1 examines the implications for patients, physicians and the medical profession when conflict arises 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.

Considerable testimony was provided regarding this report, with many strongly arguing for referral. Those testifying in support of adoption stated that the Council on Ethical and Judicial Affairs presented a thoughtful and thorough report that appropriately balances a physician's right of conscience with the medical needs of patients, and that the recommendations of the report provide necessary ethical guidance where there currently is none. Testimony opposed to adoption, however, noted several concerns. In particular, there was considerable testimony questioning the use of the word "prospectively" in recommendation (b) which was unclear in its definition and could create ambiguity for application in practice. The body of this report provides a clear explanation of this term, but unfortunately that clarity did not extend to the recommendation. The considerable confusion heard in testimony leads your Reference Committee to urge CEJA to make that particular recommendation clearer so physicians needing this guidance can fully understand it. Further, missing from this report on page 2, line 27, is the classification of gender as a protected class. Therefore, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 1 be referred.

(16) RESOLUTION 5 - AMERICAN BOARD OF MEDICAL SPECIALTIES  
SHOULD ADHERE TO ITS MISSION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 5 be not adopted.

**HOD ACTION: Resolution 5 referred.**

Resolution 5 asks that our AMA communicate to the ABMS our AMA's opposition to scope of practice limitations through board certifications.



This resolution was submitted due to a particular case of scope of practice limitations through board certifications. While the majority of testimony agreed that this is a practice which should not occur, the organizations who were involved in the original case also testified that this was a limited circumstance and was appropriately addressed between the parties affected. They acknowledged that the boards overstepped their bounds in that instance and do not have policies which impose scope of practice limitations. Your Reference Committee believes that while scope of practice limitations through board certification is not appropriate, this is not a practice beyond the one specific case. Therefore, your Reference Committee recommends that Resolution 5 be not adopted.

(17) RESOLUTION 3 - SOCIAL MEDIA GUIDANCE  
RESOLUTION 4 - SOCIAL MEDIA

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy E-9.124 “Professionalism in the Use of Social Media” be reaffirmed in lieu of Resolution 3 and Resolution 4.

**HOD ACTION: Policy E-9.124 “Professionalism in the Use of Social Media” reaffirmed in lieu of Resolution 3 and Resolution 4.**

Resolution 3 asks that our AMA collaborate with other medical organizations and stakeholders to develop recommendations for physicians’ social media use.

Resolution 4 asks that CEJA undertake a study to chart the course for the ethical and HIPAA compliant use of social media for the physicians of the US.

Limited testimony supported Resolution 3, and the only testimony heard for Resolution 4 was the author who supported considering the two resolutions together. It was pointed out that current policy E-9.124 “Professionalism in the Use of Social Media” provides sufficient guidance for physician use of social media, and is broad enough to continue to be applicable in the changing landscape of technology and applications. Your Reference Committee also notes that continuing medical education modules are currently being developed by AMA staff and will be available online this year for those wishing to learn more about professionalism in this area. Your Reference Committee therefore recommends that Policy E-9.124 be reaffirmed in lieu of Resolution 3 and Resolution 4.

(18) RESOLUTION 6 - AMERICAN MEDICAL ASSOCIATION SUPPORT FOR PATIENTS’ ACCESS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy D-165.940 be reaffirmed in lieu of Resolution 6.

**HOD ACTION: Policy D-165.940 reaffirmed in lieu of Resolution 6.**

Resolution 6 asks that CEJA make a public opinion regarding the AMA’s support for the ACA in regards to any imposition the ACA may have on impeding patients’ access to appropriate health care services. Resolution 6 further asks that CEJA provide an opinion on any future AMA positions which may impede the same.

Testimony was overwhelmingly against the adoption of this resolution.

Although the introduction of this resolution voiced concern about impediments to care experienced by patients, the majority of testimony saw this resolution as counterproductive to the American Medical Association’s continued support for health care reform. Not only was the resolution interpreted as reopening debate about the Accountable Care Act, but the House already has in place policy that calls for the AMA to monitor the progression of the ACA. Your Reference Committee therefore recommends that American Medical Association Policy D-165.940 be reaffirmed in lieu of Resolution 6.

(19) RESOLUTION 7 - ESTABLISH A MORATORIUM ON THE  
MEDICALIZATION OF CAPITAL PUNISHMENT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-140.950 and E-2.06 be reaffirmed in lieu of Resolution 7.

**HOD ACTION: Policies H-140.950 and E-2.06 reaffirmed in lieu of Resolution 7.**

Resolution 7 asks that all states cease the execution of prisoners until the numerous problems with medicalized executions are solved or a non-medical model of execution that is neither cruel nor unusual is adopted.

The majority of testimony on this resolution stood in opposition to its adoption. The authors of this resolution discussed the appalling medicalization of capital punishment, and how this situation stands in conflict with every ethical duty of physicians. However, those testifying against this resolution stated that the American Medical Association already has policies prohibiting a physician's involvement in capital punishment, irrespective of the method, and therefore reaffirmation of existing policy is sufficient. Your Reference Committee therefore recommends that American Medical Association Policy H-140.950 and E-2.06 be reaffirmed in lieu of Resolution 7.

## REPORT OF REFERENCE COMMITTEE A

- (1) COUNCIL ON MEDICAL SERVICE REPORT 2 - EXTENDING MEDICAID PRIMARY CARE PAYMENT INCREASES TO INCLUDE OBSTETRICIANS AND GYNECOLOGISTS  
RESOLUTION 103 - CONTINUATION OF FEDERAL AUGMENTATION OF PRIMARY CARE MEDICAID PAYMENTS

## RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 2 be adopted in lieu of Resolution 103 and the remainder of the report be filed.

**HOD ACTION: Council on Medical Service Report 2 and Resolution 103 referred.**

Council on Medical Service Report 2 recommends that our AMA advocate that the Affordable Care Act's primary care payment increases for Evaluation and Management codes and vaccine administration codes include obstetricians and gynecologists as a qualifying specialty, and for the ACA's Medicaid primary care payment increase to continue past 2014.

Resolution 103 asks that our AMA advocate strongly for Congress to continue the federal augmentation of primary care Medicaid payments to Medicare rates in perpetuity.

There was generally supportive testimony on Council on Medical Service Report 2 and Resolution 103. A member of the Council on Medical Service introduced the report, explaining that the recommendation of the report to include obstetricians and gynecologists as a qualifying specialty to receive the Affordable Care Act's primary care payment increase builds off of already existing policy that recognizes the specialty as capable of providing both primary care and consultative care. In addition, the Council member noted that the report recommends advocating for the ACA's Medicaid primary care payment increase to continue past 2014, the wording of which accounts for the budgetary implications of extending the payment increase. Your Reference Committee believes that Recommendation 4 of CMS Report 2 addresses the intent of Resolution 103.

An amendment was offered to Council on Medical Service Report 2 to include obstetricians and gynecologists as a qualifying specialty to receive the ACA's Medicaid primary care payment increases only if they can attest that at least 60 percent of their Medicaid codes billed for the year are for the designated primary care and vaccination service codes. To qualify for the increased Medicaid payments, your Reference Committee notes that physicians must first attest to practicing in a qualifying specialty (currently family medicine, general internal medicine or pediatrics) or a subspecialty of one of these categories. After that, there are two avenues for a physician in an eligible specialty to receive the increased Medicaid payments. Physicians can either self-attest that they are board-certified, or that at least 60 percent of the codes they submitted to Medicaid in 2012 were for primary care services. The amendment offered would require obstetricians and gynecologists to meet different attestation requirements to qualify for the ACA Medicaid payment increases than those required for family medicine, general internal medicine and pediatrics. However, your Reference Committee notes that AMA policy recognizes all four specialties as primary care specialties, and therefore believes the same attestation requirements to qualify for the Medicaid primary care payment increases as family medicine, general internal medicine and pediatrics should apply to obstetricians and gynecologists.

Another amendment was offered that would include obstetricians and gynecologists, psychiatrists and neurologists as qualifying specialties to receive the Affordable Care Act's primary care payment increases. However, psychiatrists and neurologists are not recognized in AMA policy as providing primary care. Your Reference Committee notes that the third recommendation of CMS Report 2 calls for the reaffirmation of Policy H-290.976[2], which advocates that Medicaid payments to physicians – including psychiatry, neurology and other specialties - be at a minimum 100 percent of Medicare payment rates. After all amendments were offered, a member of the Council

on Medical Service reiterated that the recommendations of CMS Report 2 were highly consistent with AMA policy defining primary care specialties and supporting increasing Medicaid payment rates to Medicare levels, and therefore recommended that they not be amended. Your Reference Committee agrees, and recommends that the recommendations in Council on Medical Service Report 2 be adopted in lieu of Resolution 103, and the remainder of the report filed.

(2) COUNCIL ON MEDICAL SERVICE REPORT 9 - IMPROVING THE AFFORDABLE CARE ACT

RECOMMENDATION:

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

**HOD ACTION: Recommendations in Council on Medical Service Report 9 adopted and the remainder of the report filed.**

Council on Medical Service Report 9 recommends the reaffirmation of policies in support of the AMA proposal to cover the uninsured and expand choice, and continued AMA advocacy to modify portions of the ACA and address critical issues that the ACA did not address.

There was generally supportive testimony on this report. Some speakers cited issues with the Affordable Care Act, including its impact on health care costs, the uninsured and physician office efficiencies. However, your Reference Committee notes that CMS Report 9, along with CMS Report 5-I-13, addressed those concerns. Several speakers expressed their strong support for health savings accounts. Your Reference Committee notes that CMS Report 9 recommends that Policy H-165.852 in support of health savings accounts be reaffirmed. Policy H-165.852 also supports annual HSA account contribution limits being determined by the full family deductible or the dollar-limit for family policies, which responds to concerns raised in testimony. Additional testimony highlighted support for the Medicare Patient Empowerment Act, support for which is included in Policies H-165.833 and H-165.838 recommended for reaffirmation. Your Reference Committee commends the Council on a strong report, which was forward-thinking in highlighting emerging issues with ACA implementation. Accordingly, your Reference Committee recommends the adoption of Council on Medical Service Report 9.

(3) RESOLUTION 109 - STANDARDIZATION OF ADVANCE BENEFICIARY NOTIFICATION OF NON-COVERAGE FORMS FOR MEDICARE ADVANTAGE PLANS AND ORIGINAL FEE-FOR-SERVICE MEDICARE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 109 be adopted.

**HOD ACTION: Resolution 109 adopted.**

Resolution 109 asks that our AMA request the Centers for Medicare & Medicaid Services provide a standardized Advance Beneficiary Notice of Non-coverage (ABN) that will be sufficient notification to inform all Medicare Advantage Plan and Original (Fee-For-Service) Medicare beneficiaries when Medicare may deny payment for an item or service. Resolution 109 also that Medicare Advantage Plan requirements for carrier specific advance beneficiary notice of non-coverage and similar forms be eliminated.

Testimony was supportive of Resolution 109. Your Reference Committee concurs that the administrative simplification of ABN forms would benefit physician practices and reduce payment delays and therefore recommends that this resolution be adopted.

(4) RESOLUTION 124 - GENERIC CHANGES IN MEDICARE (PART D) PLANS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 124 be adopted.

**HOD ACTION: Resolution 124 adopted.**

Resolution 124 asks that our AMA investigate the incidence and reasoning behind the conversion of one generic drug to another generic drug of the same class in Medicare Advantage drug plan, and request Centers for Medicare & Medicaid Services to ensure that pharmaceutical vendors, when they do ask for generic transitions of drugs, list the drugs they believe are more cost effective along with their tier price and alternative drug names.

Testimony was supportive of Resolution 124. Your Reference Committee agrees with the sponsor that it can be problematic for Medicare patients when a generic drug they are taking is no longer on their plan's formulary and they are switched to a different generic. Your Reference Committee therefore recommends that Resolution 124 be adopted.

(5) RESOLUTION 134 – PRESCRIPTION OF DURABLE MEDICAL EQUIPMENT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 134 be adopted.

**HOD ACTION: Resolution 134 adopted.**

Resolution 134 asks that our AMA amend Policy H-330.955, Prescription of Durable Medical Equipment to include insurers.

Testimony on this resolution was limited to the sponsor who proposed broadening AMA policy to the commercial insurer field. Your Reference Committee recommends that Resolution 134 be adopted.

H-330.955 Prescription of Durable Medical Equipment

(1) Our AMA continues to voice its objection to CMS and other insurers regarding its onerous requirements that physicians initiate and complete the entire certification of medical necessity form for the prescription of durable medical equipment. (2) Our AMA advocates 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. (3) Our AMA calls for CMS to revise its interpretation of the law, and advocates for other insurers, to permit that the physician's prescription be the only certification of medical necessity needed to initiate an order for and to secure Medicare or other insurer payment for durable medical equipment. (4) Our 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.

(6) RESOLUTION 135 - PRESCRIPTION DRUG PLANS AND PATIENT ACCESS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 135 be adopted.

**HOD ACTION: Resolution 135 adopted.**

Resolution 135 asks that our AMA explore problems with prescription drug plans, including issues related to continuity of care, prior authorization, and formularies, and work with the Centers for Medicare & Medicaid Services and other appropriate organizations to resolve them.

Testimony was supportive of Resolution 135. Your Reference Committee notes that several resolutions addressing problems with prescription drug plans were submitted to the HOD for consideration at this meeting. Your Reference Committee thanks the OMSS for this resolution and recommends that it be adopted.

(7) BOARD OF TRUSTEES REPORT 11 - MEDICATION NON-ADHERENCE AND ERRORS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 11 be amended by addition and deletion to read as follows:

That our American Medical Association recommend the Centers for Medicare and Medicaid Services conduct a cost/benefit analysis and an analysis of the ability of seniors and people with disabilities to use blister packs in order to ~~and~~ determine the feasibility of expanding coverage for timed calendar blister packs for prescription medications beyond residents of long term care facilities.

RECOMMENDATION B:

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

**HOD ACTION: Recommendation in Board of Trustees Report 11 adopted as amended and the remainder of the report filed.**

Board of Trustees Report 11 recommends that our AMA ask the Centers for Medicare and Medicaid Services to conduct a cost/benefit analysis and determine the feasibility of expanding coverage for timed calendar blister packs for prescription medications beyond residents of long term care facilities.

There was limited but supportive testimony on this report. Your Reference Committee agrees that further analysis by the Centers for Medicare & Medicaid Services (CMS) is warranted before the agency should expand coverage of timed calendar blister packs beyond patients in long-term care. A member of the AMA Board of Trustees testified that the proposed recommendations to CMS in this report are reasonable and in order. A Senior Physicians Section representative spoke about the difficulty that some seniors have opening blister packs and offered an amendment addressing this issue. Your Reference Committee agrees with the suggested amendment from the Senior Physicians Section and recommends that Board of Trustees Report 11 be adopted as amended.

(8) COUNCIL ON MEDICAL SERVICE REPORT 1 – COUNCIL ON MEDICAL SERVICE SUNSET REPORT OF 2004 HOUSE POLICIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendation of Council on Medical Service Report 1 be amended by addition and deletion on lines 32-34 to read as follows:

The Council on Medical Service recommends that our American Medical Association policies listed in the appendix to this report be acted upon in the manner indicated, with the exception of Policy D-330.964, which should be retained. ~~and the remainder of the report be filed.~~ (Directive to Take Action)

RECOMMENDATION B:

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

**HOD Action: Recommendation in Council on Medical Service Report 1 adopted as amended and the remainder of the report filed.**

Council on Medical Service Report 1 contains recommendations to retain or rescind 2004 AMA socioeconomic policies.

There was limited testimony on Council on Medical Service Report 1. A member of the Council on Medical Service introduced the report and noted the efforts of the Council to review and analyze the policies that it was assigned. A speaker requested that Policy D-330.964 be retained, which states that our AMA urge the Centers for Medicare and Medicaid Services to immediately update the ambulatory surgery center list of covered procedures. Your Reference Committee agrees with this suggestion, as the list of covered procedures is continuously changing. Therefore, your Reference Committee recommends adoption of Council on Medical Service Report 1 as amended.

(9) COUNCIL ON MEDICAL SERVICE REPORT 3 - MEDICARE UPDATE FORMULAS ACROSS OUTPATIENT SITES OF SERVICE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 4 in Council on Medical Service Report 3 be amended by addition and deletion to read as follows:

4. That our AMA amend Policy H-330.925 by insertion and deletion as follows:  
H-330.925 Appropriate Payment Level Differences by Place and Type of Service

Our AMA (1) encourages CMS to adopt policy and establish mechanisms to fairly reimburse physicians for office-based procedures; (2) encourages CMS to adopt a ~~single facility payment schedule~~ site neutral payment policy for hospital outpatient departments and ambulatory surgical centers; (3) advocates for the use of valid and reliable data in the development of any payment methodology for the provision of ambulatory services; (4) advocates that in place of the Consumer Price Index for all Urban Consumers (CPI-U), CMS use the hospital market basket index to annually update ambulatory surgical center payment rates; ~~(4) continues to oppose the implementation of any prospectively determined classification and payment system for Medicare ambulatory services that is based upon a methodology that bundles or groups services;~~ (5) advocates



~~for payments for hospital outpatient department services and ambulatory surgical services that are based on individual services;~~ (65) encourages the use of CPT codes across all sites-of-service as the only acceptable approach to payment methodology; and (76) will join other interested organizations and lobby for any needed changes in existing and proposed regulations affecting payment for ambulatory surgical centers to assure a fair rate of reimbursement for ambulatory surgery. (Modify HOD Policy)

#### RECOMMENDATION B:

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

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

Council on Medical Service Report 3 recommends that the Centers for Medicare & Medicaid Services use the hospital market basket index to annually update ambulatory surgical center (ASC) payment rates, and that our AMA continue to encourage CMS to collect data on the frequency, type and cost of services furnished in off-campus, provider-based departments.

Testimony was generally supportive of Council on Medical Service Report 3. A member of the Council on Medical Service pointed out that AMA policy already addresses most of the concerns raised in Resolution 112-A-13, which led to the development of this report, and that Medicare payment disparities across outpatient sites of service are also addressed in Council on Medical Service Report 3-A-13.

There was substantial support for the Council's recommendation regarding use of the hospital market basket index to calculate annual inflationary updates for ASC payment rates, which is the same index used to update hospital outpatient department payment rates. Your Reference Committee agrees that the hospital market basket index better reflects changes in ASC costs than the CPI-U, which measures prices paid for household goods and is highly weighted for housing.

Hospital acquisition of physician practices and resulting changes to Medicare payments when hospital-owned practices bill as outpatient departments under the Outpatient Prospective Payment System was mentioned by several speakers. Concerns were also expressed regarding efforts to "level the playing field" that may result in payment reductions to hospital outpatient departments. Speakers emphasized the need to equalize payments in a way that is fair to physicians and hospitals in all settings. Your Reference Committee opted not to amend Recommendation 2, which recommends reaffirmation of Policy D-330.997, as suggested by testimony because this is a longstanding policy of the AMA. Your Reference Committee agrees with another speaker's suggestion to substitute "site neutral payment policy" for "single facility payment schedule" in Policy H-330.925[2], and recommends that Council on Medical Service Report 3 be adopted as amended.

#### (10) COUNCIL ON MEDICAL SERVICE REPORT 4 - ANALYSIS OF PLACE-OF-SERVICE CODE FOR OBSERVATION SERVICES RESOLUTION 127 – OBSERVATION STATUS

#### RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 4 be amended by addition of a seventh recommendation to read as follows:

7. That our AMA advocate with Centers for Medicare & Medicaid Services that the status of any observation patient who remains confined at a hospital for more than 24 hours be changed automatically to inpatient, and if they had spent a

midnight in observation status, that midnight would be counted toward the three-day prior hospitalization requirement for Medicare coverage of skilled nursing facility care. (Directive to Take Action)

#### RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 4 be adopted as amended in lieu of Resolution 127 and the remainder of the report be filed.

**HOD ACTION: Recommendations in Council on Medical Service Report 4 adopted as amended in lieu of Resolution 127 and the remainder of the report filed.**

Council on Medical Service Report 4 recommends the reaffirmation of policy in support of repealing the Two-Midnight Rule, as well as the continuation of AMA advocacy in support of the Centers for Medicare & Medicaid Services exploring payment solutions to reduce the inappropriate use of hospital observation status.

Resolution 127 asks that our AMA advocate with the Centers for Medicare & Medicaid Services for the modification of their observation status rules, such that observation status would be limited to patients cared for in either the outpatient or inpatient setting of a hospital for less than 24 hours. Resolution 127 also asks that our AMA advocate with CMS that the status of any observation patient who remains confined at a hospital for more than 24 hours be changed automatically to inpatient, and if they had spent a midnight in observation status, that midnight would be counted toward the three midnight rule.

Testimony on Council on Medical Service Report 4 was supportive and also indicative of ongoing physician concerns regarding the inappropriate assignment of patients to hospital observation status. Many speakers testified as to the enormity of the problems related to observation care, especially the financial consequences for observation patients who may be surprised to learn that they are responsible for Medicare Part B cost-sharing amounts for services provided as part of observation care.

Your Reference Committee points out that AMA policy designates a hospital stay of 24 hours as a guideline for patient inpatient admissions, which is the focus of the first resolve clause in Resolution 127. The AMA has consistently advocated that CMS use a 24-hour benchmark to distinguish between hospital inpatient and observation status instead of the two-midnight rule, which AMA is actively working to repeal. Your Reference Committee was persuaded by testimony to amend Council on Medical Service Report 4 by incorporating Resolution 127's second resolve clause as a new recommendation.

Your Reference Committee commends the Council for a comprehensive and well-written report. Your Reference Committee feels strongly that the AMA should continue working diligently to ensure that CMS develops payment solutions that address the inappropriate use of hospital observation status, and is pleased to hear that CMS may investigate use of a short-stay outlier as a potential option. Your Reference Committee recommends adoption of the recommendations in Council on Medical Service Report 4 as amended in lieu of Resolution 127.

#### (11) COUNCIL ON MEDICAL SERVICE REPORT 7 - COVERAGE OF AND PAYMENT FOR TELEMEDICINE

##### RECOMMENDATION A:

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

1. That American Medical Association (AMA) policy be that telemedicine services should be covered and paid for if they abide by the following principles:

a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:

- A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine;  
or
- A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or
- Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.

Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.

at minimum a face to face examination provided in person or virtually using real time audio and video technology, if a face to face encounter would otherwise be required in the provision of the same service not delivered via telemedicine.

b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.

c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.

d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.

e) The delivery of telemedicine services must be consistent with state scope of practice laws.

f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.

g) The standards and scope of telemedicine services should be consistent with related in-person services.

h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.

i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.

j) The patient's medical history must be collected as part of the provision of any telemedicine service.

k) The provision of telemedicine services must be properly documented, which and should include providing a visit summary to the patient and a copy of the medical record to any identified primary and/or referring physician, in order to facilitate continuity of care.

l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.

mk) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.

RECOMMENDATION B:

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: Recommendations in Council on Medical Service Report 7 adopted as amended and the remainder of the report filed.**

Council on Medical Service Report 7 recommends principles to ensure the appropriate coverage of and payment for telemedicine services, supporting additional research, pilot programs and demonstration projects regarding telemedicine, and national specialty societies to take the lead in the development of telemedicine clinical practice guidelines.

There was generally supportive testimony on Council on Medical Service Report 7. At the time of introducing the report, a member of the Council on Medical Service offered proposed language to Recommendation 1(b) to clarify that physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services. In addition, the member of the Council offered language for a new Recommendation 1(c), based off of the testimony given in the online member forum, which asserts that physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board. Your Reference Committee believes that this amendment is very consistent with existing policy that supports a full and unrestricted state license for the practice of telemedicine, while allowing for flexibility for states that have license reciprocity agreements and other arrangements. Your Reference Committee heard additional testimony concerning licensure, but believes that the focus of CMS Report 7 was coverage of and payment for telemedicine, not changing licensure pertaining to the provision of telemedicine services. Rather, your Reference Committee notes that Resolution 118 addressed issues associated with state licensure for telemedicine services. There was also a suggestion that the recommendations of the report address geographic variations in physician payment, but your Reference Committee believes that such an amendment is outside the scope of the report. However, your Reference Committee notes that a member of the Council on Medical Service indicated that the Council will continue to monitor this evolving issue.

A member of the Council on Legislation (COL) offered an amendment that outlined different avenues through which a valid patient-physician relationship could be established before the provision of telemedicine services, outlined in Recommendation 1(a), and included language that emphasized that telemedicine must include care coordination with the medical home where the patient receives in-person care. The Council on Medical Service accepted the COL amendment as friendly. Your Reference Committee commends the COL for its amendment to Recommendation 1(a) concerning the need to establish a valid patient-physician relationship. Your Reference Committee believes that the amendment strongly defines a valid patient-physician relationship pertaining to telemedicine, while not being overly prescriptive and recognizing that specialties use telemedicine differently. Your Reference Committee believes that these amendments sufficiently respond to testimony given, and accordingly recommends that Council on Medical Service Report 7 be adopted as amended.

(12) RESOLUTION 101 - PROVIDING COMPLETE MATERNITY CARE UNDER THE AFFORDABLE CARE ACT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 101 be amended by addition of a second resolve to read as follows:

RESOLVED, That our American Medical Association advocate that individual, small and large group health plans provide 60 days of newborn coverage for all newborns born to participants in the plan. (Directive to Take Action)

RECOMMENDATION B:

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

**HOD ACTION: Resolution 101 adopted as amended.**

Resolution 101 asks that our AMA advocate for expanding coverage of maternity care to dependent women under the age of 26 on their parents' large group plans.

There was highly supportive testimony on this resolution. An amendment was offered to assure coverage of newborns born to all health plan participants, including dependents of the policyholder. Your Reference Committee finds this amendment to be consistent with Policy H-185.997, which encourages health insurance coverage for care of the newborn from the moment of birth. Another amendment was offered to require pregnancy be considered a qualifying life event that would trigger a special enrollment period. However, your Reference Committee believes that this amendment broadens the intent of this resolution, which is to fill the gap in maternity coverage that currently exists. Resolution 101 would support expanding coverage of maternity coverage to dependent women on their parents' large group health plans. Having a baby is considered to be a qualifying life event so these women would have additional coverage options upon giving birth.

Your Reference Committee believes that dependent coverage without maternity benefits is incomplete, and could impose substantial costs on dependents and their parents. As extending maternity coverage to dependents would be consistent with Policy H-185.997 in support of insurance coverage for complete maternity care, and Policy H-180.964 in support of extending family coverage to young adults to age 28, your Reference Committee recommends that Resolution 101 be adopted as amended.

(13) RESOLUTION 104 - PHYSICIAN PAYMENT BY MEDICARE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends adoption of Substitute Resolution 104.

RESOLVED, that our AMA reaffirm Policies H-400.956, H-400.959, H-400.969, H-330.925 and D-330.997 (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA study the impact of hospital acquisition of physician practices on health care costs, patient access to health care and physician practice. (Directive to Take Action)

**HOD ACTION: Substitute Resolution 104 adopted.**

Resolution 104 asks that our AMA annually examine the methodology for determining "allowable" Medicare fee schedules (E&M and CPT code) to determine if the reimbursement is consistent with the government's stated amounts and alert its membership as to that consistency or lack thereof, and examine the reason that Medicare pays far more for "hospital-based" clinics\doctors than for private practice physicians.

Testimony acknowledged that our AMA has policy related to Resolution 104, including policy that supports the work of the RUC, which as an expert panel regularly reviews the valuation of physician services and also studies the methodology behind the valuation of CPT codes. A member of the CPT Editorial Panel and former member of the RUC testified that the RUC routinely accomplishes what is asked for in the first resolve of Resolution 104.



Your Reference Committee also points out that Policies H-330.925 and D-330.997 support defining Medicare services consistently across settings, and encourage CMS to adopt payment methodologies that assist in leveling the playing field across all sites of service. Moreover, Council on Medical Service Report 3 explains in great detail why Medicare pays more for hospital-based services than for services provided in physician offices and ASCs. However, several speakers testified that this is a complicated topic that is worthy of further study. Your Reference Committee therefore recommends substitute language that asks the AMA to study the impact of hospital acquisition of physician practices on health care costs, patient access to care and physician practice.

Because AMA policy addresses the issues put forth in Resolution 104, your Reference Committee also recommends that Policies H-400.956, H-400.959, H-400.969, H-330.925 and D-330.997 be reaffirmed.

#### H-400.956 RBRVS Development

(1) That the AMA strongly advocate CMS adoption and implementation of all the RUC's recommendations for the five-year review; (2) That the AMA closely monitor all phases in the development of resource-based practice expense relative values to ensure that studies are methodologically sound and produce valid data, that practicing physicians and organized medicine have meaningful opportunities to participate, and that any implementation plans are consistent with AMA policies; (3) That the AMA work to ensure that the integrity of the physician work relative values is not compromised by annual budget neutrality or other adjustments that are unrelated to physician work; (4) That the AMA encourage payers using the relative work values of the Medicare RBRVS to also incorporate the key assumptions underlying these values, such as the Medicare global periods; and (5) That the AMA continue to pursue a favorable advisory opinion from the Federal Trade Commission regarding AMA provision of a valid RBRVS as developed by the RUC process to private payers and physicians. (BOT Rep. 16, A-95; BOT Rep. 11, A-96; Reaffirmed: CMS Rep. 4, I-02; Reaffirmed: BOT Rep. 14, A-08)

#### H-400.959 Refining and Updating the Physician Work Component of the RBRVS

The AMA: (1) supports the efforts of the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee's (RUC's) work with the American Academy of Pediatrics and other specialty societies to develop pediatric-specific CPT codes and physician work relative value units to incorporate children's services into the RBRVS; (2) supports the RUC's efforts to improve the validity of the RBRVS through development of methodologies for assessing the relative work of new technologies and for assisting CMS in a more comprehensive review and refinement of the work component of the RBRVS; and (3) continues to object to use of the relative values as a mechanism to preserve budget neutrality. (BOT Rep. I-93-26; Reaffirmed by BOT Rep. 8 - I-94; Res. 806, I-94; Reaffirmed: Sub. Res. 816, I-99; Reaffirmed: CMS Rep. 4, I-02; Reaffirmed: BOT Rep. 14, A-08)

#### H-400.969 RVS Updating

Status Report and Future Plans: The AMA/Specialty Society RVS Update Committee (RUC) represents an important opportunity for the medical profession to maintain professional control of the clinical practice of medicine. The AMA urges each and every organization represented in its House of Delegates to become an advocate for the RUC process in its interactions with the federal government and with its physician members. The AMA (1) will continue to urge CMS to adopt the recommendations of the AMA/Specialty Society RVS Update Committee for physician work relative values for new and revised CPT codes; (2) supports strongly use of this AMA/Specialty Society process as the principal method of refining and maintaining the Medicare RVS; (3) encourages CMS to rely upon this process as it considers new methodologies for addressing the practice expense components of the Medicare RVS and other RBRVS issues; and (4) opposes changes in Relative Value Units that are in excess of those recommended by the AMA/Specialty Society Relative Value Scale Update Committee (RUC). (BOT Rep. O, I-92; Reaffirmed by BOT Rep. 8 - I-94; Reaffirmed by BOT Rep. 7, A-98; Reaffirmed: CMS Rep. 12, A-99; Reaffirmed: CMS Rep. 4, I-02; Reaffirmed: BOT Rep. 14, A-08; Reaffirmation I-10; Appended: Res. 822, I-12; Reaffirmation I-13)

#### H-330.925 Appropriate Payment Level Differences by Place and Type of Service

#### H-330.925 Appropriate Payment Level Differences by Place and Type of Service

Our AMA: (1) encourages CMS to adopt policy and establish mechanisms to fairly reimburse physicians for office-based procedures; (2) encourages CMS to adopt a single facility payment schedule for hospital

outpatient departments and ambulatory surgical centers; (3) advocates for the use of valid and reliable data in the development of any payment methodology for the provision of ambulatory services; (4) continues to oppose the implementation of any prospectively determined classification and payment system for Medicare ambulatory services that is based upon a methodology that bundles or groups services; (5) advocates for payments for hospital outpatient department services and ambulatory surgical services that are based on individual services; (6) encourages the use of CPT codes across all sites-of-service as the only acceptable approach to payment methodology; and (7) will join other interested organizations and lobby for any needed changes in existing and proposed regulations affecting payment for ambulatory surgical centers to assure a fair rate of reimbursement for ambulatory surgery. (Sub. Res. 104, A-98; Reaffirmation I-98; Appended: CMS Rep. 7, A-99; Reaffirmation A-00; Reaffirmation I-03; Reaffirmation A-11; Reaffirmed: CMS Rep. 3, A-13)

**D-330.997 Appropriate Payment Level Differences by Place and Type of Service**

Our AMA encourages CMS to: (1) define Medicare services consistently across settings and, in particular, to avoid the use of diagnosis codes in determining Medicare payments to hospital outpatient departments and other ambulatory settings; and (2) adopt payment methodology for hospital outpatient departments and ambulatory surgical centers that will assist in leveling the playing field across all sites-of-service. If necessary, the AMA should consider seeking a legislative remedy to the payment disparities between hospital outpatient departments and ambulatory surgical centers. (CMS Rep. 7, A-99; Reaffirmation I-03)

**(14) RESOLUTION 106 - ENDORSE MEDICARE PART D EDUCATIONAL WEBSITE**

**RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends adoption of Substitute Resolution 106.

**RESOLVED**, That our American Medical Association request that the Centers for Medicare & Medicaid Services educate Medicare beneficiaries on how to access assistance for enrolling in Medicare Part D and Medicare Advantage plans. (Directive to Take Action)

**HOD ACTION: Substitute Resolution 106 adopted.**

Resolution 106 asks that our AMA request that the federal government provide on an annual basis to the Medicare population an individualized report showing the estimated out of pocket costs for each of the available Medicare D and Advantage plans, based on the medications taken during the prior year, similar to the report which an individual can obtain on medicare.gov; and that the AMA ask electronic medical record vendors to provide the capability to give patients on Medicare such reports.

Testimony on Resolution 106 was supportive but limited. Your Reference Committee is uncertain about the intent of Resolution 106 as originally written. Your Reference Committee also points out that the Medicare.gov website provides Medicare patients with a tool to look up estimated out-of-pocket costs under various available Medicare Part D and Medicare Advantage plans. Based on testimony from the sponsor indicating concern regarding patients' use of insurance brokers to enroll in Medicare Part D and Medicare Advantage plans, your Reference Committee developed Substitute Resolution 106 which is recommended for adoption in lieu of Resolution 106.

**(15) RESOLUTION 115 - OPPOSITION TO GENETIC TESTING RESTRICTIONS BASED ON SPECIALTY**

**RECOMMENDATION A:**

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 115 be amended by addition to read as follows:



RESOLVED, That our AMA oppose public and private payers imposing a standard of practice with requirements for utilization of non-affiliated medical specialists or non-physicians prior to ordering genetic testing (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 115 be amended by the addition of a fourth resolve to read as follows:

RESOLVED, That our AMA continue to support the importance of pre- and post-testing counseling when a patient is considered to be at risk for a hereditary susceptibility for cancer and other diseases by a qualified health professional so that patients have the benefit of informed decision-making regarding genetic testing. (New HOD Policy)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 115 be adopted as amended.

**HOD ACTION: Resolution 115 adopted as amended.**

Resolution 115 asks that our AMA oppose limiting the ordering of genetic testing based solely on physician specialty or other non-medical care based criteria, and requirements for utilization of non-affiliated medical specialists or non-physicians prior to ordering genetic testing. Resolution 115 also asks that our AMA, working with other interested specialty and component societies, communicate our opposition to non-medical restrictions to genetic testing to relevant health insurers.

Testimony was supportive of amendments that (1) suggested a new resolve clause reiterating the AMA's support of the importance of pre-and post-testing counseling by qualified health professionals for patients thought to be genetically susceptible to cancer and other diseases; and (2) specified that the AMA oppose requirements by outside agencies that the standard of practice include utilization of non-affiliated medical specialists or non-physicians prior to ordering genetic testing. Because your Reference Committee believes "outside agencies" to be vague, substitute language was offered to the second amendment to specify its intent.

Your Reference Committee appreciates the efforts of the resolution's sponsors to work collaboratively with organizations that focus on genetic testing to craft these amendments, and recommends that Resolution 115 be adopted as amended.

(16) RESOLUTION 117 - METHADONE SHOULD NOT BE DESIGNATED AS A PREFERRED ANALGESIC

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 117 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association recommend that methadone should not be designated as the sole preferred analgesic by any insurance payer, whether public or private, (New HOD Policy); ~~and be it further~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends the second resolve of Resolution 117 be deleted.

~~RESOLVED, That our AMA send letters to all of the states who currently have methadone on their Preferred Drug List that clearly states this new policy. (Directive to Take Action)~~

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 117 be adopted as amended.

**HOD ACTION: Resolution 117 adopted as amended with a title change.**

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 117 be changed to read as follows:

METHADONE SHOULD NOT BE DESIGNATED AS THE SOLE  
PREFERRED ANALGESIC

Resolution 117 asks that our AMA recommend that methadone should not be designated as a preferred analgesic by any insurance payer, whether public or private; and send letters to all of the states who currently have methadone on their Preferred Drug List that clearly states this new policy.

There was limited testimony on this resolution. An amendment was offered to specify that the AMA recommend that methadone should not be the sole preferred analgesic included on drug formularies because it contributes disproportionately to opioid-related overdose deaths when prescribed for pain. Testimony noted the substantial increase in methadone-associated overdoses that is far beyond its proportional prescribing rate.

Your Reference Committee agrees with these concerns and also points out that methadone may be prescribed for some hospice patients and neonates who may benefit from its unique properties. Furthermore, your Reference Committee believes it would be inappropriate for the AMA to send letters to all states that include methadone on their preferred drug list. Therefore, your Reference Committee recommends that Resolution 117 be adopted as amended.

(17) RESOLUTION 118 - FACILITATING STATE LICENSURE FOR  
TELEMEDICINE SERVICES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 118 be amended by addition and deletion to read as follows:

~~RESOLVED, That our American Medical Association study the issues of telemedicine and telehealth services, as well as issues of associated with state-based licensure to aid in the development of national standards to facilitate support and portability of state licensure for telemedicine services with report back at I-14. (Directive to Take Action)~~

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 118 be adopted as amended.

**HOD ACTION: Resolution 118 adopted as amended.**

Resolution 118 asks that our AMA study the issues of telemedicine and telehealth services, as well as issues of state licensure, to aid in the development of national standards to facilitate state licensure for telemedicine services.

There was mixed testimony on this resolution. A member of the Council on Medical Service suggested that the focus of the study called for in Resolution 118 be narrowed to focus on state licensure for telemedicine, as Council on Medical Service Report 7 being considered at this meeting addressed the coverage of and payment for telemedicine services. A member of the Council on Medical Education suggested an amendment to remove the reference to national standards due to strong AMA policy in support of state licensure for telemedicine. In addition, the amendment suggested that the aim of the study should be to develop standards to support portability of state licensure for telemedicine services. Other speakers concurred with striking the reference to national standards. Accordingly, your Reference Committee recommends that Resolution 118 be adopted as amended.

(18) RESOLUTION 120 - USING NASCENT TECHNOLOGY IN LIEU OF FACE-TO-FACE INTERACTION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 120 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with the Centers for Medicare & Medicaid Services to enable the use of HIPAA-compliant telemedicine and video monitoring services ~~including Skype~~ to satisfy the face-to-face requirement in recommending certifying eligibility for Medicare home health care qualifications services. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 120 be adopted as amended.

**HOD ACTION: Resolution 120 adopted as amended.**

Resolution 120 asks that our AMA work with the Centers for Medicare & Medicaid Services to enable the use of telemedicine and video monitoring services including Skype to satisfy the face-to-face requirement in recommending home care qualifications.

There was generally supportive testimony on Resolution 120. The sponsor of the resolution introduced an amendment to remove the reference in the resolution to Skype, as it is not HIPAA-compliant. While a speaker raised a concern that communications over the radio are not considered to be HIPAA-compliant, your Reference Committee notes that Resolution 120 only addresses the face-to-face encounter to certify eligibility for Medicare home health services. Your Reference Committee recommends that Resolution 120 be adopted as amended.

(19) RESOLUTION 126 - MEDICARE COVERAGE OF CONTINUOUS GLUCOSE MONITORING DEVICES FOR PATIENTS WITH INSULIN-DEPENDENT DIABETES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends adoption of Substitute Resolution 126.

RESOLVED, that our American Medical Association support efforts to achieve Medicare coverage of continuous glucose monitoring systems for patients with insulin-dependent diabetes. (New HOD Policy)

**HOD ACTION: Substitute Resolution 126 adopted.**

Resolution 126 asks that our AMA actively pursue all possible regulatory and legislative actions to achieve coverage for continuous glucose monitors (CGMs) under Medicare to help Medicare patients maintain control of their diabetes, improve their health and quality of life and prevent the costly debilitating complications of diabetes; and further, that our AMA work with all interested medical societies, patient groups, and other stakeholders to achieve coverage of CGMs under Medicare.

Testimony was limited but supportive of Resolution 126. Your Reference Committee is aware that the resolution's sponsors have been advocating with CMS on this issue. In addition, legislation introduced in the Congress (H.R. 3710) would require Medicare to cover continuous glucose monitoring systems as durable medical equipment. Your Reference Committee recommends adoption of substitute language which establishes that the AMA supports efforts to achieve coverage of these devices.

**(20) RESOLUTION 129 - CMS "TWO MIDNIGHT" POLICY****RECOMMENDATION A:**

Mr. Speaker, your Reference Committee recommends that Resolution 129 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~demand that~~ encourage the Centers for Medicare & Medicaid Services to educate the public and ~~produce documents~~ develop tools for physicians and patients that outline the ~~potential negative financial consequences~~ impact of the "two midnight" policy. (Directive to Take Action)

**RECOMMENDATION B:**

Mr. Speaker, your Reference Committee recommends that Resolution 129 be adopted as amended.

**HOD ACTION: Resolution 129 adopted as amended**

Resolution 129 asks that our AMA demand that the Centers for Medicare & Medicaid Services educate the public and produce documents that outline the potential negative financial consequences of the "two midnight" policy.

Testimony was supportive of Resolution 129. Speakers described concerns about Medicare's two-midnight policy and also spoke about the AMA's advocacy on this issue which has resulted in the policy's enforcement being delayed. Testimony also pointed to the need for tools for both patients and physicians that explain hospital admissions policy and what it means to be assigned to hospital observation status versus inpatient status. Your Reference Committee appreciates the testimony on Resolution 129 but does not believe it would be productive for the AMA to "demand" action from CMS. Instead, your Reference Committee recommends that the resolution be adopted as amended.

**(21) RESOLUTION 102 - CRITICAL ACCESS HOSPITAL NECESSARY PROVIDER DESIGNATION  
RESOLUTION 133 - ECONOMIC VIABILITY OF RURAL SOLE COMMUNITY HOSPITALS****RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends that Resolutions 102 and 133 be referred.

**HOD ACTION: Resolution 102 adopted. Resolution 133 referred.**

Resolution 102 asks that our AMA call on the Centers for Medicare & Medicaid Services to support individual states in their development of rural health networks; oppose the elimination of the state-designated Critical Access Hospital (CAH) “necessary provider” designation; and pursue steps to require the federal government to fully fund its obligations under the Medicare Rural Hospital Flexibility Program.

Resolution 133 asks that our AMA study the complex economic factors that threaten the viability of Sole Community Hospitals, and develop recommendations for advocacy and new policies addressing this urgent concern, with a report back by the 2015 Annual Meeting.

Testimony on Resolutions 102 and 133 described the value of critical access hospitals (CAHs) and sole community hospitals (SCHs), which enable rural patients to access hospital services and also provide economic benefits to rural America as large employers. Speakers also emphasized that many rural hospitals are basically on life support due to funding cuts and increased costs. Your Reference Committee is unsure whether those who testified are familiar with the report by the Office of the Inspector General at HHS, which is the subject of Resolution 102 and recommends changes to the CAH program. Therefore, your Reference Committee is hesitant to adopt new policy on CAHs without additional study. Because Resolution 133 recommends that the AMA study issues related to SCHs, your Reference Committee recommends referral of both resolutions to study the economic viability of rural hospitals and the need for new or updated AMA policy on Medicare designations for rural hospitals.

(22) RESOLUTION 108 - MODERNIZING TRICARE PAYMENT POLICIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 108 be referred.

**HOD ACTION: Resolution 108 referred with report back at I-14.**

Resolution 108 asks that our AMA help to insure the continued access of our nation’s military dependents and retirees to the services of civilian physicians by actively pursuing the modernization of Tricare policies to reflect standard fair payment policies to physicians, specifically with regard to a) accepting the “incident to” Medicare model for payment for mid-level provider services, if under the general supervision of a physician, b) paying for treatment of mental health conditions, regardless of the specialty of the treating physician, and c) covering the copayment of a Medicare patient who receives transition of care services (CPT 99495, 99496) by a physician. Resolution 108 also asks that a progress report on these discussions be presented to this House, if possible at the 2014 Interim Meeting, but no later than the 2015 Annual Meeting.

Testimony on Resolution 108 was limited and mixed. The resolution’s sponsor spoke about access problems associated with Tricare and the need to modernize Tricare payment policies so they are in line with other payment policies. Testimony from another speaker contradicted some of the specific information referenced in Resolution 108. Your Reference Committee believes that concerns about Tricare coverage and patient access to care are legitimate and worthy of further study. Your Reference Committee therefore recommends that Resolution 108 be referred.

(23) RESOLUTION 112 - MINIMUM INSURANCE BENEFITS FOR PATIENTS WITH CHRONIC PAIN

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 112 be referred.

**HOD ACTION: Resolution 112 referred.**

Resolution 112 asks that our AMA and interested stakeholders advocate for a minimum set of health insurance benefits for people in pain severe enough to require ongoing therapy; advocate for an interdisciplinary clinical approach that recognizes the interdependency of treatment methods in the treatment of chronic pain; and recommend and provide expertise for legislation to require that all payers offer coverage for a comprehensive, interdisciplinary

pain program, which would include such care modalities as cognitive-behavioral therapy, for patients who have disabling pain and have failed more conservative therapy. Resolution 112 also asks that our AMA advocate for parity in coverage for people with pain, similar to that accorded people with mental-health disorders [MHPAEA 2008].

There was mixed testimony on this resolution, with speakers expressing support for a comprehensive approach to treat chronic pain and the appropriate insurance coverage of chronic pain treatment. Other speakers expressed concern with the level and scope of insurance coverage for chronic pain highlighted in this resolution. A speaker also suggested referral of this item. Your Reference Committee agrees that this is a complex issue and that further study is needed, and therefore recommends that Resolution 112 be referred.

- (24) RESOLUTION 113 - NETWORK ADEQUACY  
RESOLUTION 125 - EXPANDING PATIENTS' CHOICE IN THE  
EXERCISE OF HEALTH INSURANCE BENEFITS  
RESOLUTION 130 - ENSURING AFFORDABLE CARE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolutions 113, 125 and 130 be referred.

**HOD ACTION: Resolutions 113, 125 and 130 referred.**

Resolution 113 asks that our AMA study the issue of network adequacy, including the impact on access to and quality of care, with a report back by the 2014 Interim Meeting; advocate for adherence to existing statutory and regulatory measures designed to ensure network adequacy, and work with state medical societies to advocate for the same in states where measures do not currently exist; and support the right of patients and physicians to seek appropriate recourse when and if harmed by inadequate networks.

Resolution 125 asks that our AMA study the growing problem of restrictions on a patient's ability to use their health insurance benefits with the providers of their choice; and report back to the House of Delegates on the extent of the problem, with recommended strategies to more effectively engage the public on the problem, and to address the issue with both state and federal government.

Resolution 130 asks that our AMA advocate for regulation and legislation to provide that insurers give reasonable credit for out of network expenses based on Fair Health toward a participant's annual deductibles and out of pocket maximums.

There was supportive testimony on Resolutions 113 and 125. A member of the Council on Medical Service indicated that the issue of network adequacy is under study by the Council on Medical Service, and welcomed referral of Resolutions 113 and 125 so that the issues raised in the resolution can be included in its report for the 2014 Interim Meeting on network adequacy, narrow networks and access to care. Testimony on Resolution 130 was limited to the sponsor. As the treatment of out-of-network expenses is directly related to narrow networks and network adequacy, your Reference Committee believes that the issue of Resolution 130 would also benefit from further study by the Council on Medical Service. As such, your Reference Committee recommends that Resolutions 113, 125 and 130 be referred.

- (25) RESOLUTION 114 - LUNG CANCER SCREENING TO BE CONSIDERED  
STANDARD CARE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 114 be referred.

**HOD ACTION: Substitute Resolution 114 adopted.**



**RESOLVED, That our American Medical Association recommend that coverage of screening low-dose CT (LDCT) scans for patients at high risk for lung cancer by Medicare, Medicaid, and private insurance be a required covered benefit.**

Resolution 114 asks that our AMA recommend that coverage of lung cancer screening for high risk patients by Medicare, Medicaid, and private insurance be a required covered benefit to ensure that everyone at risk has a fair and equitable opportunity to survive a lung cancer diagnosis.

Your Reference Committee heard mixed testimony on Resolution 114. Testimony in support of the resolution noted a reduction in morbidity and mortality associated with lung cancer resulting from the screening called for in Resolution 114. However, concerns were raised regarding the impact of the coverage of the lung cancer screening as called for in Resolution 114 on Medicare premium levels. Your Reference Committee notes that the U.S. Preventive Services Task Force recommended, with a “B” grade, annual screening for lung cancer with low-dose computed tomography in high-risk adults aged 55 to 80 years. However, the Medicare Evidence Development and Coverage Advisory Committee (MEDCAC) recently recommended against covering annual screenings for high-risk adults based on a lack of evidence to support the benefits of the screening. The final National Coverage Decision by Medicare has not yet been issued. With this discrepancy, your Reference Committee believes that the topic of Resolution 114 could benefit from further study, and accordingly recommends that Resolution 114 be referred.

(26) RESOLUTION 105 - SENIORS SLEEP

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 105 not be adopted.

**HOD ACTION: Resolution 105 not adopted.**

Resolution 105 asks that our AMA support the American Academy of Sleep Medicine in their efforts to add medical history questions discussing daytime sleepiness, snoring, and sleep breathing to the free Welcome to Medicare preventive service benefit provided to Medicare beneficiaries.

Several speakers opposed Resolution 105. While acknowledging that sleep disorders, including obstructive sleep apnea, are prevalent among the Medicare population, your Reference Committee agrees with those who questioned whether the Welcome to Medicare visit is the appropriate time to screen for sleep disorders. Welcome to Medicare visits are intended to focus on a defined set of components and already include a plethora of questions which make these visits onerous for primary care physicians. Testimony further noted that it would be burdensome to screen every patient for sleep disorders as well as potentially intrusive into the practice of medicine. For these reasons, your Reference Committee recommends that Resolution 105 not be adopted.

(27) RESOLUTION 110 - SUPPORT A NATIONAL POLL OF PHYSICIAN’S  
OPINION REGARDING A SINGLE PAYER NATIONAL HEALTH  
PROGRAM, IMPROVED MEDICARE FOR ALL

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 110 not be adopted.

**HOD ACTION: Resolution 110 not adopted.**

Resolution 110 asks that our AMA nationally survey physicians, asking the question, “When considering the topic of health care reform, would you prefer to make improvements to the current public/private system, or a single-payer system such as a “Medicare for all” approach?” Resolution 110 also asks that our AMA disseminate the survey results to physicians and the public.



There was mixed testimony on this resolution. Speakers in support of the resolution noted that the poll outlined in the resolution could monitor changes in physician opinion on health reform. Your Reference Committee also heard testimony regarding the inclusiveness of the AMA House of Delegates, as it represents all state and specialty societies. Several speakers raised concerns that Resolution 110 is inconsistent with AMA policies that oppose a single payer system, instead favoring health system reform alternatives that promote pluralism, freedom of choice, freedom of practice, and universal access for patients. Your Reference Committee notes that Resolution 110 has a fiscal note estimated to be between \$35,000 and \$68,000. Your Reference Committee agrees with testimony that the intent of Resolution 110 is inconsistent with AMA policy. As such, your Reference Committee recommends that Resolution 110 not be adopted.

(28) RESOLUTION 107 - SLEEP ILLNESS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-160.949 and D-440.943 be reaffirmed in lieu of Resolution 107.

**HOD ACTION: Policies H-160.949 and D-440.943 reaffirmed in lieu of Resolution 107.**

Resolution 107 asks that our AMA work with state and federal legislators, policymakers, state and federal agencies, insurance companies, employers, and other providers to require that patients receive a consultation with a physician and that the physician is intricately involved in the testing, treatment, and long-term management of a patient's sleep illness.

Testimony on Resolution 107 was limited. Based on testimony from the sponsor, your Reference Committee believes that the intent of the resolution relates to scope of practice, or non-physician providers attempting to treat obstructive sleep apnea. The AMA has policy that recognizes obstructive sleep apnea as a major public health issue (Policy D-440.943), and opposes allowing non-physicians to practice medicine (Policy H-160.949). Your Reference Committee recommends reaffirmation of these policies in lieu of Resolution 107.

D-440.943 Obstructive Sleep Apnea

Our AMA: (1) recognizes Obstructive Sleep Apnea (OSA) as a major public health issue; (2) encourages a national public education campaign by appropriate federal agencies and relevant advocacy groups; (3) encourage research into the association of OSA with metabolic, cardiovascular, respiratory, and other diseases; and (4) encourages that all physicians become knowledgeable about the diagnosis and management of OSA. (Res. 521, A-09)

H-160.949 Practicing Medicine by Non-Physicians

Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given; (2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers; (3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision; (4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision; and (5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine. (Res. 317, I-94; Modified by Res. 501, A-97; Appended: Res. 321, I-98; Reaffirmation A-99; Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00; Reaffirmed: CME Rep. 1, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Res. 208, I-10; Reaffirmed: Res. 224, A-11; Reaffirmed: BOT Rep. 9, I-11)

(29) RESOLUTION 111 - INCLUDING BARIATRIC SURGERY AS PART OF THE ESSENTIAL BENEFITS PLAN

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-185.964 and H-165.856 be reaffirmed in lieu of Resolution 111.

**HOD ACTION: Substitute Resolution 111 adopted.**

**RESOLVED, That our American Medical Association, consistent with H-440.842 Recognition of Obesity as a Disease, work with national specialty and state medical societies to advocate for patient access to the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions). (Directive to Take Action)**

Resolution 111 asks that our AMA advocate, in concert with national specialty societies and state medical societies, for coverage of bariatric surgery as part of the essential benefits package for health insurance plans sold through the state health insurance exchanges.

There was mixed testimony on this resolution. Supportive testimony underscored the importance of insurance coverage of bariatric surgery, in light of Policy H-440.842 that recognizes obesity as a disease. Additional speakers noted the cost of obesity to society, and the likelihood for obese persons to have other comorbidities. However, a member of the Council on Medical Service testified that the Council presented CMS Report 2 at the 2011 Annual Meeting on essential health care benefits, which stressed that the essential health benefits package needs to be flexible to enable patient choice in health plan and the respective benefits covered while still offering meaningful coverage. The Council also testified that AMA has policy that supports minimizing, not adding, benefit mandates to allow markets to determine benefit packages and permit a wide choice of coverage options. There was additional testimony in support of our AMA continuing to minimize benefit mandates, stating their direct correlation to health plan costs. Your Reference Committee concurs that our AMA should continue its efforts to minimize benefit mandates to allow for patients to have ample choice of health plan and coverage options, and therefore recommends that Policies H-185.964 and H-165.856 be reaffirmed in lieu of Resolution 111.

H-185.964 Status Report on the Uninsured

Our AMA opposes new health benefit mandates unrelated to patient protections, which jeopardize coverage to currently insured populations. (CMS Rep. 2, A-99; Reaffirmed: CMS Rep. 5, A-09)

H-165.856 Health Insurance Market Regulation

Our AMA supports the following principles for health insurance market regulation: ... (10) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically: (a) Legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed; (b) Benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and (c) Any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed. (CMS Rep. 7, A-03; Reaffirmed: CMS Rep. 6, A-05; Reaffirmation A-07; Reaffirmed: CMS Rep. 2, I-07; Reaffirmed: BOT Rep. 7, A-09; Res. 129, A-09; Reaffirmed: CMS Rep. 9, A-11; Reaffirmed in lieu of Res. 811, I-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed in lieu of Res. 125, A-12; Reaffirmed: Res. 239, A-12)

(30) RESOLUTION 131 - ALTERNATIVES TO VALUE BASED MODIFIERS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies D-390.954 and D-450.961 be reaffirmed in lieu of Resolution 131.

**HOD ACTION: Policies D-390.954 and D-450.961 reaffirmed in lieu of Resolution 131.**

Resolution 131 asks that our AMA continue to advocate for alternative mechanisms for calculating a value-based modifier (VBM) for all physicians in conjunction with efforts to identify relevant episodes of care that could be used in the calculation. Resolution 131 also asks that our AMA advocate for policy efforts that would provide an option for all physicians involved in hospital patient care to tie the VBM to their hospital's performance in the hospital value-based purchasing program, if they so choose, as it is a mechanism that appropriately measures the direct health care team physicians' value in the hospital care setting.

Your Reference Committee heard mixed testimony on this resolution. Speakers voiced concerns with advocating for alternative mechanisms for calculating a value-based modifier as called for in the first resolve, as existing policy advocates that the value-based payment modifier be repealed or significantly modified. In addition, your Reference Committee notes that Policy D-450.961 also addresses the intent of this resolution. As such, your Reference Committee recommends that Policies D-390.954 and D-450.961 be reaffirmed in lieu of Resolution 131.

#### D-390.954 Hospital-Based Physicians and the Value-Based Payment Modifier

Our AMA will continue to advocate that the Value-Based Payment Modifier program be repealed or significantly modified. (CMS Rep. 3, I-13)

#### D-450.961 Hospital-Based Physicians and the Value-Based Payment Modifier

Our AMA encourages national medical specialty societies to pursue the development of relevant performance measures that demonstrate improved quality and lower costs, and work with the Centers for Medicare & Medicaid Services to have those measures incorporated into the Value-Based Payment Modifier program and other quality measurement and improvement programs. (CMS Rep. 3, I-13)

### (31) RESOLUTION 132 - DELAYS IN MEDICAID PAYMENT FOR PROVIDER SERVICES

#### RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends Policies H-385.921, H-190.959, H-190.981 and H-390.976 be reaffirmed in lieu of Resolution 132.

#### **HOD ACTION: Policies H-385.921, H-190.959, H-190.981 and H-390.976 reaffirmed in lieu of Resolution 132.**

Resolution 132 asks that our AMA work to educate legislators and the public about the importance of maintaining financial viability for physician practices, especially as increased numbers of patients have access to insured care under the Affordable Care Act; assist states in investigating and resolving delays in payment for services provided under Medicaid; work with state and specialty societies to advocate for state level laws and regulations that ensure timely payment for services provided to Medicaid patients; and advocate with Congress and the Centers for Medicare & Medicaid Services for legislation or regulation to make permanent the requirement that medical services provided under Medicaid be reimbursed at rates no less than would be provided by Medicare.

There was supportive testimony on Resolution 132. Your Reference Committee notes that the AMA has been very active on this issue on both the state and national levels. Based on already existing policy, the AMA has sent several letters and has met with CMS officials concerning the delays and problems with Medicaid payments. In addition, the AMA has been involved in advocating with Congress to continue the increased Medicaid payments beyond 2014. The AMA also surveyed state medical societies about whether they were receiving payments. Your Reference Committee believes that existing AMA policies address the intent of Resolution 132, and therefore recommends that Policies H-385.921, H-190.959, H-190.981 and H-390.976 be reaffirmed in lieu of the resolution.

#### H-385.921 Health Care Access for Medicaid Patients

It is AMA policy that to increase and maintain access to health care for all, payment for physician providers for Medicaid, TRICARE, and any other publicly funded insurance plan must be at minimum 100% of the RBRVS Medicare allowable. (Res. 103, A-07; Reaffirmed: CMS Rep. 2, I-08; Reaffirmation A-12)

**H-190.959 Physician Reimbursement by Health Insurance and Managed Care Companies**

(1) Our AMA shall make it a top priority to seek regulatory and legislative relief to ensure that all health insurance and managed care companies pay for clean claims submitted electronically within fourteen days. (2) When electronic claims are deemed to be lacking information to make the claim complete, the health insurance and managed care companies will be required to notify the health care provider within five business days to allow prompt resubmission of a clean claim. (3) Our AMA shall advocate for heavy penalties to be imposed on health insurance and managed care companies, including their employees, that do not comply with laws and regulations establishing guidelines for claims payment. (Sub. Res. 713, A-02; Modified: Res. 714, A-03; Reaffirmation I-04)

**H-190.981 Required Timely Reimbursements by all Health Insurers**

Our AMA will prepare and/or seek sponsorship of legislation calling for all health insurance entities and third party payers--inclusive of not-for-profit organizations and health maintenance organizations--to pay for "clean" claims when filed electronically within 14 days and paper claims within 30 days, with interest accruing thereafter. These time periods should be considered ceilings, not floors or fixed differentials between paper and electronic claims. (Sub. Res. 112, A-95; Modified: BOT Rep. 17, I-00; Reaffirmation A-02; Reaffirmed: Res. 815, I-02; Reaffirmation I-04)

**H-390.976 Delayed Payment of Medical Insurance Claims**

Our AMA (1) expresses its concern and displeasure about CMS's practice of slowing payment of Medicare claims, which places an unwarranted financial burden upon the elderly and the practitioners and facilities which serve senior citizens; (2) supports model state legislation to establish incentives and/or penalties among private and public third party payers to rectify the problem of delayed insurance reimbursements; and (3) believes that reasonable interest should begin on uncontroverted claims not later than 30 days following receipt of a claim by the payer. (Sub. Res. 20, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed by Res. 138, A-98; Reaffirmation I-04; Reaffirmed: CMS Rep. 5, A-10)

**(32) BOARD OF TRUSTEES REPORT 17 – TUBAL LIGATION AND VASECTOMY CONSENTS****RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 17 be filed.

**HOD ACTION: Board of Trustees Report 17 filed.**

Board of Trustees Report 17, an informational report, concludes that there is ample evidence to support of advocating for changing Medicaid's sterilization waiting period policy, in accord with AMA policy.

Your Reference Committee heard limited testimony on Board of Trustees Report 17. A member of the Board of Trustees introduced the report, and summarized Policy D-75.994 adopted at the 2013 Interim Meeting. Additional speakers reiterated the importance of advocating for the implementation of Policy D-75.994. Your Reference Committee concurs with the conclusion outlined by the Board of Trustees in its report that there is ample evidence to support advocating for changing Medicaid's sterilization waiting period policy. Accordingly, your Reference Committee recommends that Board of Trustees Report 17 be filed.

## REPORT OF REFERENCE COMMITTEE B

- (1) BOARD OF TRUSTEES REPORT 23 – NON-PHYSICIAN PRACTITIONERS CERTIFYING MEDICARE PATIENTS’ NEED FOR THERAPEUTIC SHOES AND INSERTS

## RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation of Board of Trustees Report 23 be adopted in lieu of Resolution 213-I-12 and that the remainder of the report be filed.

**HOD ACTION: Recommendation of Board of Trustees Report 23 adopted in lieu of Resolution 213-I-12 and that the remainder of the report filed.**

The Board of Trustees recommends that our AMA support authorization of physician assistants, and nurse practitioners who practice in physician-led teams to certify Medicare beneficiaries’ need for therapeutic shoes and/or inserts. (New AMA Policy)

Your Reference Committee heard testimony strongly in support of Board of Trustees Report 23, and therefore recommends that the recommendations of Board of Trustees Report 23 be adopted in lieu of Resolution 213-I-12 and that the remainder of the report be filed.

- (2) RESOLUTION 202 – BANNING SMOKING WHILE DRIVING IN VEHICLES WHERE MINORS ARE PRESENT

## RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 202 be adopted.

**HOD ACTION: Resolution 202 adopted.**

Resolution 202 asks that our American Medical Association support legislation that prohibits smoking while operating or riding in a vehicle that contains children.

Your Reference Committee heard overwhelming supportive testimony on Resolution 202. Your Reference Committee strongly believes that Resolution 202 is consistent with longstanding AMA policy that supports tobacco-free and smoke-free environments, especially for children, to protect them from the effects of second-hand smoke. While testimony suggested that model state legislation might be warranted, your Reference Committee believes that sufficient state legislation exists so as to enable your AMA to immediately work with state and specialty medical associations interested in pursuing similar legislation at the state level. Your Reference Committee thanks the Medical Student Section for raising this important issue, and recommends that Resolution 202 be adopted.

- (3) RESOLUTION 210 – MEDICAL TEXTBOOKS AND PEER-REVIEWED JOURNAL REPRINTS PER THE SUNSHINE ACT

## RECOMMENDATION:

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

**HOD ACTION: Resolution 210 adopted.**

Resolution 210 asks that: (1) our American Medical Association work, first, with the Centers for Medicare & Medicaid Services (CMS) to administratively expand the Sunshine Act exception that covers “...educational materials that directly benefit patients or are intended for patient use” to include medical textbooks and peer-reviewed journal articles provided to physicians; {given that such resources are, in fact, ‘continuing educational materials’ that assist physicians to become better informed about their clinical decision-making and thus “...directly benefit patients...”}; and be it further, (2) that if no redress is obtained from CMS, our AMA will work with the Congress to legislatively expand the exception in ACA section 1128G(e)(10)(B)(iii) to include medical textbooks and peer-reviewed journal articles provided to physicians.

Your Reference Committee heard testimony strongly in support of Resolution 210. Your Reference Committee believes that reprints and textbooks are education materials that directly benefit patients and should be excluded from reporting under the Sunshine Act. Your Reference Committee supports efforts to obtain relief from CMS to revise this regulation or congressional action, if necessary. Therefore, your Reference Committee recommends that Resolution 210 be adopted.

(4) RESOLUTION 222 – SUNSHINE ACT AMENDMENT TO LIMIT EXPENSE REPORTING TO TRANSFERRED VALUE GREATER THAN \$100

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 222 be adopted.

**HOD ACTION: Resolution 222 adopted.**

Resolution 222 asks that our American Medical Association lobby Congress to amend the Sunshine Act to limit transfer of value reporting to items with a value of greater than \$100.

Your Reference Committee heard testimony strongly in support of Resolution 222. Your Reference Committee believes the current reporting requirement under the Sunshine Act obscures significant and relevant transfers of value and increases the potential for publication of erroneous and inaccurate information. Your Reference Committee supports efforts to improve transparency while reducing the cost and administrative burden of reporting, reviewing, and correcting a high volume of small dollar transfers, and, therefore, recommends that Resolution 222 be adopted.

(5) RESOLUTION 225 – 911 GOOD SAMARITAN LAWS

RECOMMENDATION:

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

**HOD ACTION: Resolution 225 adopted.**

Resolution 225 asks that: (1) our American Medical Association support and endorse policies and legislation that provide protections for callers or witnesses seeking medical help for overdose victims; and be it further (2) that our AMA promote 911 Good Samaritan policies through legislative or regulatory advocacy at the local, state, and national level.

Your Reference Committee heard testimony strongly in favor of Resolution 225. Testimony focused on the need to encourage individuals, such as callers or witnesses, to seek medical help for drug overdose victims without fear of a criminal justice response. Testimony also was provided that our AMA adopted similar policy supporting medical amnesty policies for underage alcohol intoxication. Accordingly, your Reference Committee recommends that Resolution 225 be adopted.



(6) RESOLUTION 228 – PROPOSED CHANGES IN MEDICAL REQUIREMENTS FOR 3RD CLASS PILOTS' LICENSES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 228 be adopted.

**HOD ACTION: Resolution 228 adopted.**

Resolution 228 asks: (1) that our American Medical Association oppose efforts to substitute the third class medical certificate with a driver's license; and be it further (2) that our AMA write a letter encouraging the Federal Aviation Administration to retain the third class medical certification process.

Your Reference Committee heard overwhelming testimony in support of Resolution 228. In particular, your Reference Committee heard testimony that it would not be in the best interest of pilots or public safety to allow pilots to fly recreationally without having to hold an Federal Aviation Administration-issued medical certificate of any class. As such, testimony strongly suggested that any effort to supplant the third class medical certification process with a state driver's license be opposed. Therefore, your Reference Committee recommends that Resolution 228 be adopted.

(7) RESOLUTION 229 – ADVANCE APPROPRIATIONS FOR THE INDIAN HEALTH SERVICE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 229 be adopted.

**HOD ACTION: Resolution 229 adopted.**

Resolution 229 asks that: (1) our American Medical Association request that Congress amend the Indian Health Care Improvement Act to authorize Advanced Appropriations; and be it further (2) that our AMA request that Congress include our recommendation for IHS Advanced Appropriations in the Budget Resolution; and be it further (3) that our AMA request that Congress include in the enacted appropriations bill IHS Advanced Appropriations.

Your Reference Committee heard testimony largely in support of Resolution 229. Your Reference Committee heard compelling testimony on the number of states with large Native American populations that depend on the Indian Health Service (IHS) for their health care. Testimony highlighted that these populations have been severely affected by cuts to IHS funding and are facing the likelihood of significant reductions in services offered, with potentially life-threatening consequences for patients. Your Reference Committee strongly agrees with this testimony and recognizes that it is critical that appropriations for IHS be stabilized and established in advance to ensure IHS is maintained at appropriate funding levels. Your Reference Committee also agrees with testimony highlighting the need to support those physicians who work for the IHS. Therefore, your Reference Committee recommends that Resolution 229 be adopted.

(8) BOARD OF TRUSTEES REPORT 19 – COUNCIL ON LEGISLATION SUNSET REVIEW OF 2004 HOUSE POLICIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 19 be amended by addition, to read as follows:

The Board of Trustees recommends that the House of Delegates policies listed in Appendix 1 to this report be acted upon in the manner indicated, with the



exception of Policies H-250.987 and H-415.998 that should be retained, and the remainder of this report be filed.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 19 be adopted as amended and the remainder of the report be filed.

**HOD ACTION: Board of Trustees Report 19 adopted as amended and the remainder of the report filed.**

Board of Trustees Report 19 recommends that the House of Delegates policies listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. Your Reference Committee heard overwhelming supportive testimony on Board of Trustees Report 19. Testimony, however, highlighted that the report should be amended to retain two policies that were recommended for rescission: H-250.987, Duty-Free Medical Equipment and Supplies Donated to Foreign Countries and H-415.998, Preferred Provider Organizations. Your Reference Committee agrees with this change and the remainder of the Report's recommendation regarding the listed policies. Accordingly, your Reference Committee recommends that Board of Trustees Report 19 be amended to retain Policies H-250.987 and H-415.998, and that the remainder of the report be filed.

(9) BOARD OF TRUSTEES REPORT 22 – RESTRICTING PRESCRIPTIONS TO MEDICARE BENEFICIARIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendation of Board of Trustees Report 22 be amended by addition and deletion to read as follows:

1. That our AMA work with the Centers for Medicare & Medicaid Services and state medical societies as needed to preserve access to care and ~~reduce~~eliminate the burden of provisions in the Patient Protection and Affordable Care Act that require physicians to enroll in Medicare, Medicaid and other governmentally sponsored health insurance programs as a condition of referring, ordering or prescribing for patients enrolled in these programs. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends the addition of a second recommendation to Board of Trustees Report 22 to read as follows:

2. That our AMA support federal legislation to eliminate the burden of provisions in the Patient Protection and Affordable Care Act that require physicians to enroll in Medicare, Medicaid and other governmentally sponsored health insurance programs as a condition of referring, ordering or prescribing for patients enrolled in these programs. (Directive to Take Action)

RECOMMENDATION C:

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

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

The Board of Trustees recommends: That our AMA work with the Centers for Medicare & Medicaid Services and state medical societies as needed to preserve access to care and reduce the burden of provisions in the Patient Protection and Affordable Care Act that require physicians to enroll in Medicare, Medicaid and other governmentally sponsored health insurance programs as a condition of referring, ordering or prescribing for patients enrolled in these programs.

Your Reference Committee heard testimony in support of Board of Trustees Report 22. Your Reference Committee heard testimony on the various ordering and referring enrollment requirements and observed particular concern about the requirement for prescribers of Part D drugs to be enrolled in Medicare. Testimony stated that our AMA has previously been successful in shaping the implementation of similar requirements for physicians who order and refer certain imaging, lab, durable medical equipment (DME), and home health services. As CMS moves forward with the implementation for Part D prescribers, our AMA will continue its strong advocacy to oppose regulatory burdens flowing from the requirement. Testimony asked our AMA to support federal legislation consistent with these advocacy efforts. Your Reference Committee also agrees with testimony suggesting that our AMA work to eliminate, not reduce, these regulatory burdens. Therefore, your Reference Committee recommends that the recommendations of Board of Trustees Report 22 be adopted as amended and the remainder of the report be filed.

(10) RESOLUTION 203 – E-PRESCRIBING AND MEANINGFUL USE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 203 be amended by addition to read as follows:

RESOLVED, That our American Medical Association petition the Centers for Medicare & Medicaid Services and the federal government to have all pharmacies, including government pharmacies, accept e-prescriptions or to temporarily halt the e-prescribing requirements of meaningful use until this is accomplished. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 203 be adopted as amended.

**HOD ACTION: Resolution 203 adopted as amended.**

Resolution 203 asks that our American Medical Association petition the Centers for Medicare & Medicaid Services and the federal government to have all government pharmacies accept e-prescriptions or to temporarily halt the e-prescribing requirements of meaningful use until this is accomplished.

Your Reference Committee heard mixed testimony on Resolution 203. Testimony highlighted the patient safety concerns that arise where pharmacies are unable to accept electronic prescriptions. Other testimony addressed problems with the Meaningful Use (MU) program and the challenges physicians are facing in meeting the program's prescriptive requirements. To mitigate this burden, an amendment was offered to remove government pharmacies from the denominator of the MU e-prescribing measure; however, subsequent testimony suggested that this change would not accomplish the intended goal of this Resolution since other pharmacies will still not accept e-prescriptions. To reconcile these opinions, while still supporting the purpose of this Resolution, your Reference Committee recommends that Resolution 203 be amended to ensure that all pharmacies, including government pharmacies, accept e-prescriptions. Accordingly, your Reference Committee recommends that Resolution 203 be adopted as amended.

- (11) RESOLUTION 204 – MEDICARE CLAIMS DATA RELEASE  
RESOLUTION 211 – RELEASE OF PROVIDER-SPECIFIC MEDICARE  
PART B PAYMENT DATA BY CMS  
RESOLUTION 226 – RELEASE OF PHYSICIAN MEDICARE CLAIMS  
DATA

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 204 be adopted in lieu of Resolutions 204, 211 and 226.

MEDICARE CLAIMS DATA RELEASE

RESOLVED, That our American Medical Association continue to work with the Centers for Medicare & Medicaid Services to identify appropriate modifications to improve the usefulness and accuracy of any existing or future provider-specific data released by that agency. (Directive to Take Action); and be it further

RESOLVED, That our AMA engage with data experts and other stakeholders to develop guiding principles on the data and transparency efforts that should be pursued in order to assist physicians to improve the quality of care and reduce costs. (Directive to Take Action)

**HOD ACTION: Substitute Resolution 204 adopted in lieu of Resolutions 204, 211 and 226.**

Resolution 204 asks: (1) that our American Medical Association adopt policy condemning the release of the Centers for Medicare & Medicaid Services (CMS) flawed and misleading Medicare claims data; and be it further; (2) that our AMA adopt policy opposing the release of such information to the general public without an explanation as to the distribution of those dollars; and be it further (3) that the current data release be further clarified to reflect the distribution. Resolution 211 asks that our American Medical Association work with the Centers for Medicare & Medicaid Services to identify appropriate modifications that might improve the usefulness and accuracy of any existing or future provider-specific data released by that agency. Resolution 226 asks that our American Medical Association use regulatory or legislative means to accomplish changes to Centers for Medicare & Medical Services' (CMS) policy 1) allowing for physician review of the physician claims data prior to release in order to allow corrections of systematic problems and assistance with detailed data, and 2) establishing a feedback mechanism and process for correcting errors and making changes in the data; and be it further that our AMA prepare data and other information with the purpose of assisting media and lawmakers with appropriate interpretation of the data in cases of future data releases by CMS; and that our AMA will release such information to the media before or concurrently with any release of physician data by CMS.

Your Reference Committee heard mixed testimony with respect to Resolutions 204, 211, and 226. Testimony in support of these resolutions stated that the claims data released by the Centers for Medicare & Medicaid Services (CMS) has limited use to physicians and was easily misinterpreted due to the lack of safeguards or clear explanations published alongside the data. Those in support of the Resolutions emphasized that physicians, at a minimum, should have the authority to review and correct their individual data. Others testified that the data release could improve transparency and provide needed information on health care services.

Additional testimony acknowledged the extensive advocacy by our AMA to improve the existing format of the claims data, educate reporters about the appropriate use of the data, and ensure that future publication of such data is focused on providing information that is useful and beneficial to patients and physicians. Testimony also highlighted that CMS has recently released additional hospital data, signaling that that the agency is still focused on transparency initiatives and may release more physician claims data in the future. In light of these views and actions by CMS, your Reference Committee recommends a substitute resolution that encompasses the goals expressed in Resolutions 204, 211, and 226.

Your Reference Committee believes that the language of this substitute resolution captures the concerns expressed in testimony and is sufficiently broad to maximize the flexibility of AMA advocacy efforts to address future publications of physician information. The substitute resolution seeks to mitigate problems related to the current data release, while reflecting that our AMA is actively working to improve this information. The substitute resolution would also include proactive recommendations on how to improve any future release of physician data to help educate patients and improve the quality of care. Your Reference Committee, therefore, recommends that Substitute Resolution 204 be adopted in lieu of Resolutions 204, 211 and 226.

(12) RESOLUTION 207 – ICD-10 TRANSPARENCY AND CONVERSION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 207 be amended by addition and deletion to read as follows:

RESOLVED, That during the delay in implementation of the ICD-10 transition our AMA will seek and support ~~new federal legislation and/or administrative rules~~ efforts to ~~that~~ ensure that:

- any health plan (commercial, Medicare, Medicaid, or other) markets operating in the United States, ~~whether in the commercial or Medicare or Medicaid markets~~, shall provide to their provider network sufficient and timely information apprising providers of all planned changes, including ~~to~~ coverage, guidelines, authorization, certifications, claims adjudications, pricing, payment, reporting, incentives and other rules, as well as resources such as crosswalks or maps, based on the conversion from ICD-9 to ICD-10.
- ~~and that such information shall include but not be limited to any “cross-walk” or “map” which will be used internally by the health plan to achieve the conversion from ICD-9 to ICD-10. (Directive to Take Action)~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 207 be adopted as amended.

**HOD ACTION: Resolution 207 adopted as amended.**

Resolution 207 asks that our American Medical Association affirm that the provisions of the Protecting Access to Medicare Act of 2014 delaying the compliance date for the ICD-10 transition are consistent with and supported by existing AMA policy; and be it further that during the delay in implementation of the ICD-10 transition our AMA will seek and support new federal legislation and/or administrative rules that ensure that: (1) any health plan operating in the United States, whether in the commercial or Medicare or Medicaid markets, shall provide to their provider network sufficient information apprising providers of all planned changes to coverage, guidelines, authorization, certifications, claims adjudications, pricing, payment, reporting, incentives and other rules based on the conversion from ICD-9 to ICD-10, and (2) that such information shall include but not be limited to any “cross-walk” or “map” which will be used internally by the health plan to achieve the conversion from ICD-9 to ICD-10.

Your Reference Committee heard testimony in support of Resolution 207. Testimony highlighted the problems and costs of adopting ICD-10 and was generally supportive of the additional one-year delay enacted as part of the Protecting Access to Medicare Act of 2014. Testimony also noted the need for health plans to be transparent with respect to coverage and claims processing changes that may occur as a result of implementation of the new code set. An amendment was offered to include an implementation period where plans would be required to accept codes from ICD-9, ICD-10, or both, as well as another change to speed the implementation of ICD-11. However, others recognized that these changes may cause implementation problems and suggested that consideration of ICD-11 may

not be appropriate at this time. Testimony also noted that, while physicians and others should have access to any maps and crosswalks used by a health plan to facilitate the conversion to ICD-10, certain information may be proprietary and suggested amending the language to incorporate this concern. Based on this testimony, your Reference Committee recommends that Resolution 207 be amended. Specifically, your Reference Committee agrees with the suggestion relevant to maps and crosswalks. In addition, federal laws and regulations are unlikely to formalize these requirements, which may be more effectively accomplished through other advocacy efforts. Your Reference Committee also believes that the intent of this resolution would encourage that information be provided in a timely manner to inform physicians prior to the ICD-10 compliance date. Therefore, your Reference Committee recommends that Resolution 207 be adopted as amended.

- (13) RESOLUTION 208 – COMPLETING THE ELECTRONIC PRESCRIPTION LOOP FOR CONTROLLED SUBSTANCES  
RESOLUTION 209 – IMPROVEMENT OF ELECTRONIC PRESCRIPTION SOFTWARE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 209 be adopted in lieu of Resolution 208.

**HOD ACTION: Resolution 208 adopted. Resolution 209 adopted as amended.**

RESOLVED, That our American Medical Association advocate for changing the national standards for controlled substance prescriptions so that prescriptions for controlled substances can be transmitted electronically directly to the pharmacy in a secure manner (Directive to Take Action); and be it further

RESOLVED, That our AMA work with pharmacies, vendors, the national pharmacy bodies and other appropriate entities ~~which set standards for the software that allows electronic transmission of prescriptions~~ to encourage the use of standards ~~addition of a feature to that software~~ that would allow the transmission of short messages regarding prescriptions so that both physicians and pharmacists could communicate directly with each other within the secure health records systems that they are already using. (Directive to Take Action)

Resolution 208 asks that our American Medical Association seek from the US Drug Enforcement Administration (DEA) and/or Centers for Medicare & Medicaid Services (CMS) a requirement that all pharmacies and Pharmacy Benefits Managers (PBMs) acquire and implement the appropriate electronic prescribing of controlled substances (EPCS) software application to accept electronically transmitted controlled substance prescriptions from any physician or hospital-based computer system that complies with CMS and DEA certification requirements on e-prescribing. Resolution 209 asks that our American Medical Association advocate for changing the national standards for controlled substance prescriptions so that prescriptions for controlled substances can be transmitted electronically directly to the pharmacy in a secure manner; and be it further that our AMA work with the national pharmacy bodies and other appropriate entities which set standards for the software that allows electronic transmission of prescriptions to encourage the addition of a feature to that software that would allow the transmission of short messages regarding prescriptions so that both physicians and pharmacists could communicate directly with each other within the secure health records systems that they are already using.

Your Reference Committee heard favorable testimony on Resolutions 208 and 209. Your Reference Committee strongly believes that barriers to e-prescribing controlled substances should be removed since e-prescribing has the potential to reduce diversion and prescription drug abuse as well as may assist with health information technology reporting requirements. Modification to the current standards and software, as proposed in Resolution 209, is likely to facilitate implementation and include additional elements to allow for transmission of essential information needed by pharmacists when controlled substances are prescribed and dispensed. Your Reference Committee is concerned, however, that a federal mandate on pharmacy benefit managers and pharmacies, as proposed in Resolution 208, federalizes state-based activities in this area and federal mandates could further extend to

physicians. The Drug Enforcement Administration (DEA) already permits e-prescribing of controlled substances when the proper requirements are met. In addition, your Reference Committee believes that existing AMA policy addresses the concerns contained in Resolution 208. In particular, D-120.958 calls on our AMA to “investigate regulatory barriers to electronic prescription of controlled substances so that physicians may successfully submit electronic prescriptions for controlled substances..., work with the Centers for Medicare & Medicaid Services to eliminate from any program (e.g., the Physician Quality Reporting System, meaningful use, and e-Prescribing) the requirement to electronically prescribe controlled substances, until such time that the necessary protocols are in place for electronic prescribing software vendors and pharmacy systems to comply, [and]...work with representatives of pharmacies, pharmacy benefits managers, and software vendors to expand the ability to electronically prescribe all medications.” For these reasons, your Reference Committee recommends that Resolution 209 be adopted in lieu of Resolution 208.

(14) RESOLUTION 215 – REDUCING GUN VIOLENCE  
RESOLUTION 224 – FIREARM VIOLENCE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends adoption of Substitute Resolution 215 in lieu of Resolution 224.

RESOLVED, That our American Medical Association support Congressional passage of legislation requiring licensing and background checks for all buyers of firearms.

**HOD ACTION: Substitute Resolution 215 referred.**

Resolution 215 asks that our American Medical Association support Congressional passage of legislation requiring criminal background checks for all gun sales, public and private.

Resolution 224 asks that our American Medical Association support federal efforts to promote legislation to make licensing and background checks mandatory for all firearm purchases and transfers regardless of seller or individual making a transfer.

Your Reference Committee heard overwhelming testimony in support of the intent of both Resolutions 215 and 224. Our AMA has long-standing policy related to the issues addressed in these resolutions. The sentiments expressed during the testimony are not only timely but also of great public health importance. In order to fully capture the essence of the testimony heard, your Reference Committee believes that a substitute resolution is appropriate. Your Reference Committee agrees that the substitute resolution should include a broader definition in terms of background checks, consistent with existing AMA policy. Your Reference Committee also is concerned that there may be circumstances where federal legislation related to background checks for the transfer of all firearms would be unworkable and raises questions as to the feasibility of implementing such a background check system. As a result of all of the above, your Reference Committee recommends that substitute Resolution 215 be adopted in lieu of Resolution 224.

(15) RESOLUTION 218 – OPPOSE THE VALUE MODIFIER OR VALUE-BASED PATIENT MODIFIER

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends adoption of Substitute Resolution 218.

IMPROVEMENTS TO THE VALUE-BASED MODIFIER



RESOLVED, That our American Medical Association seek a delay in the Value-Based Modifier (VBM) penalty for smaller practices (Directive to Take Action); and be it further that

RESOLVED, That our AMA continue to encourage selection of VBM quality measures that are physician-defined, clinically meaningful, specialty-appropriate, realistic, and within reasonable control of the physician. (Directive to Take Action)

**HOD ACTION: Substitute Resolution 218 adopted as amended.**

Resolution 218 asks: (1) that our American Medical Association immediately study Medicare’s roll-out of the “value modifier” or “value-based payment modifier” program to all physicians by 2017 including the impact of rewards and penalties based on flawed quality measures and the failed Physician Quality Reporting System program and advocate for the abolition of this approach until solid performance indicators are tried, tested, and widely accepted; and be it further (2) that our AMA educate physicians about the ramifications of Medicare’s “value modifier” or “value-based payment modifier” program that could be another SGR in the making in light of the *New England Journal of Medicine* comment that “the medical profession has been remarkably quiet as this flawed approach proceeds.”

Your Reference Committee heard mixed testimony on Resolution 218. Testimony expressed the unfairness of the value-based modifier (VBM), problems with its methodology, and the substantial administrative and financial burden required to successfully participate. Testimony noted that existing AMA policy covered many of the points of Resolution 218, and suggested an amendment that would focus on advocating for relief for small practices and improvements in the VBM quality measures. Your Reference Committee agrees that our AMA must continue to advocate for improving the VBM and generally supports the offered amendment. Your Reference Committee seeks to ensure flexibility for our AMA advocacy efforts and, therefore, suggests a slightly broader approach with respect to small practices than what was defined in the proposed amendment. Your Reference Committee, however, believes this approach is consistent with the intent of the proposed amendment. Accordingly, your Reference Committee recommends Substitute Resolution 218 be adopted in lieu of Resolution 218 with a change in title that better reflects the intent of this resolution.

(16) RESOLUTION 220 – TRANSPARENCY, PARTICIPATION, AND ACCOUNTABILITY IN CMS’ PAYMENT DETERMINATION PROCESS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 220 be amended by addition to read as follows:

RESOLVED, That our American Medical Association urgently advocate for the Centers for Medicare and Medicaid Services (CMS) to improve its rate-setting processes by first publishing modifications to Medicare physician fees that result from CMS’ misvalued codes initiative in the Medicare Physician Fee Schedule proposed rule instead of the final rule to afford adequate time for providers, professional medical societies and other stakeholders to review and comment on such changes before they take effect.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 220 be adopted as amended.

**HOD ACTION: Resolution 220 adopted as amended.**

Resolution 220 asks: (1) that our American Medical Association advocate for the Centers for Medicare and Medicaid Services (CMS) to improve its rate-setting processes by first publishing modifications to Medicare physician fees that result from CMS' misvalued codes initiative in the Medicare Physician Fee Schedule proposed rule instead of the final rule to afford adequate time for providers, professional medical societies and other stakeholders to review and comment on such changes before they take effect; and be it further; (2) that our AMA demand that CMS be transparent in its processes and methodologies for establishing physician work values and allow adequate opportunity for public comment on its methodologies before changes in physician work values take effect.

Your Reference Committee heard overwhelmingly supportive testimony regarding Resolution 220 and the need for greater transparency and opportunities for input into how CMS sets relative values for physicians' services, especially when they depart from the RVS Update Committee (RUC) recommendations. Testimony described how AMA policy and advocacy support the general principles behind this resolution. Testimony also supported that it would be helpful to move the publication of changes in relative values, resulting from the review of potentially misvalued codes, up to the physician fee schedule proposed rule, to provide an opportunity for notice and comment by physicians, specialties, and other stakeholders. Your Reference Committee agrees with this testimony and testimony suggesting that our AMA's advocacy be urgently conveyed. Consequently, your Reference Committee recommends that Resolution 220 be adopted as amended.

- (17) RESOLUTION 231 – ENCOURAGING PHYSICIAN PARTICIPATION IN VETERANS' CARE  
RESOLUTION 233 – IMMEDIATE RESOLUTION OF VETERANS ADMINISTRATION WAITING LISTS FOR VETERAN ACCESS TO CARE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends adoption of Substitute Resolution 231 in lieu of Resolution 233.

ENSURING ACCESS TO CARE FOR OUR VETERANS

RESOLVED, That our American Medical Association encourage all physicians to participate, when needed, in the health care of veterans (New HOD Policy); and be it further

RESOLVED, That our American Medical Association support providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner; (New HOD Policy); and be it further

RESOLVED, That our AMA advocate strongly that 1) the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion, 2) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans, and 3) that the AMA issue a press release regarding these actions by June 12, 2014 (New HOD Policy); and be it further

RESOLVED, That our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration (New HOD Policy).

**HOD ACTION: Substitute Resolution 231 adopted as amended in lieu of Resolution 233.**

Resolution 231 asks that our American Medical Association encourage all physicians to participate in the health care of veterans; and be it further that our AMA develop guidelines to aid physicians who wish to participate in the VA health care program and publicize to the physician community the availability of these guidelines. Resolution 233 asks that our American Medical Association publicly insist (by June 12, 2014) that the President of the United States take immediate action to provide full health coverage financial benefits to ensure that United States Veterans can rapidly access the Medical care they need outside the Veterans Administration (VA) until the VA can provide promised care.

Your Reference Committee heard unanimous testimony in support of the intent of Resolutions 231 and 233. Testimony acknowledged that all Americans should have access to health care, especially those who bravely serve our country. Testimony also discussed the deep concern with current wait times for veterans at certain VA hospitals and the lack of appropriate policies to address these access to care problems. Testimony emphasized that our veterans are deserving of the highest-quality, coordinated, physician-led team-based care, while other testimony encouraged that any resolution adopted by our House of Delegates focus on providing care to veterans and not be watered-down with related but secondary concerns. Those testifying also noted pending legislation in Congress and action by the Administration designed to quickly address and provide solutions to these issues. Your Reference Committee agrees that our AMA should support solutions to these problems by encouraging physicians to participate in the care of veterans. Furthermore, your Reference Committee believes that our nation must guarantee that benefits offered outside of the Veterans Administration are comprehensive. Your Reference Committee, therefore, recommends adoption of Substitute Resolution 231 that highlights our commitment to ensuring care for our veterans.

(18) RESOLUTION 232 – COMPLIANCE WITH "MEANINGFUL USE" REQUIREMENTS AS A CONDITION OF MEDICAL LICENSURE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 232 be amended by addition to read as follows:

RESOLVED, That our AMA, working with state and specialty medical societies, make efforts at all appropriate levels of government to secure the reversal of any requirements that medical licensure be conditioned upon compliance with "Meaningful Use" requirements. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 232 be adopted as amended.

**HOD ACTION: Resolution 232 adopted as amended.**

Resolution 232 asks that our American Medical Association stand on record as opposing any requirement that medical licensure be conditioned upon compliance with "Meaningful Use" requirements; and be it further that our AMA, working with state medical societies, make efforts at all appropriate levels of government to secure the reversal of any requirements that medical licensure be conditioned upon compliance with "Meaningful Use" requirements.

Your Reference Committee heard strong support for Resolution 232. Testimony highlighted the significant problems physicians are facing in meeting the Meaningful Use (MU) requirements due to the pass-fail approach of the program. In addition, testimony explained that the measures do not apply to all specialties, require significant costs for practices, and are not evidence-based. Accordingly, tying licensure to the MU program would place many physicians at risk of losing their ability to practice despite the fact that these physicians provide high quality care to patients and are competent practitioners. Your Reference Committee recognizes that many physicians are opting out of the MU program due to the lack of available technology and usable electronic health records (EHRs) and that these barriers should not impact a physician's license to practice medicine.

In addition, your Reference Committee notes that your AMA has developed model state legislation that prohibits conditioning medical licensure upon compliance with MU. This model state legislation, which is available through our AMA Advocacy Resource Center, also prohibits conditioning physician licensure upon participation in any public or private insurance plan, public health care system, public service initiative, or emergency room coverage. Your Reference Committee agrees with testimony suggesting that our AMA work with both state and specialty medical associations to effectuate the intent of this resolution. Therefore, your Reference Committee recommends that Resolution 232 be adopted as amended.

(19) RESOLUTION 201 – MEDICATION MANAGEMENT IN ASSISTED LIVING FACILITIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 201 be referred.

**HOD ACTION: Resolution 201 referred.**

Resolution 201 asks: (1) that our American Medical Association create a national policy in support of medication management and administration by appropriately trained facility staff for residents of assisted living, sheltered care, and dementia care facilities; and be it further, (2) that our AMA support or cause to be introduced federal legislation fostering medication management and administration by appropriately trained facility staff for residents of assisted living, sheltered care, and dementia care facilities.

Your Reference Committee heard mixed testimony on Resolution 201. Testimony highlighted the risks of adverse events associated with improper medication management and administration particularly for vulnerable patient populations in an institutional setting. Testimony also highlighted the need for physician leadership of the health care team. Your Reference Committee agrees with testimony that the issues raised in Resolution 201 are of sufficient complexity to warrant further study, particularly to clarify the scope of medication management and administration and to identify which types of staff may be sufficiently qualified to manage medications under physician direction. Therefore, your Reference Committee recommends that Resolution 201 be referred.

(20) RESOLUTION 213 – MEDICAL INFORMATION AND ITS USES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 213 be referred.

**HOD ACTION: Resolution 213 referred.**

Resolution 213 asks that our AMA work with federal agencies involved in the collection, receipt, and transfer of physician and patient data, including but not limited to demographic, financial, and encounter information, to make publicly known the aggregate information that is being gathered, and to which entities the information is being distributed or sold.

Your Reference Committee heard generally supportive testimony on Resolution 213. Testimony highlighted government initiatives that are already working to provide access to agency data through the Administration's Open Data Policy and HealthData.gov. In addition, testimony highlighted broader concerns with respect to the collection and transfer of this data, including protecting privacy, confidentiality, and appropriate use of this information. Your Reference Committee agrees that these issues warrant further study and therefore, recommends that Resolution 213 be referred.

(21) RESOLUTION 217 – LIABILITY RELATED TO REFERRALS FROM FREE CLINICS

RECOMMENDATION:

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

**HOD ACTION: Resolution 217 referred.**

Resolution 217 asks that our American Medical Association work to enact regulations to provide immunity from medical malpractice lawsuits to physicians who provide charity care at their offices or clinics to patients referred from free clinics similar to the immunity that would have been granted to those physicians had they performed those services within the scope of the work at the free clinic per the Free Clinic Federal Tort Claims Act (FTCA) Medical Malpractice Program at both the state and federal levels.

Your Reference Committee heard strong testimony in support of Resolution 217. Testimony highlighted that the protections afforded to physicians working in free clinics should not be limited to these facilities, but should be extended to physicians who also provide free services to these patients. Testimony emphasized that, without these protections, physicians are exposed to liability and may be deterred from providing charity care. However, testimony also noted the complexity of liability protections under the Federal Tort Claims Act, particularly with regard to differences in which types of clinics currently enjoy these important protections. Your Reference Committee agrees that these issues warrant further study and, therefore, recommends that Resolution 217 be referred.

(22) RESOLUTION 227 – OPPOSITION TO LABORATORY REPORTING PROVISIONS OF HR 4302

RECOMMENDATION:

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

**HOD ACTION: Resolution 227 referred.**

Resolution 227 asks that our American Medical Association seek changes in law to eliminate the private sector laboratory reporting requirement in HR 4302 and prohibit the use of such reporting information for rate setting.

Your Reference Committee heard mixed testimony concerning Resolution 227. Your Reference Committee believes that the reporting of private sector payment rates for laboratories presents a number of complex and unresolved issues that will not be clarified until the Centers for Medicare & Medicaid Services (CMS) promulgates regulations or issues guidance. Your Reference Committee supports efforts to improve price transparency but is concerned that burdensome reporting requirements may undermine competition and access to an array of clinical laboratories. Your Reference Committee also heard testimony from our AMA Council on Legislation that recommended referral of Resolution 227 for further study, potentially with report back by the 2014 Interim Meeting of our AMA House of Delegates. Therefore, your Reference Committee recommends that Resolution 227 be referred.

(23) RESOLUTION 230 – DEVELOPMENT AND PROMOTION OF USE OF SINGLE NATIONAL PRESCRIPTION DRUG MONITORING PROGRAM

RECOMMENDATION:

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

**HOD ACTION: Resolution 230 referred.**

Resolution 230 asks: (1) that our AMA encourage the creation of one national prescription drug monitoring program (PDMP) database of controlled substances for physicians to detect and monitor prescription drug abuse; and be it further (2) that our AMA oppose requirements that physicians must consult prescription drug monitoring programs before prescribing medications; and be it further (3) that a national PDMP not add undue burden onto patients who need chronic controlled substance treatments or the physicians who prescribe them.

Your Reference Committee heard significant testimony regarding Resolution 230. Testimony in support of this resolution highlighted that state-level Prescription Drug Monitoring Programs (PDMPs) can provide helpful clinical information if the PDMP has reliable information. Several testified as to the need to share information across state lines. Some identified the fact that several neighboring states across the country were forming collaboratives and/or pilots with the intent to share such information. Nevertheless, there seemed to be confusion as to the extent of these state pilots. Your Reference Committee also heard testimony concerned about the feasibility and cost of a national PDMP. According to the testimony, these databases largely contain information based on state licensing data. National infrastructure would be a costly and may require an overhaul of existing law, guidance, and state initiatives. There was also concern raised that a national PDMP may impose more burdens on physicians. Drug diversion and abuse is a national crisis. Our AMA is significantly involved in shaping the public policy debate at both the state and federal level on this issue. Your Reference Committee wishes to acknowledge the work of several members of our AMA Board of Trustees who have testified over the last two years, resulting in significant positive changes in the positions of national policymaking organizations like the National Governors Association, National Conference of Insurance Legislators, and others. Because of the timeliness of this issue, as well as its grave importance and complexity, your Reference Committee recommends that Resolution 230 be referred.

(24) RESOLUTION 219 – PATIENT PROTECTION FROM FORCED SWITCHING OF PATENT-PROTECTED DRUGS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 219 be referred for decision.

**HOD ACTION: Resolution 219 referred for decision.**

Resolution 219 asks: (1) that our American Medical Association petition the Food and Drug Administration (FDA) of the United States of America to change FDA policy to require pharmaceutical manufacturers who sell products in the United States and its jurisdictions to continue selling all doses and forms of products covered by patent protection, for the entire life of the patent, unless a manufacturer ceases to produce or sell all doses and forms of the involved product; and be it further (2) that if the FDA does not require continued access to all doses and forms of patent-protected pharmaceutical products, the FDA shall change policy to require pharmaceutical manufacturers to relinquish patent protection for the doses and forms of products no longer produced or sold by a manufacturer. The FDA shall require that pharmaceutical manufacturers who relinquish patent protection for any doses or forms of products will not bring legal action against any generic pharmaceutical manufacturer that produces and sells doses or forms of products for which patent-protection has been relinquished; and be it further (3) that FDA policy changes to protect the public's access to safe, affordable medications, while continuing patent protections afforded to pharmaceutical manufacturers, shall apply to all FDA-approved drugs that are protected by patents.

Your Reference Committee heard mixed testimony in support of Resolution 219. Your Reference Committee believes that this Resolution raises complex legal and free market questions. Testimony from an FDA representative also highlighted that the FDA does not have the statutory or regulatory authority proposed by this Resolution. In response, testimony asked our AMA to pursue federal legislation to effectuate the intent of this resolution. Testimony also recommended that our AMA study the application of this issue to medication delivery devices. Your Reference Committee supports efforts to address subversion of current FDA regulation that negatively impacts access to medically necessary dosages, and agrees that this Resolution requires immediate study and action. Therefore, your Reference Committee recommends that Resolution 219 be referred for decision.



(25) RESOLUTION 212 – SPECIAL INSPECTOR GENERAL TO OVERSEE IMPLEMENTATION OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 212 not be adopted.

**HOD ACTION: Resolution 212 not adopted.**

Resolution 212 asks that our American Medical Association support the creation of a special inspector general to oversee the administration of the Patient Protection and Affordable Care Act (ACA).

Your Reference Committee heard conflicting testimony on Resolution 212. Those who testified in support of adoption argued that given the complexity, cost, and impact of the Affordable Care Act (ACA), a Special Inspector General is necessary to ensure transparency and accountability, and protect taxpayers against unnecessary and costly waste, fraud, and abuse. On the other hand, testimony against adoption of Resolution 212 argued that a Special Inspector General is not needed since the Office of the Inspector General for Health and Human Services (OIG) is already monitoring the implementation of the ACA and the OIG's Work Plan for 2014 includes a focus on operation of the new Health Insurance Exchanges and the expanding Medicaid program. Testimony also questioned the cost and prudence of establishing a new federal agency for these purposes. Further, our AMA recognizes that our past advocacy efforts have closely monitored implementation of the ACA and its impact on physicians. Therefore, your Reference Committee recommends that Resolution 212 not be adopted.

(26) RESOLUTION 205 – PAY FOR PERFORMANCE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-450.947, H-450.941, and D-390.953 be reaffirmed in lieu of Resolution 205.

**HOD ACTION: Resolution 205 not adopted.**

Resolution 205 asks that our American Medical Association only support legislation or administrative rules creating or implementing value based purchasing or pay for performance programs if they are in compliance with all of the AMA's principles on pay for performance.

Your Reference Committee heard mixed testimony regarding Resolution 205. Testimony conveyed the frustrations of many physicians regarding the overly burdensome and costly requirements of the multiple pay-for-performance (PFP) programs. While your Reference Committee strongly agrees with these sentiments, your Reference Committee believes that the intent of this resolution is clearly delineated in existing AMA PFP policy. Your Reference Committee also heard testimony that our AMA is strongly advocating for legislative and regulatory changes consistent with this policy. Therefore, your Reference Committee recommends that existing AMA PFP policy H-450.947, H-450.941, and D-390.953 be reaffirmed in lieu of Resolution 205.

H-450.947 Pay-for-Performance Principles and Guidelines

(1) The following Principles for Pay-for-Performance and Guidelines for Pay-for-Performance are the official policy of our AMA.

**PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS**

Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:

1. Ensure quality of care - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.
2. Foster the patient/physician relationship - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.
3. Offer voluntary physician participation - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.
4. Use accurate data and fair reporting - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.
5. Provide fair and equitable program incentives - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

#### **GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS**

Safe, effective, and affordable health care for all Americans is the AMA's goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA's "Principles for Pay-for-Performance Programs" and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.

#### **Quality of Care**

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.
- Evidence-based quality of care measures must be the primary measures used in any program. 1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties. 2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program. 3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession. 4. Performance measures should be scored against both absolute values and relative improvement in those values. 5. Performance measures must be subject to the best-available risk-adjustment for patient demographics, severity of illness, and co-morbidities. 6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years. 7. Performance measures must be selected for clinical areas that have significant promise for improvement.
- Physician adherence to PFP program requirements must conform with improved patient care quality and safety.
- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.
- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.
- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.

- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

#### Patient/Physician Relationship

- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
- Programs must not create conditions that limit access to improved care. 1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients. 2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).
- Programs must neither directly nor indirectly encourage patient de-selection.
- Programs must recognize outcome limitations caused by patient non-adherence, and sponsors of PFP programs should attempt to minimize non-adherence through plan design.

#### Physician Participation

- Physician participation in any PFP program must be completely voluntary.
- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.
- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.
- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.
- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT). 1. Programs should provide physicians with tools to facilitate participation. 2. Programs should be designed to minimize financial and technological barriers to physician participation.
- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.
- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.
- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.
- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

#### Physician Data and Reporting

- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).
- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner. 1. Programs should use accurate administrative data and data abstracted from medical records. 2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices. 3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.
- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.
- Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.
- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting. 1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives. 2. Prior to release of any

physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.

- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.

- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.

- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

#### Program Rewards

- Programs must be based on rewards and not on penalties.

- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.

- Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.

- Programs must finance bonus payments based on specified performance measures with supplemental funds.

- Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.

- Programs must not reward physicians based on ranking compared with other physicians in the program.

- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.

- Programs must not financially penalize physicians based on factors outside of the physician's control.

- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.

(2) Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-Performance." (BOT Rep. 5, A-05; Reaffirmation A-06; Reaffirmed: Res. 210, A-06; Reaffirmed in lieu of Res. 215, A-06; Reaffirmed in lieu of Res. 226, A-06; Reaffirmation I-06; Reaffirmation A-07; Reaffirmation A-09; Reaffirmed: BOT Rep. 18, A-09; Reaffirmed in lieu of Res. 808, I-10; Modified: BOT Rep. 8, I-11; Reaffirmed: Sub. Res. 226, I-13)

#### H-450.941 Pay-For-Performance, Physician Economic Profiling, and Tiered and Narrow Networks

1. Our AMA will collaborate with interested parties to develop quality initiatives that exclusively benefit patients, protect patient access, do not contain requirements that permit third party interference in the patient-physician relationship, and are consistent with AMA policy and Code of Medical Ethics, including Policy H-450.947, which establishes the AMA's Principles and Guidelines for Pay-for-Performance and Policy H-406.994, which establishes principles for organizations to follow when developing physician profiles, and that our AMA actively oppose any pay-for-performance program that does not meet all the principles set forth in Policy H-450.947. (BOT Rep. 18, A-07; Reaffirmed in lieu of Res. 729, A-08; Reaffirmation A-09; Reaffirmed: BOT Rep. 18, A-09; Reaffirmation I-10; Reaffirmed in lieu of Res. 808, I-10; Reaffirmed in lieu of Res. 824, I-10)

#### D-390.953 Sustainable Growth Rate Repeal

1. Our AMA supports SGR repeal and continues to strongly advocate for the AMA's Pay-for-Performance Principles and Guidelines (AMA Policy H-450.947). 2. Our AMA will advocate with CMS and Congress for alternative payment models, developed in concert with specialty and state medical organizations, including private contracting as an option. 3. Our AMA will continue to advocate for future positive updates in the Medicare physician fee schedule. (Sub. Res. 226, I-13)

## (27) RESOLUTION 206 – STOP THE IMPLEMENTATION OF ICD-10

## RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies D-70.952, H-70.916, D-70.951, D-70.954, and D-70.960 be reaffirmed in lieu of Resolution 206.

RESOLVED, That our American Medical Association continue to work diligently and actively with Congress to permanently remove the unnecessary administrative burden on physicians of ICD-10 implementation= (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association advocate that Congress ask the Comptroller General of the United States, in consultation with stakeholders in the medical community, to (1) conduct a study to identify steps that can be taken to mitigate the disruption on health care providers resulting from a replacement of ICD-9 in the future, and (2) the Comptroller General shall submit to each House of Congress a report on such study no later than May 1, 2015 and such report shall include appropriate recommendations (Directive to Take Action); and be it further

RESOLVED, That the Comptroller General's report at least address these four issues: ~~1) uncoupling the ICD code system from the CPT system;~~ 2) decreasing the massive number of codes down to a reasonable number such as Canada did; 3) put the replacement of ICD-9 on hold until physicians fully implement the new Electronic Medical Record systems, the new government regulations, and the Affordable Care Act regulations; and 4) consider adopting a policy for Medicare that provides a two year "implementation" period during which Medicare will not be allowed to deny payment based on the specificity of the ICD-10 code (New HOD Policy).

**HOD ACTION: Resolution 206 adopted as amended, with clause 1 of resolved 3 referred.**

Resolution 206 asks that our American Medical Association continue to work diligently and actively with Congress to permanently remove the unnecessary administrative burden on physicians of ICD-10 implementation.

Your Reference Committee heard mixed testimony regarding Resolution 206. Many testified that the implementation of ICD-10 coding will create unnecessary and significant financial and workflow disruptions for physicians. Testimony also sought an amendment to Resolution 206, calling for our AMA to seek a report by the Comptroller General that considers ways to improve implementation of ICD-10 by: 1) uncoupling the ICD code set from the CPT system; 2) decreasing the number of codes; 3) delaying the implementation of the code set until physicians have fully implemented electronic health records, requirements from the Affordable Care Act, and other new regulations; and 4) consider adopting a policy that provides a two-year implementation period during which Medicare will not be allowed to deny payment based on the specificity of the ICD-10 code. Your Reference Committee agrees that many of these alternatives could offer valuable and critical improvements to implementation and should be considered and evaluated by our AMA. Testimony, however, cautioned that any outside report studying implementation alternatives will likely highlight the substantial investments already made by other stakeholders and may ultimately reach conclusions that undermine our advocacy efforts. Your Reference Committee agrees with these concerns and recognizes that AMA policy already supports assessing appropriate alternatives to ICD-10, including studying the feasibility of moving from ICD-9 directly to ICD-11 and other alternative implementation considerations. To ensure that our AMA continue to vigorously work to stop ICD-10 and offer valid alternatives that may mitigate the burdens for physicians, your Reference Committee recommends that Policies, D-70.952, H-70.916, and D-70.960 be reaffirmed in lieu of Resolution 206.



**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)

**H-70.916 Delay or Canceling of ICD-10**

Our AMA supports delaying or canceling the implementation of ICD-10. (Res. 220, I-13)

**D-70.960 Implementation of ICD-10-CM**

Our AMA will work for delayed implementation of a simplified, modified ICD-10-CM coding system which is less burdensome on practicing physicians, hospitals, and the health insurance industry. (Res. 719, A-06)

(28) **RESOLUTION 223 – PHYSICIAN LIABILITY AND PATIENT PROTECTION UNDER THE FALSE CLAIMS ACT**

**RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends that Policies H-175.984 and H-330.974 be reaffirmed in lieu of Resolution 223.

**HOD ACTION: Policies H-175.984 and H-330.974 reaffirmed in lieu of Resolution 223.**

Resolution 223 asks that our American Medical Association advocate for changes to the False Claims Act that assure that physician liability under the False Claims Act is limited to those instances where the practitioner has actual knowledge that a claim presented is false.

Your Reference Committee heard mixed testimony on Resolution 223. Testimony highlighted that physician liability under the False Claims Act should focus on intentional actions, rather than situations where a physician inadvertently submits a false claim. Other testimony highlighted that the term “actual knowledge” was not clearly defined and that it could contribute to misunderstanding regarding the required level of intent. Your Reference Committee agrees with these concerns and believes existing AMA policy is clear and already covers the intended



goals of Resolution 223. Your Reference Committee, therefore, recommends that Policies H-175.984 and H-330.974 be reaffirmed in lieu of Resolution 223.

H-175.984 Health Care Fraud and Abuse Update

AMA policy is that: (1) our AMA leadership intensify efforts to urge federal policy makers to apply traditional definitions of fraud and abuse which focus on intentional acts of misconduct and activities inconsistent with accepted medical practice; (2) our AMA continue to work with federal law enforcement officials to improve the ability to root out intentional schemes to defraud public programs; (3) our AMA work with federal policymakers to balance payment integrity objectives with reasonable documentation and other administrative requirements; (4) our AMA develop model compliance plans and educational materials to assist physicians in conforming to the latest laws and regulations; and (5) our AMA continue to work in a coalition of other health care organizations to lobby for restrictions on the use of the False Claims Act. (BOT Rep. 25, I-97; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation I-00; Reaffirmed: BOT Rep. 6, A-10)

H-330.974 Modification or Repeal of the Federal False Claims Act and Other Similar Statutes

It is the policy of the AMA to expend those resources necessary to monitor situations where physicians are under investigation, to provide financial and legal assistance where it is determined these are necessary, and to lobby for modification or repeal of the Federal False Claims Act and similar federal statutes. (Res. 152, A-90; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-01; Reaffirmed: BOT Rep. 22, A-11)

## REPORT OF REFERENCE COMMITTEE C

## (1) BOARD OF TRUSTEES REPORT 25 - CMS DEFINITION OF “RESIDENT PHYSICIAN”

## RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 25 be adopted and the remainder of the report be filed.

**HOD ACTION: Recommendation in Board of Trustees Report 25 adopted and the remainder of the report filed.**

Resolution 923-I-13, “CMS Definition of “Resident Physician,” introduced by the Resident and Fellow Section, asked that our AMA “advocate, in conjunction with appropriate stakeholders, that the Centers for Medicare & Medicaid Services (CMS) use our AMA definition of Resident when formulating rules and regulations.”

Board of Trustees Report 25, CMS Definition of “Resident Physician,” recommends that Resolution 923-I-13 not be adopted and the remainder of the report be filed.

Your Reference Committee heard unanimous testimony in support of adopting this report. The nature of the roles and responsibilities of resident physicians versus fellow physicians are substantively different. In many fellowships, for example, fellows are afforded opportunities to participate in unsupervised activities and to bill accordingly—an opportunity not available to residents. If our AMA were to advocate for these changes in the CMS regulations, as proposed in Resolution 923-I-13, residents might be subject to attempts by the CMS to include them in the Physician Payment Sunshine Act (Open Payments). This unintended consequence makes the risk not worth the potential benefits (if any). Finally, it was noted that our AMA’s definition of a resident physician is intended for internal use. For these reasons, your Reference Committee recommends adoption of BOT Report 25.

## (2) COUNCIL ON MEDICAL EDUCATION REPORT 2 - CME SUNSET REVIEW OF 2004 HOUSE POLICIES

## RECOMMENDATION:

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

**HOD ACTION: Recommendations in Council on Medical Education Report 2 adopted and the remainder of the report filed.**

Council on Medical Education Report 2, CME Sunset Review of 2004 House Policies, is a review of House of Delegates’ policies related to medical education last considered in 2004, and contains Council on Medical Education recommendations for retention or rescission of policies.

The Council on Medical Education recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

Your Reference Committee heard limited but favorable testimony, and believes that this report should be adopted, to ensure the most accurate and up-to-date AMA policy on medical education matters.

(3) COUNCIL ON MEDICAL EDUCATION REPORT 4 - ALIGNMENT OF ACCREDITATION ACROSS THE MEDICAL EDUCATION CONTINUUM

RECOMMENDATION:

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

**HOD ACTION: Recommendations in Council on Medical Education Report 4 adopted and the remainder of the report filed.**

Council on Medical Education Report 4, Alignment of Accreditation Across the Medical Education Continuum, specifically examines the extent to which the current processes for accreditation are designed to facilitate an ideal medical education continuum. This report focuses on accreditation of undergraduate medical education (education leading to the MD or DO degrees) and graduate medical education (residency training).

This report recommends: (1) Our American Medical Association (AMA) supports the concept that accreditation standards for undergraduate and graduate medical education should adopt a common competency framework that is based in the Accreditation Council for Graduate Medical Education (ACGME) competency domains. (2) Our AMA recommends that the relevant associations, including the AMA, Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM), along with the relevant accreditation bodies for undergraduate medical education (Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation) and graduate medical education (ACGME, AOA) develop strategies to: a) Identify guidelines for the expected general levels of learners' competencies as they leave medical school and enter residency training; b) Create a standardized method for feedback from medical school to premedical institutions and from the residency training system to medical schools about their graduates' preparedness for entry; c) Identify areas where accreditation standards overlap between undergraduate and graduate medical education (e.g., standards related to the clinical learning environment) so as to facilitate coordination of data gathering and decision-making related to compliance. All these activities should be codified in the standards or processes of accrediting bodies. (3) Our AMA encourages the development and implementation of accreditation standards or processes that support the utilization of tools (e.g., longitudinal learner portfolios) to track learners' progress in achieving the defined competencies across the continuum.

Your Reference Committee heard limited testimony that was unanimously in favor of adoption of this report. Future study by our AMA will ensure additional evaluation of the evidence for and consideration of the consequences, challenges, and opportunities of the alignment of accreditation processes in undergraduate and graduate medical education.

(4) COUNCIL ON MEDICAL EDUCATION REPORT 6 - UPDATE ON MAINTENANCE OF CERTIFICATION, OSTEOPATHIC CONTINUOUS CERTIFICATION, AND MAINTENANCE OF LICENSURE RESOLUTION 316 – MORATORIUM ON MAINTENANCE OF CERTIFICATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that CME Report 6 be amended by addition of a new Recommendation 5, to read as follows:

5. That the AMA oppose mandatory MOC as a condition of medical licensure, and encourage physicians to strive constantly to improve their care of patients by the means they find most effective.

## RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 6 be adopted in lieu of Resolution 316 and the remainder of the report be filed.

**HOD ACTION: Recommendations in Council on Medical Education Report 6 adopted as amended in lieu of Resolution 316 and the remainder of the report filed.**

Council on Medical Education Report 6, Update on Maintenance of Certification (MOC), Osteopathic Continuous Certification (OCC) and Maintenance of Licensure (MOL), includes a comprehensive summary of AMA's ongoing efforts with the American Board of Medical Specialties to improve MOC to address concerns about the time, administrative burden and costs (monetary and other) associated with participation, the relevance of the secure, high-stakes Part III examination, and need to lessen the burden for physicians with multiple board certifications. The report also addresses the evidence to support the value of MOC. An update on OCC and the development of the MOL framework are included in the report. The report also summarizes the preliminary steps undertaken to explore the feasibility of engaging an independent entity to study the impact of MOC, OCC and MOL on the physician workforce which would require a fairly complex research effort.

This report recommends: 1) That our AMA Council on Medical Education continue to review published literature and emerging data as part of the Council's ongoing efforts to critically review maintenance of certification (MOC), osteopathic continuous certification (OCC), and maintenance of licensure (MOL) issues. 2) That our AMA continue to explore with independent entities the feasibility of conducting a study to evaluate the impact that MOC requirements and the principles of MOL have on physicians' practices, including, but not limited to physician workforce, physicians' practice costs, patient outcomes, patient safety, and patient access. 3) That our AMA work with the American Board of Medical Specialties (ABMS) and the ABMS Member Boards to collect data on why physicians choose to maintain or discontinue their board certification. 4) That our AMA work with the ABMS and the Federation of State Medical Boards to study whether MOC and the principles of MOL are important factors in a physician's decision to retire and have a direct impact on the US physician workforce.

Resolution 316 asks our AMA to work with the American Board of Medical Specialties (ABMS) and individual specialty boards to put a moratorium on maintenance of certification (MOC) until all of the following occur: 1. Pilot studies have shown the efficacy of MOC in physician care and patient outcomes; 2. An assessment of the cost of time and money on the profession per year is completed; and 3. An assessment of the impact of MOC on worsening physician shortages by the adverse effect of tying the MOC program to state licenses (i.e., estimation of physicians that would leave or be removed from the physician pool of practicing doctors) is completed.

Your Reference Committee heard mixed testimony that included differences of opinion and misunderstanding on this complex item. There was a lack of understanding of the details of MOC, especially regarding the relationship between MOC and MOL and the value of MOC. Based on the testimony, it is clear that the issues of administrative burden and costs need to be addressed, that the Council needs to be more thorough about interpreting the evidence to show the efficacy of MOC in physician care and patient outcomes and encouraging increased financial transparency among the specialty boards. More than 200 study annotations focusing on best practices in CME and the ABMS Program for MOC Part II, Lifelong Learning and Self-Assessment, are available online ([evidencelibrary.abms.org](http://evidencelibrary.abms.org)). In addition, lifelong learning and self-assessment, integral parts of MOC, OCC and MOL, were reviewed in the December 13, 2013 supplement of the *Journal of Continuing Education in the Health Professions*. The Council also must continue to review the literature to assess the impact of MOC and MOL on the physician workforce as studies become available.

Online testimony was received expressing concern that our AMA not be perceived as being against the current processes that the medical profession has in place to maintain and improve the competence of physicians and to retain the public trust. The CME has been successful in shaping ABMS standards on behalf of AMA membership. Our AMA has provided input that is reflected in the ABMS Updated Standards for 2015. Our AMA also sponsored a meeting with the ABMS that brought together subject matter experts in physician assessment and representatives from the Council, AMA sections, and the ABMS Member Boards to further discuss practice-relevant and innovative

MOC Part III activities. Your Reference Committee expects that our AMA will continue to monitor these issues closely and report back to the House of Delegates as appropriate. Resolution 316 raises important issues that need to be addressed as part of the monitoring process. On that front, your Reference Committee Recommends that CME Report 6 be adopted in lieu of Resolution 316.

(5) RESOLUTION 304 – GRADUATE MEDICAL EDUCATION FUNDING  
AND QUALITY OF RESIDENT EDUCATION

RECOMMENDATION:

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

**HOD ACTION: Resolution 304 adopted.**

Resolution 304 asks our AMA to explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.

Your Reference Committee heard testimony in strong support for adoption of Resolution 304 and the need for new and innovative approaches to GME funding that are linked to quality and outcomes. The resolution is consistent with current AMA policy and allows our AMA to broaden its definitions of GME funding. For these reasons, your Reference Committee recommends adoption of Resolution 304.

(6) RESOLUTION 311 - IMPACT OF COMPETENCY-BASED MEDICAL  
EDUCATION PROGRAMS AS OPPOSED TO TIME-BASED PROGRAMS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 311 be adopted.

**HOD ACTION: Resolution 311 adopted.**

Resolution 311 asks that our American Medical Association (1) work with the National Resident Matching Program (NRMP) and Accreditation Council for Graduate Medical Education (ACGME) to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers; and (2) work with the NRMP, ACGME and the 11 schools in the AMA's Accelerating Change in Medical Education consortium to develop pilot projects to study the impact of competency-based frameworks on student graduation, the residency match process and off-cycle entry into residency programs.

Your Reference Committee heard supportive testimony on Resolution 311. This item is timely in light of the trend towards competency-based versus time-based medical education and measures of competency across the continuum. However, as this trend continues to accelerate in undergraduate medical education, the current time-based assessments and processes for advancement into graduate medical education may lead to issues for medical students. These include graduation timing and its effect on the Match, start date for residencies, and status of Federal loans. In addition, variable educational lengths may increase the logistical complexity of a variety of worthy and important curricular efforts, such as interprofessional education. Pilot programs to explore these issues are needed, in concert with our AMA's strategic focus work in Accelerating Change in Medical Education. Therefore, your Reference Committee recommends adoption of Resolution 311.

(7) RESOLUTION 314 - COMPROMISING LIFETIME CERTIFICATIONS  
RETROACTIVELY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 314 be adopted.

**HOD ACTION: Resolution 314 adopted.**

Resolution 314 asks our AMA to adopt policy stating that no qualifiers or restrictions should be placed on lifetime certifications recognized by the American Board of Medical Specialties.

Your Reference Committee heard testimony that supported the principle of this resolution, that all physicians should be given the opportunity to maintain their competency through high quality educational activities. However, it is inappropriate to place qualifiers on lifetime certification. Your Reference Committee recommends that Resolution 314 be adopted.

(8) RESOLUTION 324 - USE OF UNMATCHED MEDICAL STUDENTS AS  
“ASSISTANT PHYSICIANS”

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 324 be adopted.

**HOD ACTION: Resolution 324 adopted.**

Resolution 324 asks that our AMA oppose special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education or American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate U.S. medical education.

Your Reference Committee heard strong support for adoption of Resolution 324. This recommendation is in line with AMA Policies H-270.958, Need for Active Medical Board Oversight of Medical Scope-of-Practice Activities by Mid Level Practitioners, H-405.969, Definition of a Physician, and H-160.949, Practicing Medicine by Non-Physicians. Accordingly, your Reference Committee recommends that Resolution 324 be adopted.

(9) COUNCIL ON MEDICAL EDUCATION REPORT 3 - COMPETENCY-  
BASED MEDICAL EDUCATION ACROSS THE CONTINUUM OF  
EDUCATION AND PRACTICE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 2 in Council on Medical Education Report 3 be amended by addition and deletion, to read as follows:

2. That our AMA Council on Medical Education work to establish a framework of consistent vocabulary and definitions across the continuum of health sciences education that will facilitate competency-based curriculum, andragogy ~~pedagogy~~ and assessment implementation. (Directive to Take Action)



## RECOMMENDATION B:

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

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

Council on Medical Education Report 3, Competency-Based Medical Education Across the Continuum of Education and Practice, summarizes information from a review of the literature regarding the current state of competency-based medical education (CBME) in the health professions. CBME focuses on the skills and progression of learning of an individual, promoting greater learner centeredness and potentially allowing greater flexibility in the time required for training.

The report recommends: (1) That our American Medical Association (AMA) Council on Medical Education continue to study and identify challenges and opportunities and critical stakeholders in achieving a competency-based curriculum across the medical education continuum and other health professions that provides significant value to those participating in these curricula and their patients. (2) That our AMA Council on Medical Education work to establish a framework of consistent vocabulary and definitions across the continuum of health sciences education that will facilitate competency-based curriculum, pedagogy and assessment implementation.

Your Reference Committee heard limited but favorable testimony in favor of adoption of CME Report 3. An editorial change was noted in that pedagogy is a teacher-focused model of learning, whereas andragogy moves the learner from dependency to independence and self-directed learning, a model more appropriate for medical student and physician learners. There was some testimony noting the report's connection to Resolution 311, but your Reference Committee believes the report and resolution stand on their own, as separate items, and urges adoption of CME Report 3 as amended.

(10) COUNCIL ON MEDICAL EDUCATION REPORT 5 - AMA DUTY HOURS POLICY

## RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 4 in Council on Medical Education Report 5 be amended by addition and deletion, to read as follows:

4) Our AMA endorses the ~~future~~ study of innovative models of duty hour requirements and, pending the outcomes of ongoing and future research, should consider endorses the evolution of specialty and rotation-specific duty hours requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.

## RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 7 in CME Report 5 be amended by addition and deletion, to read as follows:

g) Resident physicians should be ensured a sufficient duty-free interval ~~of at least 10 hours~~ prior to returning to duty.

## RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the recommendations in CME Report 5 be adopted as amended and the remainder of the report be filed.

**HOD ACTION: Recommendations in CME Report 5 adopted as amended and the remainder of the report filed.**

Council on Medical Education Report 5, AMA Duty Hours Policy, builds on information provided in three previous Council reports to the House of Delegates on this topic in 2011, 2009, and 2008, reviews recent research on duty hours and related concerns and outlines potential areas for further research. A second goal of this report is to review and consolidate existing AMA policy on duty hours.

This report recommends: (1) That our AMA adopts the following Principles of Resident/Fellow Duty Hours, Patient Safety, and Quality of Physician Training: 1) Our AMA reaffirms support of the 2003 Accreditation Council for Graduate Medical Education (ACGME) duty hour standards. 2) Our AMA will continue to monitor the enforcement and impact of duty hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents. 3) Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of duty hours, to include such topics as: Extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice. 4) Our AMA endorses the future study of innovative models of duty hour requirements and, pending the outcomes of ongoing and future research, endorses the evolution of specialty- and rotation-specific duty hours requirements that will optimize patient safety and competency-based learning opportunities. 5) Our AMA encourages the ACGME to: a) Decrease the barriers to reporting of both duty hour violations and resident intimidation. b) Ensure that readily accessible, timely and accurate information about duty hours is not constrained by the cycle of ACGME survey visits. c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of resident duty hour rules. d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of duty hours. 6) Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to: a) Offer incentives to programs/institutions to ensure compliance with duty hour standards. b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor. c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home. d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue. 7) Our AMA supports the following statements related to duty hours: a) Resident physician total duty hours must not exceed 80 hours per week, averaged over a four-week period (Note: "Total duty hours" includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients). b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers' patients, or continuity clinic during that time. c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks. d) At home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period." f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, duty hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, to the 16-hour

shift limit for first-year residents, or allowing a limited increase to the total number of duty hours when need is demonstrated. g) Resident physicians should be ensured a duty-free interval of at least 10 hours prior to returning to duty. h) Duty hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total duty hour limits for all resident physicians. i) Scheduled time providing patient care services of limited or no educational value should be minimized. j) Accurate, honest, and complete reporting of resident duty hours is an essential element of medical professionalism and ethics. k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of duty hour regulations, and opposes any regulatory or legislative proposals to limit the duty hours of practicing physicians. l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy. m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program. n) The costs of duty hour limits should be borne by all health care payers. o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations. 8) Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/ fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety. (2) That our AMA rescinds the following AMA policies: H-310.918, "Resident and Duty Hours: A Review of the Institute of Medicine Recommendations," H-310.926, "Resident/Fellow Work and Learning Environment," H-310.927, "Resident Physician Working Conditions," H-310.928, "Resident/Fellow Work and Learning Environment," H-310.957, "Resident Working Conditions Reform Update," H-310.963, "Residency/Fellowship Working Hours and Supervision," D-310.955, "Resident/Fellow Duty Hours, Quality of Physician Training, and Patient Safety," D-310.961, "Use of At-Home Call by Residency Programs" D-310.964, "Enforcement of Duty Hours Standards and Improving Resident, Fellow and Patient Safety," D-310.973, "Enforcement of ACGME Duty Hour Standards," D-310.978, "Enforcement of ACGME Duty Hours Standards," D-310.981, "Resident/Fellow Work and Learning Environment," D-310.984, "Resident/Fellow Work and Learning Environment," D-310.986, "Accreditation Council for Graduate Medical Education Enforcement of Duty Hour Standards," D-310.989, "Resident Physician Working Conditions," D-310.991, "Intern and Resident Working Hours."

Your Reference Committee heard mixed testimony that was, however, largely in favor of the report. Concerns were raised about ongoing and troubling deficiencies in the competencies of newly practicing physicians, particularly in the surgical fields, and the potential for reduced quality of care. In addition, the endorsement of the duty hour standards of the Accreditation Council for Graduate Medical Education (ACGME) was seen as problematic. The 10-hour time-off period was also cited as a non-evidence-based regulation and as contributing to more handoffs and the potential for patient safety lapses. The proposed edits to the report reflect the need for an evidence-based solution. Overall, concerning duty hours, flexibility and specialty-specific solutions are needed due to the range of educational and training needs among the specialties/subspecialties of medicine. This extends to the individual level, with variations in sleep patterns and susceptibility to fatigue from one person to the next—which relates to the ongoing and accelerating trend of medical education moving towards competency-based versus time-based measures of achievement. Other testimony, which was in favor of the report's adoption, noted that two large studies looking at duty hour revisions for first-year interns and surgical residents, respectively, are currently under way. When completed, these randomized, controlled studies should provide additional insight into the large-scale impacts of duty hours. In any event, the Council on Medical Education will continue to closely monitor duty hours and report back to the House of Delegates as needed. In the interim, this report will help to solidify and simplify our AMA's multiple policies on duty hours. Therefore, your Reference Committee recommends adoption of CME Report 5 as amended.

(11) COUNCIL ON MEDICAL EDUCATION REPORT 7 - PHYSICIAN  
WORKFORCE SHORTAGE: APPROACHES TO GME FINANCING  
RESOLUTION 309 – EXPANSION OF GRADUATE MEDICAL  
EDUCATION POSITIONS THROUGH ALTERNATIVE FUNDING

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 of CME Report 7 be amended by addition, to read as follows:

1. That our American Medical Association continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 5 of CME Report 7 be amended by addition, to read as follows:

5. That our AMA work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (1) train more physicians to meet state and regional workforce needs; (2) train physicians who will practice in physician shortage/underserved areas; or (3) train physicians in undersupplied specialties and subspecialties in the state/region. (Directive to Take Action)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Recommendation 7 of CME Report 7 be amended by addition and deletion, to read as follows:

7. That our AMA continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, ~~and~~ American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce. (Directive to Take Action)

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that the Recommendations in CME Report 7 be adopted as amended in lieu of Resolution 309 and the remainder of the report be filed.

**HOD ACTION: Recommendations in CME Report 7 adopted as amended in lieu of Resolution 309 and the remainder of the report filed.**

Resolution 914-I-13, “Change Rural and Off Site Rural Training Track Requirements in order to Preserve and Encourage Interest in Rural Residency Programs,” introduced by the Mississippi Delegation, asks our AMA to 1) work with the Centers for Medicare & 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.

Council on Medical Education Report 7, Physician Workforce Shortage: Approaches to GME Financing, recommends that our AMA: 1) Continue to strongly advocate that Congress fund graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians. 2) Advocate that the Centers for Medicare & Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution. 3) Encourage the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site. 4) Encourage the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability. 5) Work with interested state and national medical specialty societies to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (1) train more physicians to meet state and regional workforce needs; (2) train physicians who will practice in physician shortage/underserved areas; or (3) train physicians in undersupplied specialties and subspecialties in the state/region. 6) Support the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes. 7) Continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, and American College of Physicians (ACP) to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce. and 8) Rescind Policies H-200.954 (12), "U.S. Physician Shortage," and D-305.967 (13), "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education," since that has been accomplished through this report.

Resolution 309 asks our AMA 1) and other graduate medical education stakeholders, such as the Accreditation Council for Graduate Medical Education and the Council on Graduate Medical Education, work towards the expansion of graduate medical education positions by creating community-funded graduate medical education positions for the existing and new graduate medical education programs and 2) in collaboration with its International Medical Graduates Section and other stakeholders within the AMA, create a Graduate Medical Education Working Group to work on a guiding principles document for the expansion of existing residency programs by utilizing alternative/community and philanthropic funding.

Your Reference Committee heard testimony largely in favor of adopting CME Report 7. Concerns were raised by representatives of specific specialties that the report's recommendations, while correctly identifying shortages in primary care fields, do not highlight similar deficits in the specialties. Language changes in, for example, Recommendation 7 help address these concerns by specifically listing specialty organizations. The insertion of "additional" in Recommendation 1 ensures that any such GME funding is supplemental to existing funding and is targeted to the most critical workforce and access to care needs. With the Institute of Medicine soon releasing a report on graduate medical education financing, it was noted that our AMA needs strong and up-to-date workforce policy to respond appropriately to the IOM's recommendations. Finally, there was testimony that Recommendation 8 suggested that our AMA had actually accomplished the goals in those policies; this was simply a misinterpretation of the language, which calls for rescission of these policies, which called for the writing of this report by the 2014 Annual Meeting. Your Reference Committee also recommends adoption of this report in lieu of Resolution 309, which would create another GME-oriented working group that would be in competition with the Council on Medical Education and its GME subcommittee. Further, the Council already has representation from our AMA Medical Student Section and Resident/Fellow Section and is pursuing the work outlined in Resolution 309.



## (12) RESOLUTION 301 - SHARED DECISION MAKING IN MEDICAL EDUCATION

## RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 301 be amended by substitution, to read as follows:

RESOLVED, That our AMA collaborate with the appropriate medical education organizations to identify resources for undergraduate and graduate medical education programs to help ensure proficiency among medical students and resident/fellow physicians in shared decision-making and effective use of shared decision-making tools, such as patient decision aids. (Directive to Take Action)

## RECOMMENDATION B:

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

**HOD ACTION: Resolution 301 adopted as amended.**

Resolution 301 asks our AMA to 1) amend policy D-373.999, Informed Patient Choice and Shared Decision Making, by addition as follows: Our AMA will work with state and specialty societies, medical schools, and others as appropriate to educate and communicate to medical students and to physicians about the importance of shared decision-making guidance through publications and other educational methods and assist the medical community in moving towards patient-centered care. and 2) collaborate with the appropriate medical education organizations to develop undergraduate medical education recommendations that ensure proficiency in shared decision making and effective use of shared decision-making tools, such as patient decision aids.

Your Reference Committee heard testimony against adoption of the second resolve as currently worded. Curriculum development should be the purview of medical schools; it is not appropriate for our AMA to impose curricular mandates on shared decision-making or any other topics in undergraduate medical education. This is consistent with our AMA's past actions in respecting the autonomy of medical schools. In addition, concerns were expressed about the wording of the resolution. Accordingly, your Reference Committee recommends adoption of Resolution 301 with the amended language as shown.

## (13) RESOLUTION 302 - PROVIDING RESIDENCY APPLICANTS A TIMELY RESPONSE TO RESIDENCY APPLICATION OUTCOME

## RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 302 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association Policy H-310.998 Residency Interview Schedules be amended by addition and deletion as below: (Modify Current HOD Policy)

Our~~The~~ AMA encourages ~~accredited~~ accredited residency and fellowship programs to incorporate in their ~~residency~~ interview dates increased flexibility, whenever possible, to accommodate applicants' schedules. Our~~The~~ AMA encourages the ACGME and other accrediting bodies to require ~~residency~~ programs to provide, by electronic or other means, representative contracts to applicants prior to the interview. Our~~The~~ AMA encourages residency and fellowship programs to inform applicants in a timely manner confirming receipt of application and ongoing changes in the status of consideration of the application of their ~~application materials and timely notification of when an applicant is no longer~~



~~under consideration for an interview, about their interview status and provide a time frame of notification dates in the application materials.~~

RECOMMENDATION B:

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

**HOD ACTION: Resolution 302 adopted as amended.**

Resolution 302 ask that our AMA amend Policy H-310.998, Residency Interview Schedules, by addition and deletion as follows: The AMA encourages ~~accredited~~ residency and fellowship programs to incorporate in their ~~residency~~ interview dates increased flexibility, whenever possible, to accommodate applicants' schedules. The AMA encourages the ACGME and other accrediting bodies to require residency programs to provide, by electronic or other means, representative contracts to applicants prior to the interview. The AMA encourages residency and fellowship programs to inform applicants in a timely manner confirming receipt of their application materials and timely notification of when an applicant is no longer under consideration for an interview. ~~about their interview status and provide a time frame of notification dates in the application materials.~~

Your Reference Committee heard limited testimony predominantly in favor of adoption of Resolution 302. Although support was expressed for the guiding concepts and spirit of this resolution (as a mechanism to assist residency program applicants), concerns were expressed about the overly prescriptive nature of the language and potential burdens on program directors. The phrase “timely notification of when an applicant is no longer under consideration for an interview” could have the unintended impact of eliminating some applicants for consideration who might otherwise have been ultimately selected. In addition, ERAS is the preferred means of communication between residency programs and applicants for notification of completeness of the residency application package. Your Reference Committee therefore recommends the insertion of less prescriptive language that would nonetheless accomplish the overarching goals of this resolution.

(14) RESOLUTION 303 - PROTECTING RESIDENTS AGAINST AVOIDABLE FINANCIAL CONSTRAINT RELATED TO REIMBURSED WORK-RELATED EXPENSES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that second resolve of Resolution 303 be amended by addition, to read as follows:

RESOLVED, That our AMA encourage a system of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement) (New HOD Policy); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the third resolve of Resolution 303 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA encourage training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended ~~in advance but at a minimum, reimbursement should be completed at 2 weeks and not to exceed 1~~

~~month after submission of relevant reimbursement documents; and unplanned expenses which includes money spent collectively above the planned amount by trainees is strongly recommended to be reimbursed by 1 month after submission of relevant reimbursement documents, with a period not to exceed 6 weeks.~~  
(New HOD Policy)

RECOMMENDATION C:

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

**HOD ACTION: Resolution 303 adopted as amended.**

Resolution 303 asks our AMA to 1) promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; 2) encourage a system of expedited repayment for purchases of \$200 or less, for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and 3) encourage training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment is strongly recommended in advance but at a minimum, reimbursement should be completed at 2 weeks and not to exceed 1 month after submission of relevant reimbursement documents; and unplanned expenses which includes money spent collectively above the planned amount by trainees is strongly recommended to be reimbursed by 1 month after submission of relevant reimbursement documents, with a period not to exceed 6 weeks.

Your Reference Committee heard testimony in support of the spirit of the resolution and the need to ensure that resident/fellow physicians are not unduly burdened by delays in work-related reimbursement. At the same time, it was expressed that the current language was too prescriptive and could be difficult to implement at an institutional level. Your Reference Committee therefore believes that the revised recommendations reflect the overarching goals of the resolution while allowing for flexibility at the ground level.

(15) RESOLUTION 305 - TRANSPARENCY ON MATERNITY AND PATERNITY LEAVE POLICIES FOR TRAINEES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 305 be amended by deletion, to read as follows:

RESOLVED, That American Medical Association House of Delegates Policy H-405.960, Policies for Maternity, Family and Medical Necessity Leave, be amended by insertion as below (Modify Current HOD Policy):

AMA adopts as policy the following guidelines for, and encourage the implementation of, Maternity, Family and Medical Necessity Leave for Medical Students and Physicians:

- (1) ~~Our~~The AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of ~~written and publicly available~~ leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement;

## RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 305 be amended by addition on page 2, to read as follows:

14) These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

## RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends the title of Policy H-405.960 be amended by addition, to read as follows:

Policies for Maternity, Paternity, Family and Medical Necessity Leave

## RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends the Resolution 305 be adopted as amended.

**HOD ACTION: Resolution 305 adopted as amended.**

Resolution 305 asks our AMA to amend Policy H-405.960, Policies for Maternity, Family and Medical Necessity Leave, as follows: AMA adopts as policy the following guidelines for, and encourage the implementation of, Maternity, Family and Medical Necessity Leave for Medical Students and Physicians: (1) The AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of written and publicly available leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement; (2) Recommended components of maternity leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; (i) leave policy for adoption; and (j) leave policy for paternity. (3) AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking maternity leave without the loss of status. (4) Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their maternity leave policies a six-week minimum leave allowance, with the understanding that no woman should be required to take a minimum leave; (5) Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave; (6) Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons; (7) Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being

required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling; (8) Our AMA endorses the concept of paternity leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice; (9) Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs; (10) Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status; (11) Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up); because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility; (12) Our AMA encourages flexibility in residency training programs, incorporating maternity leave and alternative schedules for pregnant house staff; and (13) In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year. (14) These policies as above should be available in writing to all applicants to medical school, residency or fellowship.

Your Reference Committee heard lengthy testimony in support of adoption of Resolution 305. It was noted in testimony that such policies should be freely available online as well as in writing, to ensure that applicants are afforded assurance that leave will be available as needed due to personal circumstances. The minor editorial edits as shown reflect these sentiments. In addition, it was cited that the title mentions paternity leave, but the policy being amended does not include paternity leave in the title, although it is mentioned in the body of the policy. Consistency would be helpful. This may take the form of an additional amendment of a modification of the resolution title. Similarly, the title of the resolution refers to “trainees” (generally understood to refer to post-medical school trainees), but the body refers to students also. Your Reference Committee therefore urges adoption of Resolution 305.

(16) RESOLUTION 306 – ENDORSING STANDARDIZED CORE CURRICULA ON DISABILITY EDUCATION IN MEDICAL SCHOOL

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 306 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association continue to work with medical schools and their accrediting/licensing bodies to encourage ~~require~~ disability related competencies/objectives in medical school curricula so that medical professionals are able to effectively communicate with patients and colleagues with disabilities, and are able to provide the most clinically competent and compassionate care for patients with disabilities. (Directive to Take Action)

RECOMMENDATION B:

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

**HOD ACTION: Resolution 306 be adopted as amended with a title change.**

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 306 be changed, to read as follows:

## INCLUDING DISABILITY RELATED COMPETENCIES AND OBJECTIVES IN MEDICAL SCHOOL CURRICULUM

Resolution 306 asks our AMA to continue to work with medical schools and their accrediting/licensing bodies to require disability related competencies/objectives in medical school curricula so that medical professionals are able to effectively communicate with patients and colleagues with disabilities, and are able to provide the most clinically competent and compassionate care for patients with disabilities.

Your Reference Committee heard testimony on the need that all medical professionals be well-versed in understanding the needs of people with disabilities. While sympathetic to the needs of this population, particularly in regards to their health care needs and the appropriate education of future physicians, our AMA is opposed to mandates for additional content areas in an already distended undergraduate medical education curriculum. However, a change in the title and a wording change (from “require” to “encourage”) is seen by your Reference Committee as edits that reflect less a mandate and more a suggestion. Accordingly, your Reference Committee recommends that Resolution 306 be adopted as amended.

### (17) RESOLUTION 307 – PRACTICAL USE OF ADVANCE DIRECTIVES IN MEDICAL EDUCATION

#### RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first and second resolves of Resolution 307 be amended by addition and deletion, to read as follows:

RESOLVED, Our AMA work with medical schools, graduate medical education programs and other interested groups to increase the awareness and the creation of personal advance directives for all medical students and physicians (Directive to Take Action); and be it further~~That our American Medical Association recommend that all Liaison Committee on Medical Education (LCME) and Commission on Osteopathic College Accreditation (COCA) accredited medical schools provide students the opportunity to complete an advance directive and learn to further address advance care planning in the course of their medical ethics curricula (Directive to Take Action); and be it further~~

~~RESOLVED, That our AMA encourage the LCME and COCA to include in their current accreditation standards opportunities for personal completion of advance directives by medical students and opportunities to further address advance care planning in the course of the curricula (Directive to Take Action); and be it further~~

#### RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 307 be adopted as amended.

#### **HOD ACTION: Resolution 307 adopted as amended.**

Resolution 307 asks our AMA to 1) recommend that all Liaison Committee on Medical Education (LCME) and Commission on Osteopathic College Accreditation (COCA) accredited medical schools provide students the opportunity to complete an advance directive and learn to further address advance care planning in the course of their medical ethics curricula, 2) encourage the LCME and COCA to include in their current accreditation standards opportunities for personal completion of advance directives by medical students and opportunities to further address advance care planning in the course of the curricula, and 3) encourage development of a model educational module for the teaching of advance directives and advance care planning.

Your Reference Committee heard testimony that reflected issues with the resolution's language as written. Similar to views expressed on other resolutions related to the medical education curriculum, a significant portion of the testimony focused on the issue of curricular mandates. We believe that the proposed edits address these concerns. Your Reference Committee therefore recommends adoption of Resolution 307 as amended.

(18) RESOLUTION 308 - COMPETENCY AND THE AGING PHYSICIAN

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 308 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA study the issue of competency in aging physicians and develop guidelines, if the study supports such a need, for appropriate mechanisms of assessment to assure that America's physicians remain able to provide optimal ~~best~~ care for their patients (Directive to Take Action); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 308 be adopted as amended.

**HOD ACTION: Resolution 308 adopted as amended.**

Resolution 308 asks 1) That our AMA study the issue of competency in aging physicians and develop guidelines, if the study supports such a need, for appropriate mechanisms of assessment to assure that America's physicians remain able to best care for their patients, and 2) That there be a report back to the House of Delegates.

Your Reference Committee heard significant testimony in favor of adoption of Resolution 308—a timely item of business, in that a large western state is working on a report on this topic. In testimony, concern was expressed about the use of the word “aging”; competency of all physicians needs to be assured for patient safety, and the aging process affects different individuals in different ways and at different speeds. A minor editorial change was made, which your Reference Committee agrees is appropriate.

(19) RESOLUTION 310 - PHYSICIAN REENTRY AND LICENSURE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 310 be amended by deletion, to read as follows:

~~RESOLVED, That our American Medical Association work with the Federation of State Medical Boards to establish a definition of “active practice of medicine” that is evidence-based and includes the practice of population-based medicine (Directive to Take Action);~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 310 be adopted as amended.

**HOD ACTION: Resolution 310 adopted as amended.**

Resolution 310 asks our AMA to 1) work with the Federation of State Medical Boards to establish a definition of “active practice of medicine” that is evidence-based, and 2) encourage each state which does not grant a full and



unrestricted license to physicians undergoing reentry to develop a non-disciplinary category of licensure for physicians during their reentry process.

Your Reference Committee heard testimony that was uniformly in favor of Resolution 310. With a growing physician shortage, all available physicians are needed, and licensure barriers to workforce reentry should be eased, while still ensuring protection of the public. One of the key challenges is defining clinical inactivity and elucidating the needs of a reentering physician versus one who needs remediation or retraining. Our AMA Council on Medical Education expressed its willingness to collaborate with the Federation of State Medical Boards and other appropriate entities to establish a definition of “active practice of medicine.” This is in accord with current Council work on the topic of reentry, including a forum on the topic with a number of key stakeholders during the A-14 meeting. Your Reference Committee believes that these facts support adoption of Resolution 310 as amended.

(20) RESOLUTION 312 – ASSESSING THE IMPACT OF LIMITED GME  
RESIDENCY POSITIONS IN THE MATCH

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 312 be amended by addition, to read as follows:

RESOLVED, That our American Medical Association work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 312 be adopted as amended.

**HOD ACTION: Resolution 312 adopted as amended.**

Resolution 312 asks our AMA to 1) work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; and what careers are pursued by those with an MD or DO degree who do not enter residency programs; 2) work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs; and 3) work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program.

Your Reference Committee heard supportive testimony on Resolution 312, which seeks to address concerns about the growing number of unmatched students. Further study is required to document the prevalence of the issue and further elucidate what career alternatives these individual pursue. An additional phrase is proposed for addition to the report to reflect the need for focused analysis on the possible disproportionate effects of unsuccessful matching on individuals from racial and ethnic groups. Your Reference Committee therefore recommends adoption of Resolution 312 as amended.

## (21) RESOLUTION 318 - ASSISTING MEDICAL STUDENTS APPLYING FOR AWAY ROTATIONS

## RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 318 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association ~~encourage appropriate work with~~ stakeholders to develop, promulgate, and ~~have adopted~~ a uniform immunization form for medical students seeking to do rotations at hospitals away from their home institutions.

## RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 318 be adopted as amended.

**HOD ACTION: Resolution 318 adopted as amended.**

Resolution 318 asks our AMA to work with the Association of American Medical Colleges and other stakeholders to develop, promulgate, and have adopted a uniform immunization form for medical students seeking to do rotations at hospitals away from their home institutions.

Your Reference Committee heard limited but supportive testimony for Resolution 318. It was noted in testimony that the American Hospital Association may be the more relevant organization in this instance than the Association of American Medical Colleges. Accordingly, the language has been revised, and your Reference Committee urges acceptance of the resolution as amended.

## (22) RESOLUTION 319 - MAINTENANCE OF LICENSURE

## RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 319 be amended by deletion, to read as follows:

~~RESOLVED, That our American Medical Association oppose any efforts to require the Federation of State Medical Boards maintenance of licensure (MOL) program as a condition of medical licensure (New HOD Policy); and be it further~~

## RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 319 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA oppose any MOL initiative that creates barriers to practice, is administratively unfeasible, is inflexible with regard to how physicians practice (clinically or not), that does not protect physician privacy, and that is used to promote policy initiatives (rather than above physician competence) such as participation in health plans, subscription to data exchanges, and specialty board certification. (New HOD Policy)

## RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Policy H-275.923 be reaffirmed.

## RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Resolution 319 be adopted as amended.

**HOD ACTION: Resolution 319 adopted as amended.**

Resolution 319 asks our AMA to 1) oppose any efforts to require the Federation of State Medical Boards maintenance of licensure (MOL) program as a condition of medical licensure and 2) oppose any MOL initiative that creates barriers to practice, is administratively unfeasible, is inflexible with regard to how physicians practice (clinically or not), that does not protect physician privacy, and that is used to promote policy initiatives (rather than competence) such as participation in health plans, subscription to data exchanges, and specialty board certification.

Your Reference Committee heard testimony to strike the first resolve and support for revising the second resolve. Existing AMA policy reflects the intent of the second resolve. Policy H-275.923 asks our AMA to continue to work with the FSMB to establish and assess MOL principles with our AMA to assess the impact of MOC and MOL on the practicing physician and the FSMB to study the impact on licensing boards. For this reason, your Reference Committee recommends reaffirmation of Policy H-275.923 and adoption of Resolution 319 as amended.

## Policy recommended for reaffirmation:

## 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; Reaffirmed in lieu of Res. 919, I-13)

(23) RESOLUTION 322 - MAINTAINING AND DEVELOPING HIGH QUALITY HOSPICE AND PALLIATIVE CARE PHYSICIAN WORKFORCE IN THE NEW MILLENNIUM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 322 be adopted.

RESOLVED, That our AMA work with relevant national medical specialty organizations to petition the American Board of Medical Specialties and relevant specialty boards to support development of innovative fellowship models that would qualify physicians for board certification in the fields of hospice and palliative medicine as well as geriatrics. (Directive to Take Action)

**HOD ACTION: Substitute Resolution 322 adopted.**

Resolution 322 asks our AMA to work with the various national medical specialty organizations to petition the American Board of Medical Specialties to develop alternative pathways to board certification for physicians with high quality experience and additional education to sit for the boards in hospice and palliative care, and geriatric medicine.

Your Reference Committee heard testimony that was in favor of Resolution 322. The American Academy of Hospice and Palliative Medicine, supported by the American Geriatrics Society and the Pain and Palliative Medicine Section Council, provided alternate language, as shown above. Your reference committee urges adoption as amended.

(24) RESOLUTION 323 - PRESERVATION OF THE CURRENT FEDERAL STUDENT AID LOAN FORGIVENESS FOR PUBLIC SERVICE EMPLOYEES PROGRAM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 323 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association advocate ~~lobby~~ against putting a monetary cap ~~of \$57,500~~ on federal loan forgiveness programs. ~~through the Federal Student Aid Loan Forgiveness for Public Service Employees Program as proposed by President Obama in the 2015 fiscal year budget.~~ (Directive to Take Action)

Resolution 323 asks our AMA to lobby against putting a cap of \$57,500 on loan forgiveness through the Federal Student Aid Loan Forgiveness for Public Service Employees Program as proposed by President Obama in the 2015 fiscal year budget.

**HOD ACTION: Resolution 323 adopted as amended.**

Your Reference Committee heard strong support for Resolution 323. Minor changes were made to the resolve, based on the testimony, because specific legislation, bill numbers, and/or presidential administrations are subject to change. Your Reference Committee therefore asks that Resolution 323 be adopted as amended.

(25) COUNCIL ON MEDICAL EDUCATION REPORT 8 - GUIDELINES FOR STUDENTS SHADOWING PHYSICIANS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that CME Report 8 be referred.

**HOD ACTION: CME Report 8 referred.**

Resolution 310-A-13, “Medical Facility Regulations for Students Shadowing Physicians,” introduced by the Georgia delegation, asked that our AMA develop standard criteria for students to shadow physicians in medical facilities. Resolution 913-I-13, “Pre-Medical School Shadowing,” submitted by the Washington delegation, asked that our AMA (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.

CME Report 8 recommends 1. That our American Medical Association encourage wide dissemination of the Association of American Medical Colleges’ clinical shadowing guidelines to interested parties, including K-12 students, pre-medical students, health professions advisors, hospitals, medical schools and physicians; 2. That our AMA encourage all physicians to provide shadowing opportunities to pre-medical students; and 3. That AMA Policy D-295.941, “Facilitating Access to Health Care Facilities for Training,” be amended by addition to state that the AMA “work with the Association of American Medical Colleges and other national organizations to expedite, wherever possible, the standardization of requirements in regards to training on HIPAA, drug screening, and health requirements for pre-medical and medical students, and resident and fellow physicians who are being educated in hospitals and other health care settings.” The report focuses on areas common to Resolutions 310-A-13 and 913-I-13, namely concerns and strategies around pre-medical students shadowing physicians.

Your Reference Committee heard mixed testimony on CME Report 8. Some individuals noted that the amount of paperwork required of physicians to offer a shadowing opportunity is onerous. Your Reference Committee recommends referral of CME Report 8 to ensure a more thorough review of physician shadowing and mechanisms to ensure that individuals from underprivileged and under-represented minority groups are afforded the equal opportunity to participate in shadowing.

(26) RESOLUTION 317 - ABOLISH DISCRIMINATION AGAINST IMGs IN MEDICAL LICENSING REQUIREMENTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 317 be referred.

**HOD ACTION: Resolution 317 referred.**

Resolution 317 asks our AMA to 1) advocate that state medical societies in states that require unequal amounts of graduate medical education (GME) for International Medical Graduates (IMGs) versus LCME graduates seek legislation in their state legislatures to make GME requirements the same for IMGs and LCME graduates and also to eliminate any other discriminatory requirements mandated for IMGs alone, and 2) lobby the Federation of State Medical Boards (FSMB) to vigorously promote its policy of equal requirements for International Medical Graduates (IMGs) and LCME graduates and to ask the FSMB to seek changes in laws in each state to eliminate unequal graduate medical education (GME) requirements that discriminate against IMGs.

Your Reference Committee heard testimony in favor of the need for parity between U.S. and international medical graduates in the requirements for licensure. It was noted that this is a state-based issue, and requires changes to individual states’ medical practice acts, but the disparity and discrimination inherent in this discrepancy among

many states need to be addressed through an equitable, evidence-based solution. Other testimony reflected the variations in quality among foreign medical schools, and the trends in graduate medical education towards achievement of milestones versus a rigid, time-based requirement. In addition, it is critical to ascertain the number of states that have discrepant regulations in this regard. Further, the resolution's language calling on our AMA to "lobby" the FSMB to seek changes in state laws is problematic; more appropriate would be for our AMA to work with the FSMB to determine the scope of the problem and the rationale (if any) for the continued existence of such laws. Due to the complexity of these issues and the need for additional study, your Reference Committee recommends referral of Resolution 317.

(27) RESOLUTION 315 - CERTIFICATION OF METHADONE EDUCATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 315 not be adopted.

**HOD ACTION: Resolution 315 not adopted.**

Resolution 315 asks: 1) our AMA to bring together interested experts in the use of Methadone (and other extended release opioids) in chronic pain patients to create or designate a certifying body (such as the American Board of Pain Medicine or American Board of Anesthesiology) to oversee a certification process regarding the use of Methadone; 2) that the certifying body be charged with creating a test aimed at the demonstration of expertise in the use of Methadone in chronic pain patients; 3) that our AMA work with the DEA or other regulatory bodies to require providers to have this certification starting by June 2016; and 4) that experts already certified in the subspecialty of Pain Medicine by an ABMS specialty or by the American Board of Pain Medicine be exempt from this new certification requirement.

Your Reference Committee heard testimony that highlighted major concerns with this resolution. These include the following: 1) Certification by one of the certifying boards is not the optimal approach; special certification in the use of a single medication would be unique and set a precedent restricting scope of practice. 2) Many other drugs are dangerous and require specific training to use safely; these include extended release narcotic medications. 3) The FDA has established risk reduction training requirements for the use of extended release pain medications—these should be sufficient for methadone as well. 4) Patient safety should be adequately addressed with the use of the FDA Risk Evaluation and Mitigation Strategy (REMS) mechanism. 5) Specialties other than pain medicine are trained in the safe use of methadone—hospice and palliative medicine, for example—and should also be exempted from such a requirement if it were to be created with an exemption for pain medicine. 6) Finally, further restriction of the availability of long-acting narcotic analgesics to the hands of such pain medication specialists would exacerbate the already severely limited availability of physicians able and willing to manage severe pain in the terminally ill and in oncology patients. The point was also made that requiring special consideration and certification for a particular drug is unwieldy and sets an unfortunate precedent. Your Reference Committee concurs with this testimony and believes that there are better avenues for addressing some of the emerging concerns with regard to methadone use in chronic pain. We therefore urge that Resolution 315 not be adopted.

(28) RESOLUTION 321 – ALTERNATE FINANCING OF POST GRADUATE EDUCATION FOR PHYSICIANS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 321 not be adopted.

**HOD ACTION: Resolution 321 not adopted.**

Resolution 321 asks our AMA to 1) work with the Congress to earmark funds from the federal higher education budget to increase graduate medical education (GME) training positions, and 2) explore funding from private sources for graduate medical education (GME) training positions and prepare a report for the House of Delegates.



Your Reference Committee heard testimony that was in opposition to this item. The potential unintended consequences of redirecting funds were noted; such actions could move GME funding into general appropriations and place the future sustainability of this funding stream in jeopardy. Concern was also expressed about use of private sources; this could lead to possible conflicts of interest for physicians in the public eye. Your Reference Committee therefore recommends that our AMA not adopt Resolution 321.

(29) RESOLUTION 313 - OPPOSITION TO THE FSMB MAINTENANCE OF LICENSURE PROGRAM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that H-275.920 be reaffirmed in lieu of Resolution 313.

**HOD ACTION: Policy H-275.920 reaffirmed in lieu of Resolution 313.**

Resolution 313 asks our AMA to 1) oppose any efforts by the Federation of State Medical Boards, Inc., (FSMB) to implement a “maintenance of licensure (MOL)” program in any state and 2) oppose any maintenance of certification (MOC) or recertification by a specialty medical board as a condition of licensure in any state.

Your Reference Committee heard mixed testimony, with support for deleting the first resolve and for reaffirming existing Policy H-275.920, in lieu of the second resolve. This policy calls for our AMA to develop alternatives for physicians who are not certified/recertified, and asks that MOC or OCC not be the only pathway to MOL for physicians. For this reason, your Reference Committee recommends reaffirmation of Policy H-275.920 in lieu of this resolution.

Policy recommended for reaffirmation:

H-275.920 Impact of Maintenance of Certification, Osteopathic Continuous Certification, Maintenance of Licensure on the Physician Workforce

1. Our AMA encourages the Federation of State Medical Boards to continue to work with state licensing boards to accept physician participation in maintenance of certification (MOC) and osteopathic continuous certification (OCC) as meeting the requirements for MOL and to develop alternatives for physicians who are not certified/recertified, and that MOC or OCC not be the only pathway to MOL for physicians. 2. Our AMA encourages the American Board of Medical Specialties to use data from maintenance of certification to track whether physicians are maintaining certification and share this data with the AMA. (CME Rep. 11, A-12)

(30) RESOLUTION 320 - MANDATORY BOARD RECERTIFICATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-275.996 be reaffirmed in lieu of Resolution 320.

**HOD ACTION: Policy H-275.996 reaffirmed in lieu of Resolution 320.**

Resolution 320 asks our AMA to urge the mandatory recertification to be replaced with a specialty-specific continuing medical education alternative.

Your Reference Committee heard testimony to reaffirm existing AMA policy that currently reflects the intent of this resolution in lieu of Resolution 320. For example, Policy H-275.996 asks our AMA to urge the FSMB and its constituent state boards to reconsider and reverse the position urging and accepting specialty board certification as evidence of continuing competence for the purpose of re-registration of licensure. Your Reference Committee recommends that Policy H-275.996 be reaffirmed in lieu of Resolution 320.

Policy recommended for reaffirmation:

H-275.996 Physician Competence

Our AMA: (1) urges the American Board of Medical Specialties and its constituent boards to reconsider their positions regarding recertification as a mandatory requirement rather than as a voluntarily sought and achieved validation of excellence; (2) urges the Federation of State Medical Boards and its constituent state boards to reconsider and reverse their position urging and accepting specialty board certification as evidence of continuing competence for the purpose of re-registration of licensure; and (3) favors continued efforts to improve voluntary continuing medical education programs, to maintain the peer review process within the profession, and to develop better techniques for establishing the necessary patient care data base. (CME Rep. J, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 302, A-10)

## REPORT OF REFERENCE COMMITTEE D

## (1) BOARD OF TRUSTEES REPORT 10 – PROVIDING PHYSICAL FITNESS GUIDELINES

## RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 10 be adopted and the remainder of the report be filed.

**HOD ACTION: Recommendations in Board of Trustees Report 10 adopted and the remainder of the report filed.**

Board of Trustees Report 10 reviews the initiatives of national organizations and specialty societies that are involved in the establishment of physical activity guidelines for patients, as well as related legislation and current policy efforts of the AMA. It recommends that (1) Policy H-470.997 be reaffirmed; (2) Policy H-60.979 be amended by addition and deletion; and (3) Policies D-470.991, D-90.993, and D-470.990 be rescinded since they have been accomplished.

Your Reference Committee heard minimal but supportive testimony on this item. Acknowledging that several Federation members and other national experts are committed to the establishment of evidence-based recommendations and guidelines related to physical activity, your Reference Committee concurs with the recommendations of the report and recommends that it be adopted.

## (2) RESOLUTION 403 – SUNSCREEN AND SUN PROTECTION COUNSELING BY PHYSICIANS

## RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 403 be adopted.

**HOD ACTION: Resolution 403 adopted.**

Resolution 403 asks that our American Medical Association encourage physicians to counsel their patients on sun-protective behavior.

Your Reference Committee received limited but favorable testimony for this resolution. Your Reference Committee is aware of the significant impact of cancers such as melanoma that result from sun exposure. It was noted that this resolve may not be applicable to all physicians and that counseling should occur when clinically appropriate. Your Reference Committee is supportive of this resolution and recommends adoption.

## (3) RESOLUTION 413 – NATIONAL NUTRITIONAL GUIDELINES FOR FOOD BANKS AND PANTRIES

## RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 413 be adopted.

**HOD ACTION: Resolution 413 adopted.**

Resolution 413 asks that our American Medical Association adopt policy in support of the use of existing national nutritional guidelines for food banks and food pantries.

Your Reference Committee heard limited but mixed testimony on this resolution. While testimony uniformly supported the spirit of the resolution, one speaker questioned whether the focus of the resolution should be directed more toward improving preventive health services for impoverished communities (including access to and availability of healthier food options) rather than ensuring that food banks and food pantries adopt existing national nutritional guidelines. Some members of your Reference Committee expressed similar sentiment and questioned the practicality and feasibility of implementing this resolution. Although implementation may be challenging, our AMA should support organizations that are already using national nutritional guidelines to provide healthier food options. Ultimately, your Reference Committee deemed that the intent of this resolution is to improve expectations for the nutritional quality of foods dispensed by food banks and food pantries is laudable and should be supported.

(4) RESOLUTION 414 – ELIMINATING PREVENTABLE MENINGOCOCCAL DISEASE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 414 be adopted.

**HOD ACTION: Resolution 414 adopted.**

Resolution 414 asks that our American Medical Association support efforts to require that school children receive meningococcal vaccine per the Advisory Committee on Immunization Practices guidelines.

Your Reference Committee received mixed testimony on this issue; however, the majority of speakers were in support of this resolution. Your Reference Committee is aware of the importance of increasing vaccination rates. Testimony recognized that this is a complex issue and that further inquiry into why 30% of school children are not getting the meningococcal vaccine should be investigated further. The Council on Science and Public Health testified that they are currently drafting a report on vaccine exemptions and agree to include noncompliance issues in immunization. Therefore, your Reference Committee is supportive of this resolution and recommends adoption.

(5) RESOLUTION 415 – SAFER CHEMICAL POLICIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 415 be adopted.

**HOD ACTION: Resolution 415 adopted.**

Resolution 415 asks that our American Medical Association review the recommendations of the National Academies of Sciences with respect to Chemical Policy reform.

Your Reference Committee received limited but favorable testimony for this resolution. It was noted that the review should expand to include what specific National Academies of Sciences guidelines and/or recommendations that our American Medical Association should support. Your Reference Committee is supportive of this resolution and recommends adoption with report back.

(6) RESOLUTION 422 - SUPPORT FOR NUTRITION LABEL REVISION AND FDA REVIEW OF ADDED SUGARS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 422 be adopted.

**HOD ACTION: Resolution 422 adopted.**

Resolution 422 asks that our American Medical Association (1) issue a statement of support for the newly proposed nutrition labeling by the Food and Drug Administration (FDA) during the public comment period; (2) recommend that the FDA further establish a recommended daily value (%DV) for the new added sugars listing on the revised nutrition labels based on previous recommendations from the World Health Organization and American Heart Association; and (3) encourage further research into studies of sugars as addictive through epidemiological, observational, and clinical studies in humans.

Your Reference Committee received favorable support for the first two resolves in this resolution. Testimony was mixed on amending the language in the third resolve to address the “potentially” addictive nature of sugar. However, your Reference Committee is supportive of the resolution as written and recommends adoption.

(7) BOARD OF TRUSTEES REPORT 1 – INCREASING AWARENESS OF NUTRITION INFORMATION IN SCHOOLS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 of Board of Trustees Report 1 amending AMA Policy H-150.948 be amended by addition and deletion to read as follows:

~~INCREASING CUSTOMER~~ AWARENESS OF NUTRITION INFORMATION AND INGREDIENT LISTS ~~IN RESTAURANTS~~

Our AMA supports ~~and seeks~~ federal legislation or rules requiring ~~(1)~~ restaurants, retail food establishments, and vending machine operators that have menu items common to multiple locations, ~~to provide standard nutrition labels for all applicable items, available for public viewing; and (2) as well as all~~ school and workplace cafeterias, especially those located in health care facilities, and restaurants to have available for public viewing ingredient lists, ~~and nutritional information, and standard nutrition labels for all menu items, available for public viewing.~~ (Modify Current HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 1 be adopted as amended and the remainder of the report be filed.

**HOD ACTION: Recommendations in Board of Trustees Report 1 adopted as amended and the remainder of the report filed.**

Board of Trustees Report 1 reviews pertinent federal action which has been enacted since 2010 regarding nutrition information in U.S. public schools, as well as related AMA policy and efforts. It recommends that (1) Policy H-150.948 be amended by addition and deletion, and (2) Policies D-60.990 and D-150.988 be rescinded since they have been accomplished.

Your Reference Committee heard limited but favorable testimony on this item. An amendment was offered to include workplace cafeterias, with emphasis on those located in health care facilities. Your Reference Committee concurs with this addition but expressed some uncertainty regarding the purview of the FDA in regulating workplace cafeterias. The amendment also acknowledges the importance of expanding this policy beyond chain restaurants to include retail food establishments and vending machine operators.

## (8) BOARD OF TRUSTEES REPORT 9 – CHEERLEADING AS A SPORT

## RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 of Board of Trustees Report 9 be amended by addition and deletion to read as follows:

1. That our American Medical Association support the designation of cheerleading as a sport.

2. That our AMA recognizes the potential dangers ~~inherent in~~ of cheerleading, including the potential for concussion and catastrophic injury, and supports the implementation of recommendations designed to improve its safety equivalent to those that apply to other athletic activities formally recognized as “sports” by appropriate accrediting bodies. These include proper training of coaches, avoidance of inappropriate surfaces when performing stunts and adherence to rules for the proper execution of stunts. (New HOD Policy)

## RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 9 be adopted as amended and the remainder of the report be filed.

## RECOMMENDATION C:

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

## INJURIES IN CHEERLEADING

**HOD ACTION: Recommendations in Board of Trustees Report 9 adopted as amended with a change in title and the remainder of the report filed.**

Board of Trustees Report 9 briefly reviews cheerleading participation and injuries, recommendations for increased safety and the question of whether cheerleading should be designated as a sport. The designation of cheerleading as a “sport” would likely subject it to formal safety requirements and injury reporting. Referral was based on the concern that school districts may face hardships due to the burdens of implementing such requirements and reporting. Additionally, the designation of cheerleading as a sport has implications under Title IX, which introduces complexity into the decision. The report recommends (1) that our American Medical Association recognizes the potential dangers inherent in cheerleading, including the potential for concussion and catastrophic injury, and supports the implementation of recommendations designed to improve its safety. These include proper training of coaches, avoidance of inappropriate surfaces when performing stunts and adherence to rules for the proper execution of stunts (New HOD Policy) and (2) Policies H-470.959 and H-470.971 be reaffirmed.

Your Reference Committee heard significant, spirited testimony on this item and acknowledges the various viewpoints expressed. As described in the report, your Reference Committee recognizes the merits as well as the challenges of designating cheerleading as a sport, given the implications on school funding at all academic levels. For example, the report cites that cheerleading does not meet current NCAA standards to qualify as a sport, and that courts have ruled that it cannot be designated a sport for Title IX purposes. Your Reference Committee acknowledges that members of the Federation and other national organizations have studied the issue and developed recommendations, some of which do designate cheerleading as a sport. Your Reference Committee appreciates that Recommendation 1 focuses on ensuring the health and safety of cheerleaders by advocating for consistent adoption and implementation of recommendations aimed at improving cheerleading safety. It was noted that the title should reflect the emphasis of the recommendations, and was amended accordingly. After extensive deliberation, your



Reference Committee deems that designating cheerleading as a sport may have various unintended consequences and furthermore that making such a designation is beyond the purview of our AMA. Therefore your Reference Committee recommends that BOT 9 be adopted as amended.

(9) RESOLUTION 411 – BAN ON SUPER MAGNETIC TOYS AS A CHOKING AND GASTROINTESTINAL HAZARD TO CHILDREN

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 411 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association encourage ~~work with~~ the Consumer Product Safety Commission (CPSC) and other relevant governmental agencies to prohibit the sale of neodymium magnetics ~~balls~~ whose flux, or magnetic, strength index is greater than 50 Gauss and also who fail the CPSC's cylinder tests for choking hazards. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 411 be adopted as amended.

**HOD ACTION: Resolution 411 referred.**

Resolution 411 asks that our American Medical Association work with the Consumer Product Safety Commission (CPSC) and other relevant governmental agencies to prohibit the sale of neodymium magnetic balls whose flux, or magnetic, strength index is greater than 50 and also who fail the CPSC's cylinder tests for choking hazards.

Your Reference Committee heard favorable testimony for this item. Testimony noted the health dangers imposed by super magnets, particularly to children. Your Reference Committee noted that Gauss, the unit of measurement for magnetic field strength, should be included. While considering testimony on the beneficial use of super magnets by adults for mechanical applications, your Reference Committee agreed that such language was not germane to the intent of the resolve. Your Reference Committee recommends that Resolution 411 be adopted as amended.

(10) RESOLUTION 416 – GUN VIOLENCE PREVENTION AS A CONTINUING MEDICAL EDUCATION TOPIC

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 416 be amended by addition to read as follows:

RESOLVED, That our American Medical Association encourage CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 416 be adopted as amended.

**HOD ACTION: Resolution 416 adopted as amended.**

Resolution 416 asks that our American Medical Association encourage inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

Your Reference Committee heard testimony in support of the concept of educating physicians on gun violence given the health implications for patients and their families. Your Reference Committee acknowledges the concerns of the Council on Medical Education with regards to stipulation of CME content; however, it was noted that the language in the resolution encourages education but does not mandate it. Your Reference Committee offers amended language asking that CME providers “consider” this option. Therefore, your Reference Committee recommends that Resolution 416 be adopted as amended.

(11) RESOLUTION 420 – SUPPORT FDA REGULATION OF ALL TOBACCO PRODUCTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 420 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA strongly oppose any FDA rule that exempts any tobacco or nicotine-containing product, including ~~certain~~ all cigars, from FDA regulation (New HOD Policy); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 420 be adopted as amended.

**HOD ACTION: Resolution 420 adopted as amended.**

Resolution 420 asks that our American Medical Association (1) support the US Food and Drug Administration (FDA) as it takes an important first step in establishing basic regulations of all tobacco products; (2) strongly oppose any FDA rule that exempts any tobacco product, including certain cigars, from FDA regulation; and (3) join with physician and public health organizations in submitting comments on FDA proposed rule to regulate all tobacco products.

Your Reference Committee heard significant supportive testimony on this resolution. Testimony was favorable to the inclusion of nicotine-containing devices in the second resolve so your Reference Committee incorporated such language as a friendly amendment. One speaker noted that four resolutions on e-cigarettes were being addressed by Reference Committee E and that your Reference Committee’s decision should be in alignment. The Council on Science and Public Health provided testimony that a report on e-cigarettes will be submitted to the House of Delegates at the 2014 Interim Meeting; the report will address many of the points raised during the Reference Committee hearing. It was noted that the AMA issued a press release in April 2014 to support the FDA for its new effort to regulate additional tobacco products. The AMA is preparing comments on the FDA proposed rule as noted in the resolution. Therefore, your Reference Committee recommends that Resolution 420 be adopted as amended.

(12) RESOLUTION 421 – SUPPORT EPA REGULATION OF CARBON POLLUTION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 421 be amended by addition and deletion to read as follows:

~~RESOLVED, That our American Medical Association support US Environmental Protection Agency in setting strong carbon pollution limits for existing power plants (New HOD Policy); and be it further~~

RESOLVED, That our ~~AMA American Medical Association~~ submit comments ~~to the U.S. Environmental Protection Agency with medical physician organizations~~ during public comment period on the new proposed rule regarding existing power plant emissions to underscore the need to keep the standards strong and protective of public health. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Policies H-135.949 and H-135.934 be reaffirmed.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 421 be adopted as amended.

**HOD ACTION: Resolution 421 adopted as amended.**

Resolution 421 asks that our American Medical Association (1) support the US Environmental Protection Agency in setting strong carbon pollution limits for existing power plants (New HOD Policy) and (2) submit comments with medical physician organizations during public comment period on the proposed rule to underscore the need to keep the standards strong and protective of public health.

Your Reference Committee heard mixed testimony on this resolution. It was noted that the first resolve aligns with current AMA Policies H-135.949 and H-135.934. The second resolve asks the AMA to submit comments on the recent EPA proposed rule. Announced on June 2, 2014, this rule calls for power plants to cut carbon emissions by 30% (below 2005 levels) and cut particle pollution, nitrogen oxides, and sulfur dioxide by more than 25%. Recognizing the major potential impact that the carbon emissions have on global climate change and the related health implications, your Reference Committee recommends that the resolution be amended such that Policies H-135.949 and H-135.934 be reaffirmed in lieu of the first resolve, and that the second resolve be adopted.

Policies for reaffirmation:

H-135.949 Support of Clean Air and Power Plant Emissions Act

Our AMA supports federal legislation that meaningfully reduces the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide. (Res. 429, A-03; Reaffirmation I-07; Reaffirmed in lieu of Res. 526, A-12)

H-135.934 EPA and Green House Gas Regulation

Our AMA supports the Environmental Protection Agency's authority to promulgate rules to regulate and control green house gas emissions in the United States. (Res. 925, I-10; Reaffirmed in lieu of Res. 526, A-12)

- (13) RESOLUTION 401 – PUBLIC HEALTH: “HEADING IN SOCCER”
- RESOLUTION 410 – EVALUATING AND REDUCING THE RISK OF YOUTH SPORTS CONCUSSION
- RESOLUTION 412 – MANAGEMENT OF CONCUSSION GUIDELINES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolutions 401, 410, and 412 be referred.

**HOD ACTION: Resolutions 401, 410, and 412 referred.**

Resolution 401 asks that our American Medical Association (1) discourage “heading” of the ball while playing soccer until the athlete is playing in an organized league, once in high school, and has been trained in the proper

technique based upon contemporaneous standards; (2) recommend that individuals trained in heading the ball similarly train athletes when they are old enough; and (3) encourage continued investigation by our local sports medicine, pediatric and neurological colleagues, into the potential consequences of nonconcussive heading involved with soccer participation.

Resolution 410 asks that our American Medical Association (1) ask our Council on Science and Public Health to prepare a report summarizing the existing data on the risk of concussion in youth sports; (2) the Council on Science and Public Health to develop specific recommendations to aid physicians in efforts aimed at reducing the risk of concussion as a result of participation in youth sports; (3) work with all appropriate state and specialty societies to enhance access to appropriate continuing education for physicians emphasizing evolving literature on the diagnosis and management of concussion resulting from participation in youth sports; and (4) work with all appropriate state and specialty societies to help educate the general public about the established risks of concussion associated with participation in youth sports, as well as theoretical risks under study.

Resolution 412 asks that our American Medical Association promote awareness of the “Evaluation and Management of Concussion in Sports: Report of the Guideline Development Subcommittee of the American Academy of Neurology.”

Your Reference Committee heard spirited and supportive testimony for a comprehensive report from our Council on Science and Public Health on the epidemiology, risks, and potential consequences of concussion as a result of participation in youth sports. This is an important and timely issue affecting male and female athletes. Your Reference Committee heard compelling testimony that the report include recommendations for both return-to-play and return-to-classroom authorizations, and who would be best suited to make such authorizations with their scope of practice. Testimony supported efforts to enhance physician knowledge and understanding of the diagnosis and management of concussion, including the additive effect of subconcussive injuries. Various speakers emphasized the need to develop a report with input from multiple Federation members and national experts; this includes recent evidence-based guidelines from the American Academy of Neurology. The report and recommendations also should be useful in educating the general public about this topic. Testimony from our Council on Science and Public Health expressed keen interest in researching and compiling this report.

(14) **RESOLUTION 409 – FEDERAL RESOURCES TO PROTECT THE PUBLIC AND THE MEDICAL PROFESSION FROM AND DURING A COMMUNICABLE DISEASE OUTBREAK**

**RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends that Resolution 409 be referred for decision.

**HOD ACTION: Resolution 409 referred for decision.**

Resolution 409 asks that our American Medical Association (1) study the nature, magnitude and frequency of the problem of citizens being unable to receive established clinical preventive services in instances of public health threats and emergencies because of a lack of an established source of emergency resources to assure the capacity of an individual and/or community to provide such services; and (2) no later than A-2015, present a report, recommendations and an action plan (including legislative proposals), to the HOD whereby our AMA will advocate to address this serious resource deficiency.

Your Reference Committee heard limited but supportive testimony for this resolution. For the first resolve, the sponsor clarified that the focus of the intended study should be on receipt of community preventive services rather than clinical preventive services in emergency situations. Despite this clarification, your Reference Committee had difficulty determining the precise “problem” or “resource deficiency” that warrants further study. It is unclear whether the proposed study relates to funding, access to services, infrastructure, countermeasures (e.g., vaccines, prophylactic antimicrobials), or other resource challenges, which can be encountered for any infectious disease outbreak or for large-scale public health emergencies. With implementation of the Affordable Care Act, there have been and will continue to be significant changes in the US health system. It is not clear what impact these changes

will have on medical and public health preparedness programs and services. Rather than adopt the resolution as submitted, your Reference Committee deemed it more appropriate to ask the sponsor to work with AMA staff to more clearly articulate the research question(s) that need to be addressed in the requested study, and then ask our Board of Trustees to recommend the most prudent course of action.

(15) RESOLUTION 408 – GLOBAL WARMING

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy H-135.977 be reaffirmed in lieu of Resolution 408.

**HOD ACTION: Policy H-135.977 reaffirmed in lieu of Resolution 408.**

Resolution 408 asks that our American Medical Association (1) support that all fuels as well as their utilization should be evaluated to determine their relative impact on CO<sub>2</sub> increase and global warming and (2) support higher pricing and taxation on environmentally harmful fuels such as gasoline and coal.

Your Reference Committee heard testimony that supports the evaluation of fuels and their utilization as described in the first resolve. Testimony was not in favor of higher prices and taxation as described in the second resolve, citing concerns about the fiscal impact upon consumers and that this issue is beyond the purview of the AMA. It was noted that AMA Policy H-135.977 reflects the intent of the first resolve. As such, your Reference Committee recommends that Policy H-135.977 be reaffirmed in lieu of this resolution.

Policy for reaffirmation:

H-135.977 Global Climate Change - The "Greenhouse Effect"

Our AMA: (1) endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting; (2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production; (3) endorses increased recognition of the importance of nuclear energy's role in the production of electricity; (4) encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and (5) encourages humanitarian measures to limit the burgeoning increase in world population. (CSA Rep. E, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-12)

(16) BOARD OF TRUSTEES REPORT 5 - ANNUAL UPDATE ON TOBACCO ACTIVITIES AND PROGRESS IN TOBACCO CONTROL: MARCH 2013 THROUGH FEBRUARY 2014

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 5 be filed.

**HOD ACTION: Board of Trustees Report 5 filed.**

This report summarizes American Medical Association activities and progress in tobacco control from March 2013 through February 2014 and is written in response to AMA Policy D-490.983 "Annual Tobacco Report".

This report is an informational report and as such, does not contain any recommendations. Testimony from the individual who extracted the report asked that recommendations be added to provide guidance to states with low tobacco taxes on how to increase such taxes, as well as guidance on how to introduce legislation on clear air. While these proposed additions are well intended and have merit, they go beyond the scope of this retrospective informational report. To address these concerns, your Reference Committee encourages the speaker to consider introducing a resolution for future deliberation.

Your Reference Committee received limited but supportive testimony on this report and acknowledges that this report is valuable in keeping physicians informed about tobacco control issues. Therefore, your Reference Committee recommends that this report be filed.



## REPORT OF REFERENCE COMMITTEE E

- (1) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 1 - CSAPH  
SUNSET REVIEW OF 2004 HOUSE POLICIES

## RECOMMENDATION:

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

**HOD ACTION: Recommendation in Council on Science and Public Health Report 1 adopted and the remainder of the report filed.**

Council on Science and Public Health Report 1 makes recommendations on the disposition of 2004 House policies assigned to the Council. The report recommends that the House of Delegates policies that are listed in the Appendix to the report be acted upon in the manner indicated in the Appendix and the remainder of the report be filed.

No extractions were requested from the Council's Sunset Report. Accordingly, your Reference Committee recommends adoption.

- (2) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 2 - GENOMIC-BASED APPROACHES TO THE RISK ASSESSMENT, MANAGEMENT AND PREVENTION OF TYPE 2 DIABETES

## RECOMMENDATION:

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

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

Council on Science and Public Health Report 2 reviews genomic-based strategies aimed at improving the clinical care of type 2 diabetes. The report recommends that our American Medical Association encourage continued research into the potential of genomic information to improve risk assessment, management and prevention of type 2 diabetes, and report back on important advances as appropriate.

Supportive testimony was offered on the Council's report, noting that type 2 diabetes is a complex disease with a growing public health burden and that innovative solutions are required to adequately address it. The Council noted that genomic approaches to the management and prevention of diabetes are promising, and that further research should be encouraged. Your Reference Committee agrees and urges adoption of the report's recommendation.

- (3) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 4 -  
BIOSIMILAR PRODUCT APPROVAL AND MARKETING

## RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 4 be adopted and the remainder of the report filed.

(2) That Policy D-125.989, "Substitution of Biosimilar Medicines and Related Medical Products," be amended by addition and deletion to read as follows:

Our AMA urges that State Pharmacy Practice Acts and substitution practices for biosimilars in the outpatient arena: (1) ~~mirror the current practices for A-rated generic drugs by preserving physician autonomy the right of physicians and other prescribers to designate which biologic or biosimilar product is dispensed to their patients;~~ (2) allow substitution when physicians expressly authorize substitution of an interchangeable product or their consent is implied by remaining silent or expressing no preference regarding substitution of such products; (3) limits the authority of pharmacists to automatically substitute only those biosimilar products that are deemed interchangeable by the FDA. (Res. 918, I-08; Modified: CSAPH Rep. 1, I-11);

**HOD ACTION: Recommendations in Council on Science and Public Health Report 4 adopted as amended and the remainder of the report filed.**

Council on Science and Public Health Report 4 revisits the topic of biosimilars, studying emerging issues that are relevant for such products under the current abbreviated pathway for approval, and recommending changes to relevant AMA policy. The report recommends: (1) That Policy H-125.980, “Abbreviated Pathway for Biosimilar Approval,” be amended by addition and deletion to read as follows:

~~AMA policy is that pharmaceutical companies should be allowed to make biosimilar medications available to physicians and their patients in a reasonable period of time with a reasonably predictable pathway to bring them to market. Our AMA supports will advocate for appropriate FDA Guidance and implementation of the Biologics Price and Competition and Innovation Act of 2009 in a manner that: 1) includes a straightforward regulatory process for an abbreviated approval pathway for biosimilars; 2) places appropriate emphasis on the promoting patient access, protection of patient safety, and preserving market competition and innovation in both the original branded products and all biosimilar products that are brought to market; and 3) includes planning by the FDA and the allocation of sufficient resources to ensure that physicians understand the distinctions between biosimilar products that are considered highly similar, and those that are deemed interchangeable. Focused educational activities must precede and accompany the entry of biosimilars into the U.S. market, both for physicians and patients; 3) includes compiling and maintaining an official compendium of biosimilar products, biologic reference products, and their related interchangeable biosimilars as they are developed and approved for marketing by the FDA.~~ (Res. 220, A-09; Reaffirmation A-11; Modified: CSAPH Rep. 1, I-11);

(2) That Policy D-125.989, “Substitution of Biosimilar Medicines and Related Medical Products,” be amended by addition and deletion to read as follows:

Our AMA urges that State Pharmacy Practice Acts and substitution practices for biosimilars in the outpatient arena: (1) ~~mirror the current practices for A-rated generic drugs by preserving physician autonomy the right of physicians and other prescribers to designate which biologic or biosimilar product is dispensed to their patients;~~ (2) allow substitution only either when physicians expressly authorize substitution of an interchangeable product or their consent is implied by remaining silent or expressing no preference regarding substitution of such products; (3) limits the authority of pharmacists to automatically substitute only those biosimilar products that are deemed interchangeable by the FDA. (Res. 918, I-08; Modified: CSAPH Rep. 1, I-11);

(3) That our AMA urges the FDA to finalize Guidance on the naming and labeling conventions to be used for biosimilar products, including those that are deemed interchangeable. Any change in current nomenclature rules or standards should be informed by a better and more complete understanding of how such changes, including requiring a unique identifier for biologic United States Adopted Names (USANs) would impact prescriber attitudes and patient access, and affect post marketing surveillance. Actions that solely enhance product identification during surveillance but act as barriers to clinical uptake are counterproductive. However, because of unique product attributes, a relatively simple way to identify and track which biosimilar products have been dispensed to individual patients must be established. If unique identifiers for biosimilar USANs are required to support pharmacovigilance, they should be simple and the resulting names should reinforce similarities by using the same root name following standards for nonproprietary names established by the USAN Council; and

(4) That Policy D-125.988, “Updating AMA Policy on Biosimilars,” be rescinded.

Testimony was supportive of the Council's updated report on biosimilars, with many noting that biologics are complex therapeutics and regulation of them should take into account their unique properties. Some sentiment was expressed for a unique naming convention for biosimilars intended to enhance product identification and postmarketing surveillance, and for physician notification in the event that an interchangeable biosimilar is substituted at the level of the pharmacy. Considerable uncertainty exists about the need for, and potential impacts of, these specific actions on market development since there has been little development in the United States. Accordingly your Reference Committee is comfortable with the Council's analysis and adoption of the recommendations contained in Report 4.

(4) RESOLUTION 512 - RISK EVALUATION AND MITIGATION STRATEGIES (REMS) FOR METHADONE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 512 be adopted.

**HOD ACTION: Resolution 512 referred.**

Resolution 512 asks that our American Medical Association (1) urge the US Food and Drug Administration to require an "individual" Risk Evaluation and Mitigation Strategy (REMS) for the clinical use of methadone in pain management; and (2) advocate that the manufacturer deemed responsible for developing a methadone-specific REMS consult experts in pain medicine in designing the program.

Testimony noted that a risk evaluation and mitigation strategy (REMS) currently exists for methadone as part of a broader REMS for so-called extended release and long-acting (ER/LA) opioid analgesic products, and that the number of unintentional overdoses and deaths attributable to the use of methadone as a pain reliever is disproportionate to the actual prescribing rate for methadone. The view was strongly expressed that methadone is a product with such unique pharmacokinetic and pharmacodynamic properties that it is more rational for safety reasons to establish a singular REMS strategy for methadone. While considerable effort has already been extended to developing and implementing the ER/LA opioid REMS program, your Reference Committee agrees that methadone's unique safety profile is reason to request that it be separated from other opioid analgesic products.

(5) RESOLUTION 513 - ANTIBIOTIC USE IN FOOD PRODUCING ANIMALS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 513 be adopted.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Policy H-440.895 be rescinded.

**HOD ACTION: Resolution 513 adopted and Policy H-440.895 rescinded.**

Resolution 513 asks that our American Medical Association (1) support federal efforts to ban antibiotic use in food-producing animals for growth promotion purposes, including through regulatory and legislative measures; (2) support a strong federal requirement that antibiotic prescriptions for animals be overseen by a veterinarian knowledgeable of the place and intended use of these drugs, under a valid veterinarian-client-patient relationship (VCPR); and (3) support efforts to expand FDA surveillance and data collection of antibiotic use in agriculture.

Limited testimony was offered in support of Resolution 513. This remains an important public health issue with a growing body of evidence that human health is harmed by the prophylactic off-label use of antibiotics in animals.

Therefore, your Reference Committee recommends adoption. Since adoption of this resolution would create policy more stringent than H-440.895, your Reference Committee recommends rescinding that policy.

Policy to be rescinded:

H-440.895 Antimicrobial Use and Resistance

Our AMA is opposed to the use of antimicrobials at non-therapeutic levels in agriculture, or as pesticides or growth promoters, and urges that non-therapeutic use in animals of antimicrobials (that are also used in humans) should be terminated or phased out based on scientifically sound risk assessments. (Res. 508, A-01; Reaffirmed: CSAPH Rep. 1, A-11)

- (6) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 3 - NATIONAL DRUG SHORTAGES-UPDATE  
RESOLUTION 522 - DRUG SHORTAGES-FEDERAL AGENCY  
ASSESSMENT OF REIMBURSEMENT AND PRICING POLICY ON  
SHORTAGES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Science and Public Health Report 3 be amended by addition on page 7, line 35 to read as follows:

7. Our AMA urges the development of a comprehensive independent report on the root causes of drug shortages. Such an analysis should consider federal actions, the number of manufacturers, economic factors, including federal reimbursement practices, as well as contracting practices by market participants on competition, access to drugs, and pricing. In particular, further transparent analysis of economic drivers is warranted. The Centers for Medicare and Medicaid Services should review and evaluate its 2003 Medicare reimbursement formula of average sales price plus 6% for unintended consequences, including serving as a root cause of drug shortages. The Council will monitor and evaluate the forthcoming report on drug shortages from the Government Accountability Office and report back on its findings. (Modify HOD Policy).

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Science and Public Health Report 3 be adopted as amended in lieu of Resolution 522 and the remainder of the report filed.

**HOD ACTION: Recommendation in Council on Science and Public Health Report 3 adopted as amended in lieu of Resolution 522 and the remainder of the report filed.**

Council on Science and Public Health Report 3 evaluates the findings of the 2014 Government Accountability Office (GAO) report on drug shortages and the current status of drug shortages in the United States, as well as other recent developments intended to prevent new drug shortages and resolve existing ones. The report recommends that Policy H-100.956 “National Drug Shortages” be amended by addition and deletion as follows:

1. That our AMA supports the recommendations of the 2010 Drug Shortage Summit convened by the American Society of Health System Pharmacists, American Society of Anesthesiologists, American Society of Clinical Oncology and the Institute for Safe Medication Practices and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.
2. Our AMA supports requiring all manufacturers of Food and Drug Administration approved drugs and, including FDA approved drugs with recognized off-label uses, to give the agency advance notice (at least 6 months prior or otherwise as soon as practicable) of anticipated voluntary or involuntary, permanent or temporary, discontinuance of the manufacture or marketing of such a product.

3. Our AMA supports authorizing the Secretary of Health and Human Services to expedite facility inspections, and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.
4. Our AMA supports the creation of a task force to enhance the HHS Secretary's response to preventing and mitigating drug shortages and to create a strategic plan to: (a) enhance interagency coordination; (b) address drug shortage possibilities when initiating regulatory actions (including the removal of unapproved drug products from the market); (c) improve FDA's ability to track and analyze drug shortage data in an effort to develop strategies to better prevent drug shortages (ed) provide further information on expedited solutions that have worked to prevent or mitigate drug shortages; (e) communicate with stakeholders; and ~~(d)~~ (f) consider the impact of drug shortages on research and clinical trials.
5. Our AMA will advocate that the U.S. Food and Drug Administration and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.
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.
7. Our AMA urges the development of a comprehensive independent report on the root causes of drug shortages. Such an analysis should consider federal actions, the number of manufacturers, economic factors, including federal reimbursement practices, as well as contracting practices by market participants on competition, access to drugs, and pricing. In particular, further transparent analysis of economic drivers is warranted. ~~The Council will monitor and evaluate the forthcoming report on drug shortages from the Government Accountability Office and report back on its findings.~~
8. Our AMA urges that procedures be put in place: (1) for the FDA to monitor the availability of Schedule II controlled substances; (2) for the FDA to identify the existence of a shortage that is caused or exacerbated by existing production quotas; and, (3) for expedited DEA review of requests to increase aggregate and individual production quotas for such substances.
9. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.
10. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.
- ~~11.~~ Our AMA will collaborate with medical specialty partners in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs. (CSAPH Rep. 2, I-11; Modified: CSAPH Rep. 7, A-12; Modified: CSAPH Rep. 2, I-12; Modified: CSAPH Rep. 8, A-13; Modified in lieu of Res. 912, I-13.

Resolution 522 asks that our American Medical Association (1) request the Centers for Medicare & Medicaid Services review their 2003 Medicare reimbursement formula of average sales price plus 6% for the unintended consequences of affecting market availability, especially for childhood leukemia, intensive care and anesthesia injectable therapies; and (2) request CMS to review the 2003 Medicare reimbursement formula of average sales price plus 6% as a root cause for drug shortages for American patients, especially in face of the Government Accountability Office report of 2014 – Drug Shortages: Public Health Threat continues despite efforts to ensure product availability.

The Council was thanked for keeping the House informed about the ongoing nature of drug shortages in the United States. Testimony acknowledged the continuing burden that drug shortages place on physicians and their patients. Although the recent GAO report on drug shortages provided some economic analysis of the root causes of drug shortages, additional evaluation of economic drivers of drug shortages and renewed attention to the potential role of the CMS reimbursement formula as a potential root cause of drug shortages is warranted. The view also was expressed that the predominant cause of drug shortages is over-regulation by the FDA and “price fixing” based on implementation of the CMS reimbursement formula. The Council has not endorsed this view.



(7) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 5 -  
GUIDELINES FOR MOBILE MEDICAL APPLICATIONS AND DEVICES  
RESOLUTION 514 - IMPROVING FAMILIARITY WITH AND  
UTILIZATION OF MOBILE MEDICAL TECHNOLOGY

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 5 be amended by addition of a new Recommendation 3.

1. That our American Medical Association (AMA) monitor market developments in mobile health (mHealth), including the development and uptake of mHealth apps, in order to identify developing consensus that provides opportunities for AMA involvement. (Directive to Take Action)
2. That our AMA continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market. (Directive to Take Action)
3. That our AMA make an effort to educate physicians on mHealth apps that can be used to facilitate patient communication, advice, and clinical decision support, as well as resources that can assist physicians in becoming familiar with mHealth apps that are clinically useful and evidence-based.
34. That Policy D-480.975, "Guidelines for Mobile Medical Applications and Devices," be rescinded. (Rescind HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 5 be adopted as amended in lieu of Resolution 514 and the remainder of the report filed.

**HOD ACTION: Recommendations in Council on Science and Public Health Report 5 adopted as amended in lieu of Resolution 514 and the remainder of the report filed.**

Council on Science and Public Health Report 5 examines key trends and findings relevant to the developing field of mobile health (mHealth) apps, and how these realities impact the feasibility of our AMA taking a leadership or convening role in this arena. The report recommends that (1) our (AMA) monitor market developments in mobile health, including the development and uptake of mHealth apps, in order to identify developing consensus that provides opportunities for AMA involvement; (2) our AMA continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market; and (3) Policy D-480.975, "Guidelines for Mobile Medical Applications and Devices," be rescinded.

Resolution 514 asks that our American Medical Association (1) develop programming to educate physicians on how to use mobile applications for clinical decision-making support and for communication with patients, as well as how to advise patients to best use mobile technology; (2) work with other interested stakeholders, such as the innovators of existing apps and other medical societies, to develop or improve existing apps to deliver accurate medical information based on current medical guidelines; (3) educate physicians on discerning between useful, evidence-based apps and apps that are inaccurate; and (4) develop and maintain a list of "quality apps" that are evidence-based and user-friendly for provider use and for providers to recommend to their patients.

Testimony reflected the rapid development occurring in the field of mHealth around the use of mobile medical apps and the fact that an urgent need exists for a trusted source to provide guidance for physicians and their patients on



mobile medical apps. The AMA was urged to step into the developing gap between the pace of mobile medical app development and marketing, and the need for evidence-based evaluation of usefulness. General support was offered for Resolves 1 and 3 in Resolution 514 and your Reference Committee has incorporated the concepts of these resolves as an amendment to the recommendations in the Council report. Your Reference Committee believes this approach still offers the necessary flexibility for our AMA to determine the best course of action to become more formally engaged in this field.

(8) RESOLUTION 501 - DEVELOPMENT OF A STANDARDIZED POST-CONDUCTED ELECTRICAL EXPOSURE MEDICAL PROTOCOL AND EDUCATIONAL CAMPAIGN

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy H-145.977 be amended by addition and deletion to read as follows:

H-145.977 Use of ~~Fasers~~ Conducted Electrical Devices by Law Enforcement Agencies

Our AMA: (1) recommends that law enforcement departments and agencies should have in place specific guidelines, rigorous training, and an accountability system for the use of conducted electrical devices (CEDs) that is modeled after available national guidelines; (2) encourages additional independent research involving actual field deployment of CEDs to better understand the risks and benefits under conditions of actual use. Federal, state, and local agencies should accurately report and analyze the parameters of CED use in field applications; and (3) policy is that law enforcement departments and agencies have a standardized ~~approach to~~ protocol developed with the input of the medical community for the medical evaluation, management and post-exposure monitoring of subjects exposed to CEDs (CSAPH Rep. 6, A-09)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that amended Policy H-145.977 be adopted in lieu of Resolution 501.

**HOD ACTION: Amended Policy H-145.977 adopted in lieu of Resolution 501.**

Resolution 501 asks that our American Medical Association (1) encourage appropriate organizations and medical specialty societies to develop a standardized, post-exposure medical protocol for the use of conducted electrical devices (CEDs) using recent advances in the understanding of the risks associated with CEDs; and (2) support the incorporation of a standardized post-conducted electric device (CED)-exposure medical protocol into law enforcement procedures and training.

Testimony offered on Resolution 501 was mostly supportive, acknowledging that new data were available on the risks associated with the use of CEDs, and the need to develop standardized protocols for medical management and monitoring. Testimony also noted the need to ensure that CEDs are used appropriately by law enforcement personnel and that the use of CEDs does not present avoidable health risks to those on whom they are used. The Council on Science and Public Health reminded the Committee that it had developed a report and recommendations on CED use in 2009 that contains useful guidance. Policy adopted from that report already supports the medical evaluation and post-exposure monitoring that is called for in Resolve 2 of the resolution. Your Reference Committee recommends amending current policy to support the contemporary development of a standardized post-exposure medical protocol, based on input from the medical community, for individuals who have been exposed to CEDs.

## (9) RESOLUTION 502 - BREAST DENSITY NOTIFICATION

## RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 502 be amended by addition and deletion on line 31-34 to read as follows:

RESOLVED, That our American Medical Association supports the inclusion of breast tissue density information in the mammography report when appropriate and education of patients about the clinical relevance of such information, but opposes state the requirements for mandatory notification of breast tissue density to patients ~~unless and until it is demonstrated that supplemental ancillary screening studies are cost effective and clinically proven to improve patient care outcomes.~~ (New HOD Policy)

## RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 502 be adopted as amended.

**HOD ACTION: Resolution 502 adopted as amended.**

Resolution 502 asks that our American Medical Association oppose the mandatory notification of breast tissue density to patients unless and until it is demonstrated that supplemental ancillary screening studies are cost-effective and clinically proven to improve patient care outcomes.

Mostly supportive testimony was offered on Resolution 502. While some noted the value of fully informing patients about their health status and breast cancer risks, others cited the unclear evidence linking breast density to breast cancer risk. Concerns were aired about government intrusion into the practice of medicine, and that AMA policy on this topic is needed as more states consider breast density notification laws. Your Reference Committee recommends amendments to the resolution to support the inclusion of breast density information in the mammography report when appropriate and education of patients about the clinical relevance of such information. Your Reference Committee agrees that states should not mandate notification of patients about breast density.

## (10) RESOLUTION 503 - COMPREHENSIVE ACCESS TO SAFETY DATA FROM CLINICAL TRIALS

## RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 503 be amended by addition and deletion on page 2, lines 10-20 to read as follows:

RESOLVED, That our American Medical Association urge the ~~Federal~~ Food and Drug Administration to investigate and develop means by which ~~academic~~ scientific investigators can access original source safety data from industry-sponsored trials upon request (Directive to Take Action); and be it further

RESOLVED, That our AMA support the adoption of universal policy by medical journals requiring ~~principal~~ participating investigators to have independent access to all study data from industry-sponsored trials. (New HOD Policy)

## RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 503 be adopted as amended.  
RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 503 be changed to read as follows:

#### ACCESS TO CLINICAL TRIAL DATA

##### **HOD ACTION: Resolution 503 adopted as amended with change in title.**

Resolution 503 asks that our American Medical Association (1) urge the Federal Drug Administration to investigate and develop means by which academic investigators can access original source safety data from industry-sponsored trials upon request; and (2) support the adoption of universal policy by medical journals requiring principal investigators to have independent access to all study data from industry-sponsored trials.

Testimony was supportive of this resolution. The FDA noted that efforts to provide access to clinical trial data are currently underway and that industry also is voluntarily developing data access policies. Your Reference Committee also is aware that a number of medical journals have instituted data access policies. Your Reference Committee supports the concept that increased access to trial data by scientific investigators can enhance medical knowledge and benefit public health. Accordingly, adoption of this resolution with minor amendments is recommended. Additionally, a change in title is recommended since the resolution addresses data that is not just related to safety.

#### (11) RESOLUTION 506 - SALMONELLA STRATEGY

##### RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 506 be adopted.

#### REDUCING SALMONELLA OUTBREAKS

RESOLVED, That our AMA support USDA and FDA efforts to improve standards for *Salmonella* testing and sampling in chicken slaughter facilities and other food processing plants to reduce human *Salmonella* infection. (New HOD Policy)

##### **HOD ACTION: Substitute Resolution 506 adopted.**

Resolution 506 asks that our American Medical Association (1) advocate for more stringent sampling and testing techniques; and (2) advocate for new testing standards at slaughter facilities and the development of standards relating to salmonella contamination in cut chicken parts.

Supportive testimony was offered for Resolution 506, citing recent outbreaks of Salmonella and the number of people affected. Your Reference Committee is aware that the USDA and the FDA are working to continually improve the guidelines for food processing facilities to reduce the chances of Salmonella contamination. Your Reference Committee believes that the adoption of a substitute resolution broadly supporting these efforts is in order rather than limiting the policy only to cut chicken parts.

#### (12) RESOLUTION 508 - US PREVENTIVE SERVICES TASK FORCE REFORM

##### RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 508 be amended by deletion of the second resolve.

~~RESOLVED, That our AMA reaffirm AMA Policy D-425.992, Recommendations by the USPSTF, which states: “Our AMA will express concern regarding recent recommendations by the United States Preventive Services Task Force (USPSTF) on screening mammography and prostate specific antigen (PSA) screening and the effects these USPSTF recommendations have on limiting access to preventive care for Americans and will encourage the USPSTF to implement procedures that allow for meaningful input on recommendation development from specialists and stakeholders in the topic area under study.” (Reaffirm HOD Policy)~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 508 be adopted as amended.

**HOD ACTION: Resolution 508 adopted as amended.**

Resolution 508 asks that our American Medical Association

(1) amend existing policy H-330.896 to read as follows:

Our AMA supports the following reforms to strengthen the Medicare program, to be implemented together or separately, and phased-in as appropriate: 1. Restructuring beneficiary cost-sharing so that patients have a single premium and deductible for all Medicare services, with means-tested subsidies and out-of-pocket spending limits that protect against catastrophic expenses. The cost-sharing structure should be developed to provide incentives for appropriate utilization while discouraging unnecessary or inappropriate patterns of care. The use of preventive services ~~such as those recommended by the US Preventive Health Task Force~~ should also be encouraged. Simultaneously, policymakers will need to consider modifications to Medicare supplemental insurance (i.e., Medigap) benefit design standards to ensure that policies complement, rather than duplicate or undermine, Medicare’s new cost-sharing structure. 2. Offering beneficiaries a choice of plans for which the federal government would contribute a standard amount toward the purchase of traditional fee-for-service Medicare or another health insurance plan approved by Medicare. All plans would be subject to the same fixed contribution amounts and regulatory requirements. Policies would need to be developed, and sufficient resources allocated, to ensure appropriate government standard-setting and regulatory oversight of plans. 3. Restructuring age-eligibility requirements and incentives to match the Social Security schedule of benefits (Modify Current HOD Policy); and

(2) reaffirm AMA Policy D-425.992, Recommendations by the USPSTF, which states: “Our AMA will express concern regarding recent recommendations by the United States Preventive Services Task Force (USPSTF) on screening mammography and prostate specific antigen (PSA) screening and the effects these USPSTF recommendations have on limiting access to preventive care for Americans and will encourage the USPSTF to implement procedures that allow for meaningful input on recommendation development from specialists and stakeholders in the topic area under study.”

Extensive and mixed testimony was offered on Resolution 508. Many oppose the USPSTF’s recent recommendations on mammography and prostate specific antigen (PSA) screening, especially noting that the PSA recommendation does not adequately apply to all races and ethnicities. Others note that the group does important work for primary care physicians, many of whom rely on the Task Force to provide unbiased recommendations based on the latest high-quality evidence. Substantial debate centered on the Task Force’s process for soliciting input from the public, with many believing that medical specialties should be more involved. However, others noted the many opportunities for specialties to weigh in during the recommendation development process. Sponsors of the resolution are concerned that the reference to USPSTF recommendations in AMA policy H-330.896 implies endorsement of the recommendations. Your Reference Committee understands such concern, and recommends adoption of the first resolve. Regarding the second resolve, the directive has already been implemented by direct communication with the Task Force, and reaffirmation would not result in any further action. It therefore recommends deletion of the second resolve.

(13) RESOLUTION 509 - IMPACT OF PHARMACEUTICAL ADVERTISING ON WOMEN'S HEALTH

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 509 be amended by addition and deletion on page 1, lines 19-24 to read as follows:

RESOLVED, That our American Medical Association ~~collaborate with~~ urge the US Food and Drug Administration (FDA) to assure that all direct-to-consumer advertising of pharmaceuticals includes information regarding differing effects and risks between the sexes (Directive to Take Action); and be it further

RESOLVED, That our AMA ~~collaborate with~~ urge the FDA to assure that advertising of pharmaceuticals to health care professionals includes specifics outlining whether testing of drugs prescribed to both sexes has included sufficient numbers of women to assure safe use in this population and whether such testing has identified needs to modify dosages based on sex. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 509 be adopted as amended.

**HOD ACTION: Resolution 509 adopted as amended.**

Resolution 509 asks that our American Medical Association (1) collaborate with the US Food and Drug Administration (FDA) to assure that all direct-to-consumer advertising of pharmaceuticals includes information regarding differing effects and risks between the sexes; and (2) collaborate with the FDA to assure that advertising of pharmaceuticals to health care professionals includes specifics outlining whether testing of drugs prescribed to both sexes has included sufficient numbers of women to assure safe use in this population and whether such testing has identified needs to modify dosages based on sex.

Testimony on Resolution 509 was mostly supportive, citing the historic lack of female representation in clinical trials and the resulting differences that sometimes occur in drug metabolism and response among women and men. Your Reference Committee agrees with the intent of this resolution, but notes that no authority exists by which our AMA can “collaborate with” the FDA. It therefore recommends amendments to urge the FDA to assure that relevant sex difference data are available in direct-to-consumer advertisements for the benefit of both patients and physicians.

(14) RESOLUTION 511 - REGULATION OF ELECTRONIC NICOTINE DELIVERY SYSTEMS  
RESOLUTION 518 - TREATING E-CIGARETTES AS TOBACCO PRODUCTS  
RESOLUTION 519 - SALES AND MARKETING OF E-CIGARETTES TO MINORS  
RESOLUTION 521 - E-CIGARETTES TO BE TREATED THE SAME AS TOBACCO PRODUCTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy H-495.973 be amended by addition and deletion to read as follows:

H-495.973 FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products

Our AMA ~~will urge~~ supports: (1) the U.S. Food and Drug Administration's (FDA) proposed rule to immediately that would implement the its deeming authority written into the FDA tobacco law to allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the FDA tobacco law; (2) legislation and/or regulation addressing the minimum purchase age, locations of permissible use, the use of secure, child- and tamper-proof packaging and design, advertising and promotion activities, and sponsorship of e-cigarettes and all other non-pharmaceutical tobacco/nicotine products; (3) transparency and disclosure concerning the design, content of, and emission from e-cigarettes and all other non-pharmaceutical tobacco/nicotine products; (4) restrictions on the use of characterizing flavors that may enhance the appeal of such products to minors, and the development of strategies to prevent marketing to, and use of, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products by minors; (5) the prohibition of claims of reduced risk and/or the marketing of e-cigarettes as tobacco cessation tools until such time that credible evidence is developed that supports such claims.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that amended Policy H-495.973 be adopted in lieu of Resolutions 511, 518, 519, and 521.

**HOD ACTION: Amended Policy H-495.973 adopted in lieu of Resolutions 511, 518, 519, and 521.**

Resolution 511 asks that our American Medical Association (1) support labeling and regulating Electronic Nicotine Delivery Systems (ENDS) as tobacco products and drug delivery devices; (2) support legislation that addresses the minimum purchasing age, locations of permissible use, advertising, promotion, and sponsorship of ENDS in a manner similar to those of tobacco products; (3) support transparency and disclosure concerning the design, content and emissions of ENDS; (4) support secure, child-proof, tamper-proof packaging and design of ENDS; (5) support enhanced labeling that warns of the potential consequences of ENDS use, restriction of ENDS marketing as tobacco cessation tools, and restriction of the use of characterizing flavors in ENDS; and (6) support basic, clinical, and epidemiological research concerning ENDS.

Resolution 518 asks that our American Medical Association support the concept that e-cigarettes be considered tobacco products with all of the legal and policy restrictions with smoking in post-acute and long-term care facilities.

Resolution 519 asks that our American Medical Association (1) oppose the marketing, sales, and use of e-cigarettes and other nicotine delivery products to minors; and (2) work with federal and state lawmakers and officials to develop strategies to prevent marketing, sales, and use of e-cigarettes and other nicotine delivery products to minors.

Resolution 521 asks that our American Medical Association seek federal legislation that would place “e-cigarettes” and all nicotine delivery devices under the purview of the US Food and Drug Administration.

Testimony noted the recent proposed rule by the U.S. Food and Drug Administration that would extend the agency's tobacco authority to cover additional tobacco products and therefore already addresses some of the requests in these resolutions. Products that would be “deemed” to be subject to FDA regulation are those that meet the statutory definition of a tobacco product, including currently unregulated marketed products such as electronic cigarettes (e-cigarettes).

Consistent with currently regulated tobacco products, under the proposed rule, makers of e-cigarettes would, among other requirements, register with the FDA and report product and ingredient listings; only market new tobacco



products after FDA review; only make direct and implied claims of reduced risk if the FDA confirms that scientific evidence supports the claim and that marketing the product will benefit public health as a whole; and not distribute free samples. In addition, under the proposed rule, the following provisions would apply to newly “deemed” tobacco products: minimum age and identification restrictions to prevent sales to underage youth; requirements to include health warnings; and prohibition of vending machine sales, unless in a facility that never admits youth. Emphasis was placed on the need to strongly address issues related to the marketing of these products to, and uptake by, minors.

Testimony critical of the proposed rule contended that the FDA did not go far enough, particularly with respect to the use of flavorings, which may enhance appeal of e-cigarettes among youth. Preliminary evidence also suggests that the use of e-cigarettes may increase later adoption of other traditional tobacco products and may have other hazards associated with their use. The Council on Science and Public Health also noted that it plans to develop a report on e-cigarettes and their public health implications for I-14. In the meantime, your Reference Committee believes that current policy should be amended to provide a framework for AMA comments on the FDA’s proposed rule and for addressing certain outstanding (e.g., two year window for enforcement) and evolving issues (e.g., clarity of terminology, serious adverse events) with e-cigarettes.

(15) RESOLUTION 515 - PROMOTION OF METHADONE EDUCATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 515 be adopted.

EDUCATION TO PROMOTE RESPONSIBLE USE OF METHADONE FOR PAIN MANAGEMENT

RESOLVED, That our American Medical Association, in collaboration with Federation partners, collate and disseminate available educational and training resources on the use of methadone for pain management. (Directive to Take Action)

**HOD ACTION: Substitute Resolution 515 adopted.**

Resolution 515 asks that our American Medical Association (1) support the creation and distribution of specific training tools regarding the use of methadone and all extended-release opioids in chronic pain patients. These may include webinars, printed training materials or seminars among other choices; (2) make efforts to spread this information to all providers who would potentially treat chronic pain patients; and (3) would provide this training material and/or process by June 2015.

Testimony noted that a need exists to better educate some practitioners on the use of methadone. Methadone can be useful in the management of cancer pain, in palliative care, newborns experiencing neonatal abstinence syndrome, and in certain patients with chronic pain syndromes. The number of unintentional overdoses and deaths attributable to the use of methadone as a pain reliever is disproportionate to the actual prescribing rate for methadone. The view was strongly expressed that methadone is a product with unique pharmacokinetic and pharmacodynamic properties and focused education is necessary to allow safe use of this analgesic. A number of educational resources already exist on methadone, including modules developed as part of the extended release/long acting (ER/LA) opioid risk evaluation and mitigation strategy (REMS). Because of methadone’s unique safety profile, specific training materials and opportunities are advisable. However, your Reference Committee believes a more expedient approach is to have our AMA, in cooperation with Federation partners, collate and disseminate available educational materials addressing the appropriate clinical use of methadone for pain management.

(16) RESOLUTION 516 – SCIENCE, TECHNOLOGY, ENGINEERING, AND MATHEMATICS (STEM) UNDERGRADUATE EDUCATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 516 be amended by addition and deletion on page 2, lines 4-8 to read as follows:

RESOLVED: That our American Medical Association amend Policy H-170.985 by addition and deletion to read as follows:

H-170.985 Science, Technology, Engineering and Mathematics Education  
~~The Our~~ AMA (1) supports is committed to working with other concerned organizations and agencies to identify ways to improve science, technology, engineering and mathematics (STEM) education and ~~science~~ STEM literacy in the nation, and to increase interest in STEM science and education on the part of the nation's youth, particularly underrepresented minorities. (Modify HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 516 be adopted as amended.

**HOD ACTION: Resolution 516 adopted as amended.**

Resolution 516 asks that our American Medical Association amend Policy H-170.985 by addition and deletion to read as follows:

H-170.985 Science Education

The AMA (1) supports is committed to working with other concerned organizations and agencies to identify ways to improve science, technology, engineering and mathematics (STEM) education and ~~science~~ STEM literacy in the nation, and to increase interest in STEM science and education on the part of the nation's youth.

Broad support was offered for this resolution, stressing the importance of preparing the nation's youth for careers in the science, technology, engineering and math fields. Your Reference Committee recommends a minor amendment by deletion for grammatical purposes, but otherwise recommends adoption. Your Reference Committee appreciates the suggested amendment to include mention of minority youth by the Minority Affairs Section, but does not believe that it is necessary since the amended policy refers to all of the nation's youth.

(17) RESOLUTION 520 - MODIFICATION TO THE USP CHAPTER 797 GUIDELINES AS CURRENTLY WRITTEN

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 520 be adopted.

~~REVISIONS TO THE IMMEDIATE USE EXCEPTION IN USP GENERAL CHAPTER <797>~~

RESOLVED, That our American Medical Association encourage all interested parties to review and comment on draft revisions to USP General Chapter ~~<797>—Pharmaceutical Compounding—Sterile Preparations~~, with special attention to the “immediate use” exception, in light of recent reports of enforcement actions taken by The Joint Commission.

RESOLVED, That our American Medical Association inform physicians on the far-reaching effects of the immediate-use exception to practice and patient safety (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage and facilitate as a convener for all state, medical school, and specialty organization delegates to the United States Pharmacopeial Convention to protest the “immediate-use” exception to the USP Chapter 797 guidelines as currently written, including the “one-hour-rule,” and seek reasonable accommodation and modification of Chapter 797 guidelines with interested stakeholders (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage and facilitate as a convener for all state, medical school, and specialty organization delegates to the United States Pharmacopeial Convention to protest the USP Chapter 797 guidelines as currently written, including the prohibition to enter a container no more than twice, and seek reasonable accommodation and modification of Chapter 797 guidelines with interested stakeholders. (Directive to Take Action)

RESOLVED, That our AMA urge The Joint Commission and other deeming organizations to suspend the enforcement of the “immediate-use” exception to USP Chapter 797 as currently written, including the “one-hour-rule” until the reconvening of the USP in June 2015.

RESOLVED, That our AMA urge the USP to employ evidence-based methods to survey current medical practice as it relates to USP Chapter 797 guidelines.

**HOD ACTION: Resolution 520 adopted as amended.**

Resolution 520 asks that our American Medical Association (1) inform physicians on the far-reaching effects of the immediate-use exception to practice and patient safety; (2) encourage and facilitate as a convener for all state, medical school, and specialty organization delegates to the United States Pharmacopeial Convention to protest the “immediate-use” exception to the USP Chapter 797 guidelines as currently written, including the “one-hour-rule,” and seek reasonable accommodation and modification of Chapter 797 guidelines with interested stakeholders; and (3) encourage and facilitate as a convener for all state, medical school, and specialty organization delegates to the United States Pharmacopeial Convention to protest the USP Chapter 797 guidelines as currently written, including the prohibition to enter a container no more than twice, and seek reasonable accommodation and modification of Chapter 797 guidelines with interested stakeholders.

Testimony reflected concerns about the potential impacts on clinical care of certain standards contained in USP General Chapter <797> *Pharmaceutical Compounding—Sterile Preparations*, specifically under the category pertaining to “immediate use” compounded sterile products (CSP). Recently The Joint Commission has been interpreting certain traditional practices involving admixtures in the hospital setting as violating USP <797>. Standards in question relate to the recommended time frame for administration of an immediate use CSP, and limitation on the number of times a container can be entered during the compounding process. Testimony noted that the immediate use provision is intended only for those situations where immediate patient administration of a CSP is needed, and that the standards are intended to ensure patient safety and reduce the risk of patient harm. Those who expressed concerns about the clinical ramifications of enforcement of the “immediate use” offered assurances that they also were motivated by the best interests of the patient. General Chapter <797> is currently under revision by the Compounding Expert Committee which also created an Expert Panel in April 2013 to provide additional expertise in sterile compounding, including members who are infection control specialists and microbiologists. Once the revisions are finalized, General Chapter <797> will be posted for a 90 day public review and comment period in the Pharmacopeial Forum. All stakeholders are invited to participate in this standard setting process by providing input and comment during this 90 day period. Given these realities, no need appears to exist for our AMA to serve as a convening body to urge revision to the “immediate use” provisions in the existing chapter.

(18) RESOLUTION 523 - PRESIDENT'S COUNCIL ON SCIENCE AND TECHNOLOGY REPORT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 523 be amended by addition and deletion on lines 13-14 to read as follows:

RESOLVED, That our American Medical Association analyze the President's Council on Science and Technology Report of May 29 entitled "Better Health Care and Lower Costs: Accelerating Improvement through Systems Engineering" and respond as appropriate ~~provide recommendations as to its applicability to health care delivery.~~ (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 523 be adopted as amended.

**HOD ACTION: Resolution 523 adopted as amended.**

Resolution 523 asks that our American Medical Association analyze the President's Council on Science and Technology Report of May 29 and provide recommendations as to its applicability to health care delivery.

Limited but supportive testimony urged that our AMA review the President's Council on Science and Technology's recently released report on systems engineering approaches to health care. Your Reference Committee agrees that this would be a worthwhile endeavor for our AMA, and offers minor amendments to specify the name of the report and to allow our AMA staff to respond to the report's recommendations in a manner that would best suit its members.

(19) RESOLUTION 507 – OVER THE COUNTER (OTC) INSULIN

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 507 be referred.

**HOD ACTION: Resolution 507 referred.**

Resolution 507 asks that our American Medical Association seek federal regulation or legislation requiring insulin be available by prescription and to encourage individual states to seek regulations or legislation requiring prescriptions for insulin.

Testimony reflected concerns about the availability of several types of insulin preparations without the need for a prescription, and the possibility that patients obtaining this type of insulin may be doing so without consulting their physicians or without undergoing adequate medical evaluation. Concerns also were raised that individuals in certain occupations where a diagnosis of insulin dependent diabetes may preclude their employment (e.g., long haul truck drivers) might engage in self-treatment; in such cases, the health and welfare of the public may be threatened. However, no evidence was provided that such behaviors exist. Additionally, the impact of such a decision on patient access for those needing insulin on an emergency basis or who are unable to afford prescription insulin also is unknown. Your Reference Committee believes that more information is needed to make an informed decision about this resolution, and therefore recommends referral so that it can be sufficiently studied.

## (20) RESOLUTION 504 - ARSENIC IN FOOD

## RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 504 not be adopted.

**HOD ACTION: Resolution 504 not adopted.**

Resolution 504 asks that our American Medical Association (1) endorse the establishment of guidelines for minimally acceptable levels of arsenic content in food; and (2) work with the United States Office of Management and Budget to develop, approve and disseminate these official guidelines for minimally acceptable levels of arsenic content in food under the laws of the US government.

Testimony noted that heavy metal contamination remains a relevant topic specifically with respect to the developing central nervous system and is of general interest under the topic of environmental contaminants. Regulatory challenges exist in establishing minimally acceptable levels for arsenic concentrations in food rather than a “minimal safe daily intake” based on various patterns of food intake. Some skepticism was expressed regarding whether this resolution was needed given that FDA has a long standing program of testing arsenic in a variety of foods. Additionally the agency is working on a draft risk assessment on arsenic in rice that it expects to release sometime this year and guidelines for arsenic levels in juices have already been established. Testimony also noted that it is the FDA, not the Office of Management and Budget, that oversees guidelines for levels of arsenic in food. Your Reference Committee therefore believes that this issue is not an urgent public health issue and recommends that Resolution 504 not be adopted.

## (21) RESOLUTION 505 - COMMUNITY PEANUT ALLERGY SAFETY

## RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 505 not be adopted.

**HOD ACTION: Resolution 505 not adopted.**

Resolution 505 asks that our American Medical Association support that a) all food products and other items that may be consumed by humans be adequately labeled for 100% of all contents; b) wherever possible, especially airplanes, such peanut containing products will no longer be served; and c) adequate emergency equipment and expertise be available if needed.

Mixed testimony was offered on Resolution 505. It was noted that FDA regulations already require that packaged food containing peanuts be labeled as such, and that our AMA already has policy supporting the availability of emergency equipment and expertise on airplanes to handle allergic reactions. Your Reference Committee is aware that airlines have explored options for making flights peanut-free, but have concluded that it is impossible to guarantee a peanut-free flight because even if they do not serve peanuts, they cannot control what types of foods passengers bring onto planes. Airline policies generally encourage those with peanut allergies to contact their physician before airplane travel and carry appropriate medications with them. Your Reference Committee believes that current FDA regulations and our AMA’s current policy sufficiently address the tasks of the resolution, and therefore recommends that it not be adopted.

## (22) RESOLUTION 517 - GENETICALLY MODIFIED ORGANISMS LABELING

## RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 517 not be adopted.

**HOD ACTION: Resolution 517 not adopted.**

Resolution 517 asks that our American Medical Association (1) ask the World Health Organization to review its current support of genetically modified organisms (GMOs), specifically reviewing any potential conflicts of interest in the current research and the lack of human research, which leaves unanswered questions regarding safety; and (2) pursue and endorse a national law requiring the clear labeling of all genetically modified organisms (GMOs) or foods containing genetically modified ingredients.

Mixed testimony was offered on Resolution 519. The sponsors of the resolution believe that the public has a right to be informed about whether foods contain bioengineered ingredients. Testimony also noted that the FDA's science-based labeling policy states that labels need only list information about bioengineered ingredients if the food is significantly different from its non-bioengineered counterpart or if the food's nutritional profile has changed. The Council on Science and Public Health studied the issue of bioengineered foods two years ago, and concluded that thorough pre-market safety assessment and the FDA's labeling policy are effective in ensuring the safety of bioengineered foods. No new evidence has been published since the Council's report that suggests contrary findings. Your Reference Committee therefore recommends that the resolution not be adopted.

(23) **RESOLUTION 510 - LABELING OF PACKAGING AND FOODS  
CONTAINING ENGINEERED NANOPARTICLES**

**RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends that Policy H-480.949 be reaffirmed in lieu of Resolution 510.

**HOD ACTION: Policy H-480.949 reaffirmed in lieu of Resolution 510.**

Resolution 510 asks that our American Medical Association endorse labeling of foods and packaging containing engineered nanoparticles including nanoparticle specifications, as reasonable, to allow public health monitoring.

Limited but mixed testimony was offered on Resolution 510. Nearly all testimony supported the concept that nanotechnology is somewhat new and requires ongoing study and evaluation to determine whether it could be harmful to human health. The FDA's regulatory approach for foods containing nanoparticles is one of industry responsibility, i.e., the FDA considers industry responsible for ensuring that its products meet all applicable legal requirements, including standards for safety, regardless of the emerging nature of a technology involved in product manufacturing. The Council on Science and Public Health studied the topic of nanotechnology safety just last year, and concluded that studies have not yet determined what the effects of real-world nanotechnology exposure are, and that further study is needed. The Council also testified that in light of the uncertain health effects, it supports labeling of foods and food packaging containing nanotechnology. However, your Reference Committee believes that in the absence of data indicating any harmful effects of real-world nanotechnology exposure, it is not appropriate for labeling to be mandated. Instead, it supports further research and recommends reaffirmation of current policy.

Policy recommended for reaffirmation:

H-480.949 Nanotechnology, Safety and Regulation

Our AMA: (1) recognizes the benefits and potential risks of nanotechnology; (2) supports responsible regulation of nanomaterial products and applications to protect the public's health and the environment; and (3) encourages continued study on the health and environmental effects of exposure to nanomaterials. (CSAPH Rep. 2, A-13)



## REPORT OF REFERENCE COMMITTEE F

## (1) BOARD OF TRUSTEES REPORT 6 - AMA 2015 DUES

## RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 6 be adopted and the remainder of the Report be filed.

**HOD ACTION: Board of Trustees Report 6 adopted and the remainder of the Report filed.**

Board of Trustees Report 6 recommends no changes to our AMA membership dues levels for 2015. The Report further notes that our AMA last raised its dues in 1994.

Regular Members .....	\$420
Physicians in Their Second Year of Practice .....	\$315
Physicians in Military Service .....	\$280
Physicians in Their First Year of Practice .....	\$210
Semi-Retired Physicians .....	\$210
Fully Retired Physicians .....	\$84
Physicians in Residency Training .....	\$45
Medical Students .....	\$20

Your Reference Committee received only supportive online comments favoring adoption of Board of Trustees Report 6. Likewise, your Reference Committee is supportive of our AMA Board of Trustees' recommendation to maintain what is now a 20-year trend of maintaining membership dues levels and believes our AMA Board of Trustees and staff have developed a successful membership value proposition. Your Reference Committee further believes the stability of our AMA's membership pricing will contribute to the growth of our AMA's influence and member engagement.

## (2) BOARD OF TRUSTEES REPORT 29 - FAIR ACCESS TO SCIENCE AND TECHNOLOGY RESEARCH ACT OF 2013 FOR IMPROVED ACCESS TO MEDICAL RESEARCH

## RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 29 be adopted and the remainder of the Report be filed.

**HOD ACTION: Recommendation in Board of Trustees Report 29 adopted and the remainder of the Report filed.**

Board of Trustees Report 29 comes in response to Resolution 610-A-13, which called upon our AMA to urge its members and physicians across the country to support initiatives about open access to research literature, including two bills in Congress.

In this Report, the Board of Trustees indicated that Resolution 610-A-13 is not consistent with current AMA policy, the objectives of AMA Publishing, or the business model of The JAMA Network; therefore, the Board of Trustees recommends that Resolution 610-A-13 not be adopted.

Your Reference Committee received only one supportive online comment favoring adoption of our AMA Board of Trustees Report 29 and no onsite testimony. Your Reference Committee recommends adoption.

(3) REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON  
COMPENSATION OF THE OFFICERS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in the Report of the House of Delegates Committee on Compensation of the Officers be adopted and the remainder of the Report be filed.

**HOD ACTION: Recommendation in the Report of the House of Delegates Committee on Compensation of the Officers adopted and the remainder of the Report filed.**

The Report of the House of Delegates Committee on Compensation of the Officers recommends there be no changes to the Officers' compensation for the period beginning July 1, 2014 through June 30, 2015.

Your Reference Committee received only supportive online comments favoring adoption of the Report of the House of Delegates Committee on Compensation of the Officers and wishes to add its appreciation to the Committee for its oversight.

(4) COUNCIL ON CONSTITUTION AND BYLAWS / COUNCIL ON LONG  
RANGE PLANNING AND DEVELOPMENT REPORT 2 - AMA POLICY  
DIRECTIVES WHICH HAVE BEEN ACCOMPLISHED IN PART

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 2 be adopted and the remainder of the Report be filed.

**HOD ACTION: Recommendations in Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 2 adopted and the remainder of the Report filed.**

Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 2 presents recommendations to rescind in part or modify policies to make our AMA Policy Compendium as current as possible yet not circumvent the normal sunset review process. The Councils have determined that the modifications are editorial in nature.

One supportive online comment was received and there was no onsite testimony. Your Reference Committee expresses its appreciation to the Councils for their efforts.

(5) COUNCIL ON CONSTITUTION AND BYLAWS / COUNCIL ON LONG  
RANGE PLANNING AND DEVELOPMENT REPORT 3 - AMA POLICY  
CONSOLIDATIONS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 3 be adopted and the remainder of the Report be filed.

**HOD ACTION: Recommendations in Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 3 adopted and the remainder of the Report filed.**

Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 3 presents recommendations to consolidate AMA Policy by rescinding outdated and duplicative policies and combining policies that relate to the same topic.

Your Reference Committee received two supportive online comments and no onsite testimony. Your Reference Committee once again expresses its appreciation to the Councils for their thorough and thoughtful recommendations, which serve to provide clarity to our AMA Policy Database.

(6) COUNCIL ON CONSTITUTION AND BYLAWS / COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT 1 - AMA POLICY DIRECTIVES WHICH ARE OBSOLETE, REDUNDANT OR ACCOMPLISHED

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 1 be amended on page 2, line 22 to retain Policy D-160.991, “Licensure and Liability for Senior Physician Volunteers.”

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 1 be amended on page 3, line 2 to retain Policy D-275.984, “Licensure and Liability for Senior Physician Volunteers.”

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 1 be amended on page 3, line 10 to retain Policy H-295.969, “Nondiscrimination Toward Medical School and Residency Applicants.”

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 1 be adopted as amended and the remainder of the Report be filed.

**HOD ACTION: Recommendations in Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 1 adopted as amended and the remainder of the Report filed.**

Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 1 presents recommendations for sunsetting existing House of Delegates directives that are obsolete, redundant, or accomplished. This report is distinct from the sunset reports submitted by each Council.

Your Reference Committee received testimony favoring retention of Policies D-160.991 and D-275.984 because our AMA Senior Physician Section continues to collect and update senior physician state-based charitable immunity laws and state licensing regulations. Additionally, favorable testimony supporting retention of Policy H-295.969 was received because ACGME has not yet adopted the nondiscrimination language.

Your Reference Committee extends its congratulations to the Councils for the extensive effort and attention to detail reflected by the three joint reports presented to our AMA House of Delegates by way of this Reference Committee.

(7) RESOLUTION 602 - AMA ELECTION ACTIVITIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the following Substitute Resolution 602 be adopted:

**HOD ACTION: Substitute Resolution 602 adopted**

RESOLVED, that Policy G-610.020[6] be amended by substitution to read as follows:

6. A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) standing in a receiving line, (b) appearing by name or in a picture on a poster or notice in or outside of the party venue, or (c) distributing stickers, buttons, etc. with the candidate's name on them.

Resolution 602 calls upon our AMA to amend Policy G-610.020[6], "Election Campaigns," to clarify campaign activities.

Your Reference Committee heard testimony in support of the concept of Resolution 602 and also received compelling testimony from the Speakers indicating that the intent of this resolution could be accomplished using simpler language. Your Reference Committee concurs.

(8) RESOLUTION 603 – MEDICAL MALPRACTICE RATE DISCOUNTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 603 be amended by addition to read as follows:

RESOLVED, That our American Medical Association encourage member organizations of the Federation to offer access to discounted medical liability insurance premiums where legally permissible. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 603 be adopted as amended.

**HOD ACTION: Resolution 603 adopted as amended.**

Resolution 603 calls upon our AMA to encourage member organizations of the Federation to offer access to discounted medical liability insurance premiums.

Your Reference Committee received supportive testimony from several state medical associations, as well as a number of sections and specialty societies. Testimony indicated that discounted liability rates led to increased membership. Other societies and state associations testified that this resolution might help offset the high cost of medical malpractice insurance.

Your Reference Committee believes Resolution 603 is consistent with current AMA Policy H-435.998, "Equitable Risk Classification in Medical Liability Premiums."

(9) RESOLUTION 605 – ENCOURAGE PHYSICIANS AS LEGISLATIVE CANDIDATES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 605 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~adopt as a top priority item strategies~~ continue to identify, encourage, and support physicians to run as state and national legislative candidates. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 605 be adopted as amended.

**HOD ACTION: Resolution 605 adopted as amended.**

Resolution 605 calls upon our AMA to adopt, as a top priority item, strategies to identify, encourage, and support physicians to run as state and national legislative candidates.

Your Reference Committee received generally supportive testimony that indicated encouraging and supporting more physicians to run as state and national legislative candidates would be a positive addition to state and national governments. Your Reference Committee also notes that the intent of Resolution 605 is consistent with current AMA Policy G-640.020, “Political Action Committees and Contributions.”

Your Reference Committee also heard favorable testimony regarding AMPAC campaign and candidate schools, which are currently available and highly regarded based on past participant testimonials.

Testimony further indicated that a change in the language of the resolution is desirable due to the many priorities of our AMA.

(10) RESOLUTION 606 – A NEW AMA COUNCIL

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 606 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association encourage the study the creation of a new Council on Medical Technology or collaboration of existing - AMA eCouncils and working groups ~~that can appropriately study and make recommendations~~ on matters of new and developing technology, particularly in electronic medical records (EMR) and telemedicine ~~and others that exist or develop for consideration and approval of our AMA House of Delegates~~. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 606 be adopted as amended.

## RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 606 be changed to read as follows:

## TECHNOLOGY AND THE PRACTICE OF MEDICINE

**HOD ACTION: Resolution 606 be adopted as amended with a title change.**

Resolution 606 calls upon our AMA to study the potential creation of a new Council on Medical Technology or collaboration of existing Councils that can study and make recommendations on new and developing technology, particularly EMR and telemedicine.

Your Reference Committee heard extensive testimony indicating that medical technology is an important issue. New and emerging forms of medical technology, such as EMR and telemedicine, are vital to current physician practices. Testimony did not support the creation of a new Council. Many who testified expressed the sentiment that this role could be accomplished through a collaboration of existing AMA Councils.

## (11) RESOLUTION 607 – AMA PRESIDENT’S CITATION

## RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 607 be amended by addition to read as follows:

RESOLVED, That our American Medical Association study ways to provide recognition to member physicians in local communities, to give them and the community a greater sense of connection with our AMA. (Directive to Take Action)

## RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 607 be adopted as amended.

## RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 607 be changed to read as follows:

## MEMBER RECOGNITION

**HOD ACTION: Resolution 607 adopted as amended with a title change.**

Resolution 607 calls upon our AMA to study ways to provide recognition to physicians in local communities for a greater sense of connection with our AMA.

Your Reference Committee heard limited testimony supporting the suggestion to study ways to provide recognition to physicians as a membership initiative and potentially enhance member engagement. The purpose of the award described in Resolution 607 is to recognize individual member physicians for contributions to their local communities.

Your Reference Committee agrees with the intent of Resolution 607 but believes the award should be limited to recognition of AMA member physicians.



(12) RESOLUTION 608 – ONEROUS RESTRICTIONS ON TRAVEL OF GOVERNMENT SCIENTISTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 608 be amended by addition to read as follows:

RESOLVED, That our American Medical Association ~~take~~ pursue legislative or regulatory action to achieve easing of travel restrictions for federally-employed scientists who are attending academic or scientific conferences that are consistent with current HHS policies and procedures to include a simplified approval process. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 608 be adopted as amended.

**HOD ACTION: Resolution 608 adopted as amended.**

Resolution 608 calls upon our AMA to take legislative or regulatory action to achieve easing of travel restrictions, including a simplified approval process, for federally employed scientists attending academic or scientific conferences that are consistent with current HHS policies and procedures.

Your Reference Committee heard uniformly positive testimony in support of this resolution, which indicated that federally-employed physicians are frequently denied the opportunity to attend conferences and other educational events even when funds are available. These restrictive rules and regulations force physicians to use their own financial resources and time off to pursue necessary continuing education not always available in their local areas. Even when permission is granted to attend, often the approval comes too late for the physician to make necessary arrangements to attend.

Your Reference Committee agrees with the intent of the resolution. However, our AMA does not directly take regulatory or legislative action, but it does pursue regulatory or legislative action. Therefore, your Reference Committee recommends adoption as amended.

(13) RESOLUTION 609 – AMA PARTICIPATION IN REDUCING MEDICAL STUDENT DEBT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 609 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association explore the feasibility of the development of an affinity program in which student, resident, and fellow members of ~~the our~~ AMA could obtain new educational loans and consolidate existing loans from one or ~~multiple more~~ national banks or other financial intermediaries. Membership in ~~the our~~ AMA would be required during the life of the loan (typically 10 years or more following medical school) (Directive to Take Action); and be it further

RESOLVED, That such activities or program would neither result in ~~the our~~ AMA becoming subject to regulation as a financial institution nor impair ~~the our~~ AMA's ability to continue to be treated as a not-for-profit entity (Directive to Take Action); and be it further

RESOLVED, That our AMA HOD receive a progress report on these discussions by the 2014 Interim Meeting. (Directive to Take Action)

## RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 609 be adopted as amended.

## RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 609 be changed to read as follows:

## AMA PARTICIPATION IN REDUCING MEDICAL SCHOOL DEBT

**HOD ACTION: Resolution 609 adopted as amended with a title change.**

Resolution 609 calls upon our AMA to explore and report back at the 2014 Interim Meeting on the feasibility of developing an affinity program in which student members of our AMA might obtain loans from one or multiple national banks or other financial intermediaries without subjecting our AMA to regulation as a financial institution nor impair our AMA's not-for-profit status.

Your Reference Committee received strongly supportive testimony in response to Resolution 609. The testimony highlighted the fact that the prospect of future medical school debt can discourage students from becoming physicians. Further testimony indicated that there is interest in widening the scope of this resolution to include all who have debt due to medical education costs. Your Reference Committee concurs with the testimony and recommends Resolution 609 be amended to reflect all forms of medical education debt be eligible for participation in any affinity program that may be developed.

## (14) RESOLUTION 611 – DUES EXEMPTION / ADJUSTMENT FOR PHYSICIANS UNABLE TO ATTAIN RESIDENCY TRAINING PROGRAM

## RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 611 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association urge state societies to offer membership at significantly discounted rates for example, equal to the charge for medical students or residents, to physicians who have graduated from American medical schools or who have successfully completed Educational Commission on Foreign Medical Graduate (ECFMG) and United States Medical Licensing Examination (USMLE) examinations but have been unable to obtain American residency positions ~~at significantly discounted rates for example, equal to the charge for medical students or residents (Directive to Take Action); and be it further~~

~~RESOLVED, That our AMA develop model mentorship programs for physicians who have graduated from American medical schools or who have successfully completed ECFMG examinations but have been unable to obtain American residency positions (Directive to Take Action); and be it further~~

~~RESOLVED, That our AMA urge state societies to develop and offer mentorship programs to physicians who have graduated from American medical schools or who have successfully completed ECFMG examinations but have been unable to obtain American residency positions. (Directive to Take Action)~~

## RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 611 be adopted as amended.

**HOD ACTION: Resolution 611 adopted as amended**

Resolution 611 calls upon our AMA to urge state societies to offer significantly discounted membership to physicians who have graduated from American medical schools or who have successfully completed ECFMG examinations but have been unable to obtain American residency positions.

Resolution 611 further calls upon our AMA to develop model mentorship programs and to urge state societies to develop and offer mentorship programs to physicians who have graduated from American medical schools or who have successfully completed ECFMG examinations but have been unable to obtain American residency positions.

Your Reference Committee received limited supporting testimony, which indicated the severity of the situation and its potential negative impact on the medical workforce. Testimony emphasized the importance of keeping these graduates engaged and involved in medicine despite the lack of a residency placement. However, your Reference Committee also received testimony from the author of the resolution suggesting the deletion of the second and third resolve statements. Removing the second and third resolves eliminates the fiscal note. Testimony also indicated that candidates are not eligible for United States residency slots unless they have also passed USMLE examinations, so this language was added.

## (15) RESOLUTION 613 – IDENTITY THEFT

## RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 613 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~petition request that~~ the Internal Revenue Service (IRS) ~~to~~ adopt policies to ensure greater security protection for electronically filed federal income tax returns, including the universal use of PINs, or personal identification numbers (Directive to Take Action); and be it further

RESOLVED, That our AMA ~~petition request that~~ the IRS and the Centers for Medicare & Medicaid Services ~~to~~ promulgate regulations to prohibit the use of Social Security Number (SSN) by insurers, health care vendors, state agencies other than the state taxing authority and non-financial businesses. (Directive to Take Action)

## RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 613 be adopted as amended.

**HOD ACTION: Resolution 613 adopted as amended.**

Resolution 613 calls upon our AMA to petition the Internal Revenue Service (IRS) to adopt policies to ensure greater security protection for electronically filed federal income tax returns, including the universal use of PINs, or personal identification numbers.

Resolution 613 further calls upon our AMA to petition the IRS and the Centers for Medicare & Medicaid Services to promulgate regulations to prohibit the use of SSN by insurers, health care vendors, state agencies other than the state taxing authority and non-financial businesses.

Your Reference Committee heard testimony reflecting that many physicians have recently been victims of identity theft, which involved the filing of fraudulent tax returns. Further testimony indicated that identity theft affected thousands of physicians at an estimated cost of \$4 billion in 2012. Our AMA is proactively addressing this problem and has already communicated with the Internal Revenue Service (IRS) and the Secret Service to express concern and offer assistance.

Your Reference Committee notes that our AMA does not petition the government and has offered amended language.

(16) RESOLUTION 614 – VA ACES TRAVEL POLICY

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 614 be amended by addition to read as follows:

RESOLVED, That our American Medical Association send a letter to the Secretary of the Department of Veterans Affairs (VA) and any other appropriate entities noting that the Attendance and Cost Estimation System (ACES) system has become a barrier to VA physician attendance at medical and scientific meetings, and encourage the Secretary to adopt ACES system reforms that will allow VA-employed physicians to attend medical and scientific conferences.  
(Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 614 be adopted as amended.

**HOD ACTION: Resolution 614 adopted as amended.**

Resolution 614 calls upon our AMA to send a letter to the Secretary of the Department of Veterans Affairs (VA) to encourage reforms in the Attendance and Cost Estimation System (ACES), which has become a barrier to VA physician attendance at medical and scientific conferences.

Your Reference Committee heard uniformly positive testimony, which highlighted that VA physicians are frequently denied opportunities to travel beyond their local area for continuing education and participation in medical organization events. These overly restrictive travel policies are adversely affecting the VA's ability to recruit and retain physicians.

Your Reference Committee learned that the United States Office of Management and Budget (OMB) should be included in any correspondence on this matter as their regulations affect all Federal agencies.

(17) RESOLUTION 615 – AMA ADVOCACY ANALYSIS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the following Substitute Resolution 615 be adopted.

RESOLVED, That our American Medical Association Board of Trustees provide ~~an annual~~ report to the House of Delegates at each Interim Meeting highlighting the prior year advocacy activities to include efforts, successes, challenges, and recommendations / actions to further optimize advocacy efforts, and that the I-14 report include a summary of the review of the Advocacy Group that was performed in 2012.

**HOD ACTION: Amended Substitute Resolution 615 adopted**

Resolution 615 calls upon our AMA to fund an independent committee of the House of Delegates to evaluate all aspects of our AMA's advocacy efforts and present a report back at the 2015 Annual Meeting.

Resolution 615 directs that the analysis be coordinated through a professional consulting firm and shall include but not be limited to:

1. Evaluation of the major issues and the factors contributing to their non-passage as well as their potential for future success;
2. Our AMA lobbying team and potential improvements;
3. The potential use and/or expanded use of contract lobbying firms;
4. Evaluation of the structure and function of our AMA's Council on Legislation and potential opportunities for improvement;
5. Evaluation of the structure and function of AMPAC and potential opportunities for improvement, as well as better methods to involve more physicians in the process; and
6. Evaluate ways for the House of Delegates and other interested physicians to effectively support the legislative and advocacy teams in promoting legislative issues.

Additionally, Resolution 615 directs that the independent committee of the House of Delegates be appointed by the Speaker and elected by the members of the House of Delegates in the following manner:

1. One member elected from and by our AMA Board of Trustees;
2. One past AMPAC Board member not currently serving on an AMA council or committee selected by the current AMPAC Board;
3. One past Council on Legislation member not currently serving on an AMA council or committee selected by the current Council on Legislation board;
4. Two members with PAC or legislative experience elected from the state delegations and two members with PAC or legislative experience elected from the specialty society delegations. (The resolution indicates the best way to accomplish this is to have each state and specialty delegation submit one individual to enter a "pool" of applicants. A simple ballot will be sent to each state and specialty delegation. Each delegate from the state and specialty delegations will vote for one candidate. Votes will be collated by AMA staff.)
5. One member with PAC or legislative experience elected by the Medical Student Section, Resident and Fellow Section, and Young Physicians Section from among the members of their respective delegations. (The resolution indicates the best way to accomplish this is to have each constituency submit one name. Each Section delegate will vote for one candidate. Votes will be collated by AMA staff.)
6. One currently seated delegate or alternate with PAC or legislative experience selected by the Speaker from the remaining groups represented in our AMA House of Delegates.

Your Reference Committee received extensive testimony in response to Resolution 615, including amended language from the author that attempted to overcome concerns that this resolution stands in conflict with our AMA's current system of checks and balances. However, the proposed changes remain overly prescriptive.

Testimony indicated that engaging a consultant is an expensive and time consuming process resulting in a single snapshot in time and removes fiscal resources from other AMA priorities. Several individuals testified that going outside the organization for an evaluation violates good management principles, which state that continuous self examination is the best way to evaluate an organization. Further testimony indicated our AMA needs to be more nimble and must regularly optimize its advocacy efforts with ongoing feedback to the House of Delegates. Therefore, an annual report with opportunities for the House of Delegates to discuss recommendations would better serve the desire to have ongoing review and communication regarding advocacy activities.

Your Reference Committee heard testimony indicating that the effectiveness of AMPAC would be greatly increased if each member of our AMA, and the House of Delegates in particular, would fully support AMPAC through active membership and financial contributions.

(18) RESOLUTION 601 - A VIRTUAL MEDICAL ASSOCIATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 601 be referred.

**HOD ACTION: Resolution 601 referred.**

Resolution 601 calls upon our AMA to provide for virtual attendance of House of Delegates meetings, including the ability to communicate and vote, by 2016 and to provide for virtual reference committees by 2020.

Your Reference Committee heard mixed testimony on this Resolution. The majority of those testifying did not dispute the value of face-to-face interaction but questioned whether affordable accessible technology capable of supporting a meeting as complex as our AMA House of Delegates exists at this time. Not all experiments with virtual reference committees have achieved success, and paper handbooks are still being distributed.

Your Reference Committee acknowledges that the process for virtual participation is worthy of review and also believes that Resolution 601 is consistent with current AMA Policy G-600.0045, "Virtual Reference Committees in the House of Delegates" that allows the Speakers to experiment with the virtual reference committee process.

(19) RESOLUTION 604 – EXAMINING THE COMPOSITION OF THE AMA GOVERNANCE STRUCTURE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 604 not be adopted.

**HOD ACTION: Resolution 604 not adopted.**

Resolution 604 calls upon our AMA to convene a committee to research and develop recommendations on the composition of our AMA's governance structure (by mode of practice, state medical association, medical specialty delegation, or any other recognized group of physicians), for the purpose of ensuring that AMA members have equal representation and the governance structures are sized to promote effective policymaking processes.

Your Reference Committee received online comments against convening a new committee to research the composition of the governance structure. Board of Trustees Report 7, presented at this meeting, addresses the request for demographic and representative data on the House of Delegates. The Council on Long-Range Planning and Development produces a report on a yearly basis. AMA Policy B-6.612 gives the Council on Long Range Planning and Development the ability to evaluate and make recommendations regarding governance structure and representation, as needed. Therefore, your Reference Committee recommends that Resolution 604 not be adopted.



(20) RESOLUTION 612 – FUNDING OF AMA REGION AND SECTION DELEGATES / ALTERNATES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 612 not be adopted.

**HOD ACTION: Resolution 612 referred.**

Resolution 612 calls upon our AMA to fund transportation and housing for the Annual and Interim meetings for the medical student region delegates and alternates and the resident physician section delegates and alternates. State and specialty societies, which have section and region delegates elected from their memberships, would continue to provide meals and other miscellaneous reimbursements.

Your Reference Committee heard extensive testimony on Resolution 612 that uniformly supported the value of regional and section delegates as participants in state medical association delegations. However, several state medical associations may no longer support their delegates.

Testimony in favor of the resolution focused on the financial burdens of the states and the fact that our AMA is financially stable and could afford to pay for these delegates either fully or through some form of cost-sharing with the states. Testimony against the resolution indicated that since the states are the beneficiaries of the additional regional and section delegates, the states should also bear the expense of these delegates. Our AMA already supports the sections by funding Governing Councils and other activities. Many who testified pointed out that the regional and section delegates represent a great value to the states by establishing important relationships and preparing younger members to become active participants in the House of Delegates.

There was also testimony that the Resolution was complex enough to warrant in-depth study by our AMA and that it should be referred.

Your Reference Committee carefully considered all the testimony received including the recommendation for referral. However, your Reference Committee is concerned that adopting this Resolution will create an undesirable precedent and may encourage a two-tier system of representation in the House of Delegates with some delegations funded by member societies and some delegations directly funded by our AMA. This could lead to a devaluation of student and resident region and section delegates. Since states receive the value and representation from the regional and section delegates, states should also continue to bear the responsibility of funding the expenses of their delegates.

(21) RESOLUTION 610 – ALTERNATIVE MAINTENANCE OF CERTIFICATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies D-275.960 and H-275.923 be reaffirmed in lieu of Resolution 610.

**HOD ACTION: Policies D-275.960 and H-275.923 reaffirmed in lieu of Resolution 610.**

Resolution 610 calls upon our AMA to explore the feasibility of developing an alternative Maintenance of Certification program as a member benefit.

Your Reference Committee heard mixed testimony on this resolution. Supportive testimony pointed out that despite our AMA's efforts to work with certifying bodies, little progress has been made towards alleviating concerns about the maintenance of certification process. Despite the problems expressed, those opposing the Resolution pointed out

that as our AMA does not issue original certification, it is not within the purview of our AMA to recertify its members.

Maintenance of certification by our AMA cannot be a member benefit as the process cannot legitimately be applied only to members. In addition, experience with previous initiatives such as the American Medical Accreditation Program (AMAP) suggests that overseeing the maintenance of certification process is problematic.

Your Reference Committee believes that the concerns expressed by Resolution 610 are consistent with current AMA Policies H-275.923, “Board Certification” and D-275.960, “An Update on Maintenance of Certification, Osteopathic Certification and Maintenance of Licensure,” which state that our AMA will collaborate with certifying bodies.

D-275.960, “An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure”

1. Our AMA will encourage the American Board of Medical Specialties (ABMS) and the specialty certification boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients as an alternative to high stakes closed book examinations. 2. Our AMA will continue to monitor the evolution of Maintenance of Certification (MOC), Osteopathic Continuous Certification (OCC), and Maintenance of Licensure (MOL), continue its active engagement in discussions regarding their implementation, and report back to the House of Delegates on these issues. 3. Our AMA will (a) work with the ABMS and ABMS specialty boards to continue to examine the evidence supporting the value of specialty board certification and MOC and to determine the continued need for the mandatory high-stakes examination; and (b) work with the ABMS to explore alternatives to the mandatory high-stakes examination. 4. Our AMA encourages the ABMS to ensure that all ABMS specialty boards provide full transparency related to the costs of preparing, administering, scoring, and reporting MOC and certifying/recertifying examinations and ensure that MOC and certifying/recertifying examinations do not result in significant financial gain to the ABMS specialty boards. 5. Our AMA will work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, in particular to ensure that MOC is specifically relevant to the physician’s current practice. 6. Our AMA will solicit an independent entity to commission and pay for a study to evaluate the impact that MOL and MOC requirements have on physicians’ practices, including but not limited to: physician workforce, physicians’ practice costs, patient outcomes, patient safety and patient access. Such study will look at the examination processes of the ABMS, the American Osteopathic Association, and the Federation of State Medical Boards. Such study is to be presented to our AMA HOD, for deliberation and consideration before any entity, agency, board or governmental body requires physicians to sit for MOL licensure examinations. Progress report is to be presented at Annual 2014; complete report by Annual 2015. 7. Our AMA: (a) supports ongoing ABMS specialty board efforts to allow other physician educational and quality improvement activities to count for MOC; (b) supports specialty board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs such as pay for quality/performance or PQRS reimbursement; (c) encourages the ABMS specialty boards to enhance the consistency of such programs across all boards; and (d) will work with specialty societies and specialty boards to develop tools and services that facilitate the physician’s ability to meet MOC requirements. (CME Rep. 10, A-12; Modified: CME Rep. 4, A-13)

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; Reaffirmed in lieu of Res. 919, I-13)

(22) **RESOLUTION 616 - IMPROVING LEADERSHIP POTENTIAL AND PREVENTING ATTRITION AMONG EARLY- AND MID-CAREER PHYSICIANS**

**RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends that Policies H-200.951, G-600.030 and G-600.035 be reaffirmed in lieu of Resolution 616.

**HOD ACTION: Reference Committee recommendation not adopted.**

**RESOLVED, That future reports on the demographic characteristics of the House of Delegates identify and include information on successful initiatives and best practices to promote diversity, particularly by age, of state and specialty society delegations.**

**HOD ACTION: Substitute Resolution 616 adopted.**

Resolution 616 calls upon our AMA to study diversity, particularly by age, among AMA Delegates and develop mechanisms to promote diversity within the House of Delegates with a report back at the 2015 Annual Meeting.

Your Reference Committee heard testimony supporting the general concept of the resolution and agrees that the House of Delegates should strive to reflect the diversity of the physician workforce.

Pursuant to Policy G-600.035, “The Demographics of the House of Delegates,” an informational report is prepared annually and includes information regarding age, gender, race/ethnicity, education, life stage, present employment and self-designated specialty. Data is obtained from our AMA Physician Masterfile. Board of Trustees Report 7-A-14, “Demographics Report of the House of Delegates and AMA Membership” is included in the informational section of the 2014 Annual Meeting Handbook. The intent of these annual reports is to encourage greater awareness of and responsiveness to diversity.

In addition, Policy H-200.951, “Strategies for Enhancing Diversity in the Physician Workforce” supports increased diversity in the physician workforce.

H-200.951, “Strategies for Enhancing Diversity in the Physician Workforce”

Our AMA supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities. (CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13)

G-600.030, “Diversity of AMA Delegations”

Our AMA encourages: (1) state medical societies to collaborate more closely with state chapters of medical specialty societies, and to include representatives of these organizations in their AMA delegations whenever feasible; (2) state medical associations and national medical specialty societies to review the composition of their AMA delegations with regard to enhancing diversity; (3) specialty and state societies to develop training and/or mentorship programs for their student, resident and fellow and young physician section representatives, and current HOD delegates for their future activities and representation of the delegation; (4) specialty and state societies to include in their delegations physicians who meet the criteria for membership in the Young Physicians Section; and (5) delegates and alternates who may be entitled to a dues exemption, because of age and retirement status, to demonstrate their full commitment to our AMA through payment of dues. (CCB/CLRPD Rep. 3, A-12)

G-600.035, “The Demographics of the House of Delegates”

(1) A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty. (2) As one means of encouraging greater awareness and responsiveness to diversity, our AMA will prepare and distribute a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and to our AMA physician membership every other year. (CCB/CLRPD Rep. 3, A-12)

(23) BOARD OF TRUSTEES REPORT 4 - AUDITOR'S REPORT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 4 be filed.

**HOD ACTION: Board of Trustees Report 4 filed.**

Board of Trustees Report 4 presents our AMA’s 2012 and 2013 Consolidated Financial Statements along with an Independent Auditor’s report, which are featured in a separate booklet titled, “2013 Annual Report” distributed with the Handbook materials.

Your Reference Committee received an informative presentation of our AMA’s financial results reflecting 2013 pro forma operating results of \$17.9 million, which excludes nonrecurring charges related to our AMA’s relocation of its corporate headquarters. Permanent reserves were \$459.3 million at year-end. Additionally, our AMA achieved a third year of increases in the number of dues-paying members, with total dues revenue increasing more than 3 percent. More detailed information can be found in our AMA’s 2013 Annual Report.

No testimony was received in response to Board of Trustees Report 4. Your Reference Committee extends its appreciation to our AMA Board of Trustees and staff for their ongoing excellent stewardship of our AMA resources and for the continued growth in membership now in its third consecutive year.

## REPORT OF REFERENCE COMMITTEE G

## (1) BOARD OF TRUSTEES REPORT 12 - MENTAL HEALTH SERVICES FOR SCHOOL-AGED CHILDREN

## RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 12 be adopted and that the remainder of the report be filed.

**HOD ACTION: Recommendation in Board of Trustees Report 12 adopted and the remainder of the report filed.**

Board of Trustees Report 12 recommends that our AMA recognize the importance of developing and implementing school-based mental health programs that ensure at-risk children access to appropriate mental health services and support efforts to accomplish these objectives.

Board of Trustees Report 12 received uniformly supportive testimony. Your Reference Committee commends the Board of Trustees on this thorough report on mental-health disorders in school-aged children. Your Reference Committee agrees that the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry are best positioned to lead efforts to ensure that children have appropriate access to programs and resources designed to help treat mental-health disorders. As a result, your Reference Committee recommends that this report be adopted.

## (2) BOARD OF TRUSTEES REPORT 16 - PEDIATRIC MEDICAL ORDERS BETWEEN STATES

## RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 16 be adopted and the remainder of the report be filed.

**HOD ACTION: Recommendations in Board of Trustees Report 16 adopted and the remainder of the report filed.**

Board of Trustees Report 16 recommends that our AMA support legislation or regulation that allows licensed and registered physicians to execute conventional medical orders for their patients who are moving out of state for a transitional period of no more than sixty days and work with interested states and specialties on legislation or regulations to allow temporary honoring of medical orders by an out-of-state physician.

Your Reference Committee, in agreement with substantial testimony, believes that Board of Trustees Report 16 provides a comprehensive overview of the issues and appropriate recommendations concerning the execution of medical orders and the transition of care for children relocating to another state. Although online testimony suggested that the report be expanded to include all patients rather than just children, your Reference Committee believes that the recommendation of the report should be consistent with its childcare-focused content and therefore recommends that the report be adopted as written.



(3) BOARD OF TRUSTEES REPORT 18 - DATA TRANSITION COSTS WHEN SWITCHING ELECTRONIC MEDICAL RECORDS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 18 be adopted and the remainder of the report be filed.

**HOD ACTION: Recommendations in Board of Trustees Report 18 adopted and the remainder of the report filed.**

Board of Trustees Report 18 recommends that our AMA seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process and collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.

There was supportive testimony on this report. Your Reference Committee thanks the Board for a thorough and thoughtful report, and recommends that Board of Trustees Report 18 be adopted.

(4) BOARD OF TRUSTEES REPORT 20 - UTILIZATION OF EHR AND THE PRACTICE OF "CUTTING AND PASTING" OR CLONING

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 20 be adopted and the remainder of the report be filed.

**HOD ACTION: Recommendations in Board of Trustees Report 20 adopted and the remainder of the report filed.**

Board of Trustees Report 20 recommends that Policy D-175.985, The CMS Electronic Medical Records Initiative Should Not Be Used to Detect Alleged Fraud by Physicians, be reaffirmed, and that our AMA engage the electronic health record (EHR) vendor community to promote improvements in EHR usability.

There was mixed testimony on this report. Many speakers expressed concern about the potential limitations of using the copy and paste function in EHRs, and presented anecdotal evidence that its use can lead to problems with patient care. Other speakers noted that copy and paste functions can be useful, and that physicians should always review their notes to ensure their quality and relevance. Your Reference Committee agrees with testimony that copy and paste functions are not problematic, per se, and that our AMA should continue to emphasize improvements in the overall usability of EHRs. Your Reference Committee also agrees that our AMA needs to remain vigilant to ensure that payers do not automatically penalize physicians for using copy and paste or similar documentation shortcuts. The recommendations in the Board report address both of these important issues; accordingly, your Reference Committee recommends that Board of Trustees Report 20 be adopted.

(5) BOARD OF TRUSTEES REPORT 28 - QUALIFICATIONS, SELECTION, AND ROLE OF HOSPITAL MEDICAL DIRECTORS AND OTHERS PROVIDING MEDICAL MANAGEMENT SERVICES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 28 be adopted and the remainder of the report be filed.

**HOD ACTION: Recommendation in Board of Trustees Report 28 adopted and the remainder of the report filed.**

Board of Trustees Report 28 recommends extensive amendments to Policy H-235.981, “The Role of the Hospital Medical Director.”

There was limited testimony on this report. Your Reference Committee appreciates the work of the Board in updating AMA policy to ensure its applicability to all individuals providing medical management services, and to acknowledge the overall responsibility of the medical staff for the overall quality of care provided in the hospital. Your Reference Committee recommends that the recommendations in Board of Trustees Report 28 be adopted.

(6) COUNCIL ON MEDICAL SERVICE REPORT 5 - HEALTH INSURER  
CODE OF CONDUCT PRINCIPLES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Medical Service Report 5 be adopted and the remainder of the report be filed.

**HOD ACTION: Recommendation in Council on Medical Service Report 5 adopted and the remainder of the report filed.**

Council on Medical Service Report 5 recommends that our AMA continue to develop resources to help physician practices address ongoing and emerging issues associated with expanding health insurance coverage under the Affordable Care Act.

There was limited testimony on this report. A member of the Council on Medical Service testified that the recommendation to support the development of new resources to help physicians respond to emerging issues related to the Affordable Care Act, rather than update the Code of Conduct, reflects the fact that the majority of the principles in the Code were addressed by the Affordable Care Act, and are supported by over 200 AMA policies, which can guide ongoing AMA advocacy on these issues. The Council member noted that the Code had never been adopted or endorsed by any insurance company, as was the original intent, and our AMA’s current approach to addressing insurance-company related challenges through the development of physician-focused resources is a more effective strategy for addressing these concerns. A question was raised about what specific resources are available to assist physicians, and your Reference Committee notes that examples of resources are highlighted on page 3 of the Council’s report. Your Reference Committee also notes that the Professional Satisfaction and Practice Sustainability group is actively engaged in efforts to develop resources to help physicians navigate payment and delivery reforms. A list of existing resources from the AMA Innovator’s Committee and other sources is available online at [ama-assn.org/ama/pub/about-ama/strategic-focus/shaping-delivery-and-payment-models/payment-model-resources.page](http://ama-assn.org/ama/pub/about-ama/strategic-focus/shaping-delivery-and-payment-models/payment-model-resources.page). The Council report also notes that although the ACA did not address AMA concerns with respect to physician profiling, which were included in the original Code of Conduct, AMA advocacy efforts to address these issues are ongoing, especially in the context of advocacy related to criteria for network inclusion or tiering placement. Your Reference Committee agrees with the Council’s assessment that our AMA should continue to pursue activities that help physician practices understand and manage challenges associated with expanding health insurance coverage, and recommends that Council on Medical Service Report 5 be adopted.

(7) RESOLUTION 734 - PUBLIC REPORTING OF QUALITY AND  
OUTCOMES FOR PHYSICIAN-LED TEAM-BASED CARE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 734 be adopted.

**HOD ACTION: Resolution 734 adopted.**

Resolution 734 asks that our AMA advocate that internal reporting of quality and outcomes of team-based care should be done at both the team and individual physician level, and that public reporting of such data should be done only at the group/system/facility level. Resolution 734 also asks that our AMA reaffirm the intent of the codified mandate in the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 that public reporting of quality and outcomes data for team-based care should be done at the group/system level, not at the individual physician level, and advocate that the current regulatory framework for public reporting for Meaningful Use (MU) also provide “group-level reporting” for medical groups/organized systems of care as an option in lieu of requiring MU reporting only on an individual physician basis.

There was supportive testimony on this resolution. A suggestion was made to add a recommendation stating that public reporting related to physician-led teams should adhere to our AMA Pay-for-Performance Principles and Guidelines. Your Reference Committee felt that such a statement would be beyond the scope and intent of the resolution, which was to ensure that group level data, rather than individual data, is used for public reporting of quality and outcomes data for physician-led teams. Your Reference Committee agrees that reporting of group level data can help improve the reliability and statistical significance of the data, and recommends that Resolution 734 be adopted.

(8) RESOLUTION 737 - AMENDMENTS TO THE AMA PRINCIPLES FOR PHYSICIAN EMPLOYMENT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 737 be adopted.

**HOD ACTION: Resolution 737 adopted.**

Resolution 737 asks the AMA to amend Section (5)(f) of AMA Policy 225.950 to better protect physician interests following termination of an employment agreement.

Your Reference Committee heard supportive testimony for Resolution 737, which was the result of a detailed report of the Organized Medical Staff Section in consultation with AMA experts. The report properly protects physician interests during a potential termination of an employment agreement by amending our existing policy. The Reference Committee agrees that the AMA Principles for Physician Employment should be routinely updated in order to best establish the AMA position on employed physicians and finds this update to be strong. For these reasons, your Reference Committee recommends that Resolution 737 be adopted.

(9) COUNCIL ON MEDICAL SERVICE REPORT 6 - DEVELOPMENT OF MODELS / GUIDELINES FOR MEDICAL HEALTH CARE TEAMS

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) define “physician-led” in the context of team-based health care as 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~~ training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of these skills.

## RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the Patient-Centered elements of Recommendation 2 be amended by addition of a new element on page 7 to read as follows (this will result in resequencing of the remaining identifiers a, b, c, etc.):

- a. The patient is an integral member of the team.

## RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the Patient-Centered elements of Recommendation 2 be amended by addition and deletion on page 7, lines 15-16, to read as follows:

- a. The physician team leader establishes a patient-physician relationship at the onset of care and explains each team member's role to the patient. A relationship is established between the patient and the team at the onset of care, and the role of each team member is explained to the patient.

## RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that the Patient-Centered elements of Recommendation 2 be amended by addition on page 7, line 17, to read as follows:

- b. Patient and family-centered care is prioritized by the team and approved by the physician team leader.

## RECOMMENDATION E:

Mr. Speaker, your Reference Committee recommends that the Patient-Centered elements of Recommendation 2 be amended by addition and deletion on page 7, line 18, to read as follows:

- c. Team members are expected to adhere to agreed upon ~~best~~ practice protocols.

## RECOMMENDATION F:

Mr. Speaker, your Reference Committee recommends that the Patient-Centered elements of Recommendation 2 be amended by addition on page 7, line 21, to read as follows:

- e. Patients' access to the team, or coverage as designated by the physician-led team, is available twenty-four hours a day, seven days a week.

## RECOMMENDATION G:

Mr. Speaker, your Reference Committee recommends that the Teamwork elements of Recommendation 2 be amended by addition and deletion on page 7, line 27, to read as follows:

- b. All practitioners commit ~~have a commitment~~ to working in a team-based care model.

## RECOMMENDATION H:

Mr. Speaker, your Reference Committee recommends that the Teamwork elements of Recommendation 2 be amended by addition and deletion on page 7, lines 32-33, to read as follows:

- g. Team members complete ~~agreed upon~~ tasks ~~autonomously~~, according to ~~set~~ agreed upon protocols as directed by the physician leader, ~~and report back to the physician team leader.~~

## RECOMMENDATION I:

Mr. Speaker, your Reference Committee recommends that the Clinical Roles and Responsibilities elements of Recommendation 2 be amended by addition and deletion on page 7, lines 36-37 to read as follows:

- a. Physician leaders are focused on individualized patient care, ~~including the diagnosis of illnesses and complex cases and the development of treatment plans.~~

## RECOMMENDATION J:

Mr. Speaker, your Reference Committee recommends that the Clinical Roles and Responsibilities elements of Recommendation 2 be amended by addition and deletion on page 7, line 38, to read as follows:

- b. Non-physician practitioners are focused on ~~routine, preventive and follow-up care~~ providing treatment within their scope of practice consistent with their education and training as outlined in the agreed upon treatment plan or as delegated under the supervision of the physician team leader.

## RECOMMENDATION K:

Mr. Speaker, your Reference Committee recommends that the Practice Management elements of Recommendation 2 be amended by addition and deletion on page 7, lines 45-46, to read as follows:

- b. Quality improvement processes are used and continuously evolve according to ~~improved interventions~~ physician-led team-based practice assessments.

## RECOMMENDATION L:

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 filed.

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

Council on Medical Service Report 6 recommends a definition of “physician-led” in the context of team-based health care and support for specific elements that should be considered when planning a team-based care model.

There was generally supportive testimony on Council on Medical Service Report 6, with many speakers offering amendments to strengthen the report. Your Reference Committee’s recommendations incorporate much of the language proposed during the hearing.

Some speakers raised concerns that the report's recommendations were too prescriptive. Your Reference Committee notes that the report outlines elements to consider when planning a team-based care model according to the needs of the specific physician practice. These elements are not mandatory.

Testimony suggested physicians be responsible for developing treatment plans and treatment recommendations. This is addressed in the Clinical Roles and Responsibilities section. In addition, this report focuses on the physician-led team and specifying around the clock access to only a physician diminishes the team-based focus.

There was a suggestion to include a recommendation that physician-led teams participate in incentive-based programs that comply with the AMA's Pay-for-Performance Principles and Guidelines. Your Reference Committee felt that this was not germane to the report, which outlines how to construct team-based models rather than why it is an optimal model.

Your Reference Committee recommends adoption of Council on Medical Service Report 6 as amended.

(10) COUNCIL ON MEDICAL SERVICE REPORT 8 - CLINICAL DATA REGISTRIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 in Council on Medical Service Report 8 be amended by addition on line 25 to read as follows:

1. That our American Medical Association (AMA) encourage multi-stakeholder efforts to develop and fund clinical data registries for the purpose of facilitating quality improvements and research that result in better health care, improved population health, and lower costs. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 5 in Council on Medical Service Report 8 be amended by addition and deletion on lines 5-7 to read as follows:

5. That our AMA will continue to advocate for and support initiatives that minimize the costs and maximize the benefits of financial burden to physician practices participation of participating in clinical data registries. (New HOD Policy)

RECOMMENDATION C:

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.

**HOD ACTION: Recommendations in Council on Medical Service Report 8 adopted as amended and the remainder of the report filed.**

Council on Medical Service Report 8 makes recommendations to help maximize opportunities for clinical data registries to enhance the quality of care provided to patients.

There was supportive testimony on this report. Your Reference Committee agrees with testimony that cost is a major barrier to the development of clinical data registries, and recommends amending Recommendation 1 to encourage multi-stakeholder efforts to develop and fund clinical data registries. Your Reference Committee also proposes amendments to Recommendation 5 that are intended to emphasize the importance of minimizing the cost to



physicians of participating in clinical data registries, while also maximizing the benefits associated with data registry participation, including improved quality of care. Your Reference Committee commends the Council on a strong report and recommends the Council on Medical Service Report 8 be adopted as amended.

(11) RESOLUTION 701 - MEDICAL STAFF AND HOSPITAL ENGAGEMENT OF COMMUNITY PHYSICIANS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 701 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association encourage medical staffs to develop medical staff membership categories for ~~primary care~~ physicians who provide a low volume or no volume of clinical services in the hospital (“community physicians”) (New HOD Policy); and be it further

**HOD ACTION: Adopted**

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 701 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA encourage medical staffs and hospitals to engage community physicians, as appropriate, in ~~medical staff and hospital~~ activities, which may include but need not be limited to: (a) ~~medical staff duties and leadership~~; (b) ~~hospital governance~~; (c) population health management initiatives; (d) transitions of care initiatives; and (e) educational and other professional and collegial events. (New HOD Policy)

**HOD ACTION: Not Adopted**

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 701 be adopted as amended.

**HOD ACTION: Resolution 701 adopted as amended (per Recommendation A).**

Resolution 701 asks that our AMA encourage medical staffs to develop medical staff membership categories for primary care physicians who provide a low volume or no volume of clinical services in the hospital (“community physicians”), and encourage medical staffs and hospitals to engage community physicians, as appropriate, in medical staff and hospital activities.

There was mixed testimony on this resolution. Although most speakers were supportive of the need to involve community physicians in hospital activities, several speakers disagreed with the idea that these physicians should have the opportunity to participate in leadership activities within the hospital. Your Reference Committee agrees with testimony suggesting amending the second resolve to eliminate references to governance activities, while retaining language that encourages community physician involvement in more patient-centered and professional development activities. Your Reference Committee also appreciated testimony suggesting that community physicians from all specialties, not just primary care, should be encouraged to participate in hospital activities. Your Reference Committee believes this resolution establishes important new policy for our AMA, and recommends that it be adopted as amended.

## (12) RESOLUTION 702 - PUTTING PRICE TRANSPARENCY INTO PRACTICE

## RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 702 be amended by addition to read as follows:

RESOLVED, That our American Medical Association study appropriate mechanisms through which patients and physicians will be able to obtain price data from providers, facilities, insurers and other health care entities prior to the provision of non-emergent services, and that our AMA study the barriers to this goal and serve as a leading voice in this discussion (Directive to Take Action); and be it further

## RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 702 be amended by deletion to read as follows:

RESOLVED, That our AMA support ~~medical education~~ efforts to enhance cost transparency as a part of undergraduate and graduate medical education, focused on the cost of the tests providers order, as well as the cost of medical equipment and facility fees (Directive to Take Action); and be it further

## RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 702 be adopted as amended.

**HOD ACTION: Resolution 702 adopted as amended.**

Resolution 702 asks that our AMA study appropriate mechanisms through which patients will be able to obtain price data prior to the provision of non-emergent services, and study barriers to this goal, in order to serve as a leading voice in this discussion. The resolution also asks that our AMA support medical education efforts to enhance cost transparency as a part of undergraduate and graduate medical education, and provide regular updates to its membership on the path toward enhancing the transparency of cost within the US health care system.

There was supportive testimony on this resolution. Your Reference Committee agrees with testimony that physicians as well as patients need access to this information, and recommends amending the first resolve to include physicians as well as patients. Your Reference Committee also agrees with testimony suggesting amending the second resolve to clarify the intent that our AMA should support broad efforts to enhance cost transparency as a part of medical education. Several speakers noted that the concept of price transparency is complex, and insurance companies, providers and patients are likely to define prices, cost and price transparency in different ways, which makes it difficult to access meaningful information about the cost of individual health care services. Although some speakers suggested that the resolution be referred because of the complexity of this issue, your Reference Committee notes that the resolution calls for a study, which will allow our AMA to develop a thorough report that examines all aspects of the price/cost transparency issue. Accordingly, your Reference Committee recommends that Resolution 702 be adopted as amended.

## (13) RESOLUTION 704 - STUDYING HOSPITAL-ENFORCED ADMISSIONS, TESTING AND PROCEDURE QUOTAS

## RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 704 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association study the extent to which U.S. hospitals ~~inappropriately~~ interfere in physicians' independent exercise of medical judgment, including but not limited to the use of incentives for admissions, testing, and procedures, ~~quotas~~.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 704 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 704 be changed to read:

STUDYING HOSPITAL INCENTIVES FOR ADMISSION, TESTING, AND PROCEDURES

**HOD ACTION: Resolution 704 adopted as amended with change in title.**

Resolution 704 asks that our AMA study the extent to which hospitals inappropriately interfere in physicians' independent exercise of medical judgment, including the use of admissions, testing and procedure quotas.

Testimony overwhelmingly favored adoption of Resolution 704. Your Reference Committee notes that the AMA supports protecting a physician's right to freely exercise independent medical judgment (Policy H-225.952) and believes that the proposed study may assist the AMA in protecting future attempts to infringe on this right.

Your Reference Committee believes that any interference with a physician's exercise of medical judgment to be inappropriate, therefore rendering the term redundant in this use. Additionally, studying quotas would not likely yield meaningful results, as it is improbable that hospitals would formalize a process that would effectively constitute Medicare fraud.

For these reasons, your Reference Committee recommends that Resolution 704 be adopted as amended with a change in title.

(14) RESOLUTION 705 - PREVENTIVE SCREENING AND TREATMENT OF MALNUTRITION IN HOSPITAL PATIENTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 705 be adopted.

**HOD ACTION: Substitute Resolution 705 adopted.**

PAYMENT FOR NUTRITION SUPPORT SERVICES

RESOLVED, That our American Medical Association recognizes the value of nutrition support teams services and their role in positive patient outcomes and supports payment for the provision of their services.

Resolution 705 asks that our AMA support the standardization and accreditation of interdisciplinary nutrition support team services for provision of comprehensive nutritional screening, assessment, and management in hospitals; the establishment of national registries for the sharing of information related to the performance of nutrition support teams and other preventive nutritional interventions; and the reimbursement of assessment and

interventions provided by nutrition support teams where they are used to preclude or mitigate adverse health outcomes.

Resolution 705 received minimal testimony during the hearing. Your Reference Committee notes that the Joint Commission on Accreditation of Healthcare Organizations currently requires hospitals to establish criteria when in-depth nutritional assessment should be performed for patients and requires hospitals to have criteria for nutritional plans. Additionally, hospitals are required to conduct a nutritional screening within 24 hours of in-patient admission.

According to the American Society for Parenteral and Enteral Nutrition, a nutrition support team (NST) is a multi-disciplinary group of health care professionals with expertise in nutrition who aid in the provision of nutrition support. Your Reference Committee recognizes that NSTs provide the in-depth care required by the Joint Commission and that the use of NSTs is a beneficial method of providing nutritional care for hospital patients that should be paid accordingly. For these reasons, your Reference Committee recommends adoption of Substitute Resolution 705.

(15) RESOLUTION 707 - GRACE PERIOD  
RESOLUTION 732 - FEDERAL ADVOCACY FOR PROTECTION OF  
STATE LAW UNDER THE 90-DAY GRACE PERIOD

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 707 be amended by deletion of the first resolve:

~~RESOLVED, That our American Medical Association amend Policy H-185.938 such that health plans should notify providers immediately that an enrollee is in a grace period so that policy H-185.938 reads:~~

~~H-185.938 Health Insurance Exchange and 90-Day Grace Period~~

~~1. Our AMA opposes the preemption of state law by federal laws relating to the federal grace period for subsidized health benefit exchange enrollees. 2. Our AMA will advocate that health plans be required to notify physicians immediately 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. (Modify current HOD policy); and be it further~~

**HOD ACTION: Adopted**

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 707 be amended by substitution of the second resolve to read as follows:

RESOLVED, That our AMA amend Policy H-185.938 such that health plans should pay providers for all covered services rendered during a grace period so that policy H-185.938 reads:

H-185.938 Health Insurance Exchange and 90-Day Grace Period

1. Our AMA opposes the preemption of state law by federal laws relating to the federal grace period for subsidized health benefit exchange enrollees, and will seek appropriate changes to federal law and regulations to protect state and prompt payment laws. 2. Our AMA will 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. 3. Our AMA will continue to advocate that plans be required to pay providers for all covered claims for services rendered that would otherwise be covered under the contract during a grace period. (Modify current HOD policy); and be it further

**HOD ACTION: Adopted as amended**

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 707 be amended by deletion of the third resolve:

RESOLVED, That our AMA take all possible means available to require health plans in state exchanges to notify providers immediately that an enrollee is in a grace period (Directive to take action); and be it further

**HOD ACTION: Adopted**

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Resolution 707 be amended by addition of a new resolve to read as follows:

RESOLVED, That our AMA support the development of alternative financing solutions, such as reinsurance for unpaid premiums, for physician payments during the grace period. (Directive to Take Action)

**HOD ACTION: Adopted**

RECOMMENDATION E:

Mr. Speaker, your Reference Committee recommends that Resolution 707 be adopted as amended in lieu of Resolution 732.

**HOD ACTION: Resolution 707 adopted as amended in lieu of Resolution 732.**

Resolution 707 asks that Policy H-185.938 be amended to advocate that insurers notify physicians immediately when an enrollee enters the grace period and that insurers be required to pay providers for all covered services provided during the grace period. Resolution 707 also asks our AMA to actively advocate for changes in the federal rule regarding pending claims during the grace period, and support state societies in their legal attempts to enforce prompt pay statutes during the grace period.

Resolution 732 asks that our AMA seek federal legislation and changes to regulations in order to prevent the preemption of state prompt pay laws by federal laws and rules related to the grace period for subsidized health benefit exchange enrollees; seek federal legislation and regulations to prevent health insurance company recoupment of payments made during the grace period when the insurer has not notified the physician the insured person is in the last two months of the grace period; and support the development of alternative financing solutions, such as reinsurance for unpaid premiums, for physician payments during the grace period.

There was support for continued AMA efforts to advocate at the state level and for changes to federal rules allowing insurers to pend claims during the 90 day grace period. Your Reference Committee recommends consolidating the resolves in Resolutions 707 and 732 into one amended resolution that will reflect the supportive testimony presented in the reference committee.

Several speakers noted that the existing language in Policy H-185.938 requiring insurers to notify physicians upon an eligibility verification check by the physician is more realistic and useful for physicians than the language proposed in the first and third resolves of Resolution 707, which would require insurance companies to notify physicians “immediately” that a patient had entered the grace period. Your Reference Committee agrees with this testimony, and accordingly recommends deletion of the first and third resolves of Resolution 707.

Your Reference Committee also agrees with testimony that advocating that failure of plans to notify physicians of a patient’s grace period status should result in a binding eligibility determination, as stated in Policy H-185.938, is a strong statement of plan responsibility to provide appropriate notification to physicians, and should be retained. The second resolve of Resolution 707 recommends replacing that language with a statement that plans should pay providers for all covered services rendered during the grace period. Rather than deleting the language about binding eligibility determinations, your Reference Committee recommends amending Policy H-185.938 by adding a third section that directs our AMA to continue to advocate that plans be required to pay for all covered services provided during the grace period. Your Reference Committee believes this policy amendment is consistent with the intent of Resolutions 707 and 732, and the supportive testimony provided on these resolutions.

Your Reference Committee recommends adoption of the fourth and fifth resolves of Resolution 707 as written, and recommends adding the third resolve of Resolution 732, which would establish new policy regarding alternative financing solutions for physician payments during the grace period. The Reference Committee believes that the proposed amendments to Resolution 707 accurately reflect the testimony received on this important issue, and capture the intent of Resolutions 707 and 732.

(16) RESOLUTION 708 - PROTECTING PHYSICIANS WHO ARE PARTICIPATING IN PHYSICIAN HEALTH PROGRAMS FROM ARBITRARY DELISTING BY INSURANCE CARRIERS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 708 be amended by addition and deletion to read as follows:

RESOLVED, That American Medical Association Policy H-285.991, Qualifications and Credentialing of Physicians in Managed Care (1) (d) be amended by addition and deletion as follows:

“(d) Prior to initiation of actions leading to termination or nonrenewal of a physician's participation contract for any reason the physician shall be given notice specifying the grounds for termination or nonrenewal, a defined process for appeal, and an opportunity to initiate and complete remedial activities, except in cases where harm to patients is imminent or an action by a state medical board or other government agency effectively limits the physician's ability to practice medicine. ~~(required)~~ Participation in a Physician Health Program in and of itself shall not count as a limit on the ability to practice medicine. Our AMA supports the following appeals process for physicians whose health insurance contract is terminated or not renewed: (i) the specific reasons for the termination or nonrenewal should be provided in sufficient detail to permit the physician to respond; (ii) a name and address of the Director of Provider Appeals, or an individual with equivalent authority, should be provided for the physician to direct communications; (iii) the evidence or documentation underlying the proposed termination or nonrenewal should be provided and the physician should be permitted to review it upon request; (iv) the physician should have the right to request a hearing to challenge the proposed termination or nonrenewal; (v) the physician or his/her representative should be able to appear in person at the hearing and present the physician’s case; (vi) the physician should be able to submit supporting information both before and at the fair hearing; (vii) the physician should have a right to ask questions of any representative of the health insurance company who attends the hearing; (viii) the physician should have at least thirty days from the date the termination or nonrenewal notice was



received to request a hearing; and (ix) the hearing must be held not less than thirty days after the date the health insurer receives the physician's request for the review or hearing.

**RECOMMENDATION B:**

Mr. Speaker, your Reference Committee recommends that Resolution 708 be adopted as amended.

**HOD ACTION: Resolution 708 adopted as amended.**

Resolution 708 asks that Policy H-285.991(1)(d), be amended by addition as of the phrase: "required participation in a Physician Health Program in and of itself shall not count as a limit on the ability to practice medicine."

Your Reference Committee agrees with supportive testimony on Resolution 708. Existing AMA policy recognizes the importance of physician health programs (H-405.961) and calls on the AMA to aid in successful implementation of such services. Allowing insurance companies to disqualify any physician referred to such a program from participating in their network prevents physician health programs from successfully rehabilitating physicians to allow them to productively care for patients. Your Reference Committee agrees with testimony calling for the removal of the addition from parentheses so as not to unintentionally lessen its perceived importance. As a result, your Reference Committee recommends that Resolution 708 be adopted as amended.

**(17) RESOLUTION 709 - CHANGE OF COUMADIN REGULATION BY CMS**

**RECOMMENDATION A:**

Mr. Speaker, your Reference Committee recommends that Resolution 709 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~assist in the effort to change the thrombotic disease patient care discrepancy and~~ request a change in ~~this~~ Centers for Medicare and Medicaid Services' regulations to allow a nurse, under physician supervision, to visit a patient who cannot travel, has no family who can reliably test, or is unable to test on his/her own to obtain and perform a protime/INR without restrictions. (Directive to Take Action)

**RECOMMENDATION B:**

Mr. Speaker, your Reference Committee recommends that Resolution 709 be adopted as amended.

**HOD ACTION: Resolution 709 adopted as amended.**

Resolution 709 asks that our AMA assist in the effort to change the thrombotic disease patient care discrepancy and request a change in this regulation to allow a nurse to visit a patient who cannot travel, has no family who can reliably test, or is unable to test on his/her own to obtain and perform a protime/INR without restrictions.

There was supportive testimony on this resolution. Your Reference Committee agrees that patients who are unable to reliably self-monitor anti-coagulation should be able to receive testing by a visiting nurse. Your Reference Committee agrees with testimony that it is important to specify that the nurse should be working under physician supervision, and recommends additional amendments to clarify the language of the resolution. Your Reference Committee recommends that Resolution 709 be adopted as amended.

## (18) RESOLUTION 712 - VERBAL ADMISSION ORDER SIGNATURES

## RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 712 be adopted.

**HOD ACTION: Substitute Resolution 712 adopted.**

RESOLVED, That our AMA work with the Centers for Medicare and Medicaid Services to allow authentication of verbal admission orders within 30 days, rather than prior to discharge. (Directive to Take Action)

Resolution 712 asks that our AMA work with the American Hospital Association and the Centers for Medicare and Medicaid Services (CMS) to change the admission signature requirement from 48 hours to 30 days.

CMS eliminated the requirement for authentication of verbal orders within 48-hours in 2012, and now requires authentication prior to discharge. The sponsors of Resolution 712 offered the substitute language and clarified that the intent of the resolution is to request that a 30-day time-frame be given to signing admission orders, since failure to authenticate prior to discharge could result in payment denial for the whole hospital stay. Your Reference Committee agrees with supportive testimony on this substitute language, and recommends its adoption.

## (19) RESOLUTION 718 - IMPROVING THE HANDLING OF IN-FLIGHT MEDICAL EMERGENCIES

## RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 718 be deleted.

~~RESOLVED, That our American Medical Association partner with the Aerospace Medical Association and with the American College of Emergency Physicians in supporting the development of guidelines that may be used by physicians who assist in in-flight medical emergencies~~

**HOD ACTION: Adopted**

## RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 718 be amended by addition and deletion as follows:

RESOLVED, That our AMA support ~~participate in~~ efforts to educate the flying physician public about in-flight medical emergencies (IFMEs) to help them participate more fully and effectively when an IFME occurs.

**HOD ACTION: Adopted**

## RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 718 be adopted as amended.

**HOD ACTION: Resolution 718 adopted as amended (per Recommendations A-B), plus addition of an additional resolve:**

**RESOLVED, That such educational course be made available “on line” as a webinar.**

Resolution 718 asks that our AMA partner with the Aerospace Medical Association and with the American College of Emergency Physicians in supporting the development of guidelines that may be used by physicians who assist in in-flight medical emergencies and participate in efforts to educate the flying physician public about in-flight medical emergencies (IFMEs) to help them participate more fully and effectively when an IFME occurs.

There was substantial testimony on Resolution 718. Your Reference Committee agrees that physicians should have resources made available to gain a greater understanding of how to care for patients during IFMEs. Compelling testimony was offered establishing that organizations such as the Aerospace Medical Association already offer this type of training and offer guidance resources. The committee notes that a seminar of this type was offered as an educational session at the 2008 Interim Meeting. In order to enable the AMA to properly support existing training and resources for physicians, your Reference Committee recommends adoption of Resolution 718 as amended.

- (20) RESOLUTION 719 - CMS FACE-TO-FACE DOCUMENTATION  
RESOLUTION 730 - PAYMENT FOR CENTERS FOR MEDICARE AND  
MEDICAID SERVICES MANDATED SERVICES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 719 be adopted in lieu of Resolutions 719 and 730.

**HOD ACTION: Substitute Resolution 719 adopted in lieu of Resolutions 719 and 730.**

STUDY THE COSTS OF ADMINISTRATIVE AND REGULATORY  
BURDENS

RESOLVED, That our American Medical Association perform or commission an analysis of the direct and indirect costs and documented benefits associated with significant administrative and regulatory requirements imposed by the Centers for Medicare and Medicaid Services, including but not limited to face-to-face documentation requirements, the Physician Quality Reporting System, and the Meaningful Use program. (Directive to Take Action)

Resolution 719 asks that our AMA ask for data from the Centers for Medicare and Medicaid Services (CMS) regarding face-to-face forms for therapy, specifically requesting financial data regarding the cost for handling the additional forms and the cost of additional office visits required for this documentation versus any savings from decreased fraud and ask CMS to review, revise, or rescind the face-to-face documentation for therapy if there is no documented savings or other benefits.

Resolution 730 asks that our AMA perform or commission an analysis to compare official CMS estimates of direct and indirect costs attributable to the Physician Quality Reporting System (PQRS), Meaningful Use and ICD-10, and compare these estimates to the actual time and costs required to complete these mandates.

There was supportive testimony on both of these resolutions. Your Reference Committee agrees with testimony that there are many programs that represent significant administrative burdens to physicians, and recommends substitute language that would direct our AMA to take a more comprehensive approach to evaluating the costs of the multiple certification and documentation requirements that physicians are faced with today.

(21) RESOLUTION 721 - CAPTURING PHYSICIAN SENTIMENTS OF HOSPITAL QUALITY

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 721 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association foster the creation of ~~explore the possibility of creating a~~ quality measures and rating systems that incorporates the satisfaction and perspective of the medical staff regarding individual hospitals. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 721 be adopted as amended.

**HOD ACTION: Resolution 721 adopted as amended**

Resolution 721 asks that our AMA explore the possibility of creating a quality measure and rating system that incorporates the satisfaction and perspective of the medical staff regarding individual hospitals.

There was supportive testimony on this resolution. Your Reference Committee notes that the Professional Satisfaction and Practice Sustainability group is working closely with the American Hospital Association to identify ways to strengthen physician-hospital relationships and promote more productive, efficient and collaborative partnerships. Your Reference Committee believes that the amended language is consistent with this ongoing work, and recommends adoption of amended Resolution 721.

(22) RESOLUTION 723 - INTEGRATING PHYSICAL AND BEHAVIORAL HEALTH CARE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 723 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association, with interested specialty and state societies, will study and report back at the 2015 Annual Meeting on our current state of knowledge regarding integration of physical and behavioral health care, including pediatric and adolescent health care, and make any recommendations for further study, implementation of models of physical and behavioral health care integration, and any other tools or policies that would benefit our patients and our health care system by the integration of physical and behavioral health care. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 723 be adopted as amended.

**HOD ACTION: Resolution 723 adopted as amended.**

Resolution 723 asks that our AMA study issues related to integrating physical and behavioral health care.

There was supportive testimony on this resolution. The sponsor of the resolution proposed amended language that would expand the scope of the requested study to include the integration of physical and behavioral health care for children and adolescents. Your Reference Committee agrees that this is an important topic that our AMA should pursue, and recommends adoption of amended Resolution 723.

- (23) RESOLUTION 724 - PRIVATE HEALTH INSURANCE FORMULARY  
TRANSPARENCY  
RESOLUTION 716 - PHARMACY-PHYSICIAN COMMUNICATIONS  
REGARDING DRUG FORMULARIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 724 be adopted in lieu of Resolution 716 and Resolution 724.

**HOD ACTION: Substitute Resolution 724 adopted as amended in lieu of Resolution 716 and Resolution 724.**

RESOLVED, That our American Medical Association work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing (Directive to Take Action); and be it further

RESOLVED, That our AMA support legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, that formulary information be specific as to generic versus trade name and include copay responsibilities, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term (Directive to Take Action); and be it further

RESOLVED, That our AMA develop model legislation 1) requiring insurance companies to declare which drugs on their formulary will be covered under trade names versus generic, 2) requiring insurance carriers to make this information available to consumers by October 1 of each year and, 3) forbidding insurance carriers from making formulary deletions within the policy term. (Directive to Take Action)

RESOLVED, That our AMA promote the following insurer-pharmacy benefits manager – pharmacy (IPBMP) to physician procedural policy:

In the even that a specific drug is not or is no longer on the formulary when the prescription is presented, the IPBMP shall provide notice of covered formulary alternatives to the prescriber promptly so that appropriate medication can be provided to the patient within 72 hours.

RESOLVED, That drugs requiring prior authorization, shall be adjudicated by the IPBMP within 72 hours of receipt of the prescription.

Resolution 716 asks that our AMA adopt a new policy regarding pharmacy-physician communication: “In the event that a pharmacy reports back to the prescriber that a specific drug is not or is no longer on the formulary or needs prior authorization, the pharmacy shall consult the insurer for formulary alternatives, provide notice of the alternatives to the prescriber, and gather the prescriber’s authorization for the substitution within 72 hours either by telephone, facsimile, or through an electronic prescribing system.”

Resolution 724 asks that our AMA develop model legislation and support legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the

preceding year, that formulary information be specific as to generic versus trade name and include copay responsibilities, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term.

Testimony was somewhat divided on Resolution 716. Your Reference Committee agrees that steps should be taken to avoid patients being unable to fill prescriptions when visiting a pharmacy, but believes that addressing the issue at the time that the patient is at the pharmacist may not be the best method of addressing the issue. The most efficient method of patient drug delivery is achieved by preventing the unintended prescription of non-covered drugs. In order to achieve this efficiency, our AMA should work with pharmacies, pharmacy benefit managers, and health insurers to facilitate real-time access to formulary information and prior authorization requirements at the time of prescribing. For this reason, Resolution 716 should be considered in conjunction with Resolution 724, which seeks to improve the delivery of formulary data.

Your Reference Committee agrees with the overwhelmingly supportive testimony for Resolution 724. Your Reference Committee notes that the recommendations are largely consistent with current Medicare Part D regulations, which require plans to provide a comprehensive or abridged formulary to enrollees during enrollment in order to provide an opportunity to determine which medications are covered and whether the cost-sharing for their covered medications will change. Additionally, your Reference Committee agrees with an amendment proffered to ensure that drugs not be removed from a particular formulary while permitting the ability to add new medications as they become available.

For these reasons, your Reference Committee recommends adoption of Substitute Resolution 724 in lieu of Resolutions 716 and 724.

(24) RESOLUTION 725 - AMA TO ENDORSE THE "CHOOSING WISELY" PROGRAM

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 725 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~endorse~~ support the concepts of the American Board of Internal Medicine's Foundation's Choosing Wisely program. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 725 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 725 be changed to read as follows:

SUPPORT FOR THE CONCEPTS OF THE "CHOOSING WISELY" PROGRAM

**HOD ACTION: Resolution 725 adopted as amended with a change in title.**

Resolution 725 asks that our AMA endorse the American Board of Internal Medicine's Choosing Wisely program.

The majority of testimony on this resolution expressed support for the concept of the Choosing Wisely initiative and its effort to increase the value of health care delivery. However, many speakers indicated that specifically endorsing



the Choosing Wisely program itself could be premature. Your Reference Committee agrees that our AMA should support the concepts of the program, and accordingly recommends that Resolution 725 be adopted as amended.

(25) RESOLUTION 727 - POINT OF CARE AVAILABILITY OF BLOOD GLUCOSE TESTING

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 727 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with the Food and Drug Administration and the Centers for Medicare & Medicaid Services to ~~seek the maintenance of~~ maintain the Clinical Laboratory Improvement Act exempt status of point-of-care glucose testing. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 727 be adopted as amended.

**HOD ACTION: Resolution 727 adopted as amended.**

Resolution 727 asks that our AMA work with the Centers for Medicare and Medicaid Services (CMS) to seek the maintenance of the CLIA exempt status of point of care glucose testing.

There was supportive testimony on this resolution. Several speakers noted that the rules regarding point-of-care glucose testing have recently changed because the Food and Drug Administration (FDA) has introduced new guidelines related to blood glucose testing devices. Your Reference Committee agrees with testimony that the FDA action should not interfere with the CLIA exempt status of point of care glucose testing, which is used in a variety of clinical settings for multiple clinical purposes. Your Reference Committee believes that our AMA needs to work with both the FDA and CMS to address this issue, and recommends that Resolution 727 be adopted as amended.

(26) RESOLUTION 735 - THE FUTURE OF PRIVATE PRACTICE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 735 be amended by deletion as follows:

RESOLVED, That our AMA create and maintain a reference document establishing principles for entering into and sustaining a private practice, and, - working with the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education, encourage medical schools and residency programs to present physicians in training with information regarding private practice as a viable option.

**HOD ACTION: Adopted as amended**

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 735 be adopted as amended.

**HOD ACTION: Resolution 735 adopted as amended by addition and deletion (per Recommendation A), and by addition in the first resolve as follows:**

**RESOLVED, That our American Medical Association create, maintain, and make accessible to medical students, residents and fellows, and physicians, resources to enhance satisfaction and practice sustainability for physicians in private practice, with a progress report to the House of Delegates at the 2015 Annual Meeting (Directive to Take Action); and be it further.**

Resolution 735 asks that our AMA create, maintain, and make accessible to medical students, residents and fellows, and physicians resources to enhance satisfaction and practice sustainability for physicians in private practice; and, working with the Liaison Committee on Medical Education (LCME) and the Accreditation Council for Graduate Medical Education (ACGME), encourage medical schools and residency programs to present physicians in training with information regarding private practice as a viable option.

There was significant supportive testimony for Resolution 735, with which your Reference Committee agrees. As the resolution establishes, current AMA policy recognizes the benefits of private practice and supports efforts to preserve its viability. Educating medical students about private practice and creating resources to help enhance physician satisfaction with this practice model are a worthwhile extension of these existing policies. Your Reference Committee notes, however, that given the numerous required courses in the medical school curriculum, it is likely something that should be encouraged at the individual school level rather than pursued through the LCME and ACGME. As a result, your Reference Committee recommends that Resolution 735 be adopted as amended.

(27) RESOLUTION 736 - STUDYING PHYSICIAN ACCESS TO ACO PARTICIPATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 736 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association study:

- a. The criteria and processes by which various types of accountable care organizations (ACOs) determine which physicians will be selected to join vs. excluded from the ACO;
- b. The criteria and processes by which physicians can be de-selected once they are members of an ACO;
- ~~b.c.~~ The implications of such criteria and processes for patient access to care outside the ACO; and
- ~~c.d.~~ The effect of evolving system alignments on and integration and on physician recruitment and retention going forward.

The results of this study should be reported back to the HOD and to our AMA membership at large by the 2015 Annual Meeting. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 736 be adopted as amended.

**HOD ACTION: Resolution 736 adopted as amended.**

Resolution 736 asks that our AMA study the criteria and processes by which accountable care organizations (ACOs) determine which physicians will be included in the ACO, the implications of such criteria for patient access to care, and the effect of evolving system alignments on integration and physician recruitment and retention.

There was supportive testimony on this resolution. Your Reference Committee agrees with testimony that the study should include an examination of de-selection criteria and processes, and proposes the amended language to reflect this important addition. The amendment also reflects a correction requested by the sponsor, as the intent was to study the effect of evolving system alignments and integration on physician recruitment and retention.

(28) RESOLUTION 738 - PHYSICIAN LEADERSHIP OF THE PATIENT-CENTERED MEDICAL HOME

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 738 be amended by deletion of the second resolve:

RESOLVED, That our AMA respond to The Joint Commission's interpretation of its primary care medical home certification standards, ~~as set forth in a June 3, 2014, communication~~ addressing non-physician-led PCMHs (Directive to Take Action); and be it further

**HOD ACTION: Not adopted. Second resolve amended.**

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 738 be adopted as amended.

**HOD ACTION: Resolution 738 adopted as amended (per Recommendation A), and by deletion of the third resolve and addition of a new resolve:**

~~RESOLVED, That our AMA develop a report back at the 2015 Annual Meeting, which compares physician-led PCMHs and non-physician-led PCMHs in terms of quality of patient care, per patient total medical expenditures, total health care costs, access, and patient outcomes (Directive to Take Action)~~

**RESOLVED, That our AMA oppose any interpretation by The Joint Commission, or any other entity, of primary care medical home or patient centered medical home (PCMH) as being anything other than MD/DO physician led (Directive to Take Action).**

Resolution 738 asks that our AMA continue to support the concept of physician-led teams within the patient-centered medical home, respond to the Joint Commission's interpretation of its primary care medical home certification standards related to non-physician-led medical homes, and develop a report comparing physician-led and non-physician led medical homes.

There was strong supportive testimony on this resolution. Several speakers noted that our AMA has aggressively advocated that The Joint Commission (TJC) require physician leadership of a patient-centered medical home, and our AMA will continue to respond to TJC actions that weaken the physician's leadership role. In addition, our AMA continues its broader advocacy campaign related to state scope of practice laws, which TJC cite as justification for maintaining flexibility regarding leadership of medical homes. The Chair of the Board of Commissioners of TJC testified that a report comparing quality and costs in physician-led and non-physician led medical homes, as called for in the third resolve, would provide useful information to TJC. Your Reference Committee recommends deleting the second resolve of Resolution 738, as AMA communication with TJC on these issues is ongoing, and recommends that Resolution 738 be adopted as amended.

## (29) RESOLUTION 703 - IMPROVING HOME HEALTH CARE

## RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 703 be referred.

**HOD ACTION: Resolution 703 referred.**

Resolution 703 asks that our AMA support the establishment of state-based certification for home health care workers and regulatory oversight of home health agencies.

Testimony on Resolution 703 was mixed. Your Reference Committee supports proper oversight of home health care. However, considerable testimony raised concerns over the specific type of home care that may require certification and oversight. The term home health care can apply to a wide array of services and workers, each of which may require drastically different levels of oversight. As a result, the specific type of care warranting certification and regulation must be defined before a position can be adequately determined.

Additionally, your Reference Committee agreed with concerns over the financial implications of worker and agency certification and regulation. With a growing number of Americans reaching an age that often requires some form of home-care, it is important not to introduce fiscal barriers that may prevent those in need from receiving care. Accordingly, your Reference Committee recommends that Resolution 703 be referred.

## (30) RESOLUTION 717 - INCREASING PHYSICIAN EFFICIENCY

## RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 717 be referred.

**HOD ACTION: Resolution 717 referred**

Resolution 717 asks that our AMA encourage the integration of dictation systems into electronic medical record (EMR) systems.

There was mixed testimony on this resolution. Although some speakers agreed that the ability to integrate dictation systems into electronic medical records would be helpful, others indicated that dictation systems are not always the most effective or efficient way of maximizing the value of EMRs. In addition, there is the potential that including dictation systems as a standard feature in EMRs could raise their cost. Your Reference Committee believes this is a complex issue that merits further study, and recommends that Resolution 717 be referred.

## (31) RESOLUTION 706 - HIGH RATES OF CESAREAN DELIVERIES

## RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 706 not be adopted.

**HOD ACTION: Resolution 706 not adopted.**

Resolution 706 asks that our AMA support the American College of Obstetricians and Gynecologists' (ACOG's) recommendation of vaginal delivery over cesarean section in the absence of maternal or fetal indications and encourage appropriate entities to study the indications for cesarean section in order to achieve a greater degree of standardization in their use.

Testimony on Resolution 706 was mixed. Your Reference Committee notes that the American College of Obstetricians and Gynecologists (ACOG) Committee on Obstetric Practice opinion offers perspective and considerations for obstetricians and gynecologists to consider in developing birth plans. While such a specified recommendation is a useful resource, its focus makes it more appropriately covered by experts in the field. As a result, the development and furtherance of policy and guidance on childbirth protocol is best left to specialties, such as ACOG. For these reasons, your Reference Committee recommends that Resolution 706 not be adopted.

(32) RESOLUTION 713 - DIAGNOSIS CODE FOR EXCESSIVE RELIANCE ON ALTERNATIVE THERAPY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 713 not be adopted.

**HOD ACTION: Resolution 713 not adopted.**

Resolution 713 asks that our AMA propose development of a diagnosis code for excessive reliance on alternative therapy to the extent that it interferes with care or the patient-physician relationship.

There was limited and mixed testimony on this resolution. Your Reference Committee notes that our AMA continues to express concerns about the complexity of ICD-10, and is reluctant to encourage the creation of any new codes at this time. Your Reference Committee believes that the existing diagnosis codes related to patient non-compliance could effectively address the concerns raised in this resolution. Accordingly, your Reference Committee recommends that Resolution 713 not be adopted.

(33) RESOLUTION 710 - REIMBURSEMENT OF AUDIT REQUESTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that AMA Policies H-285.943, H-335.980, and H-315.992 be reaffirmed in lieu of Resolution 710.

**HOD ACTION: AMA Policies H-285.943, H-335.980, and H-315.992 reaffirmed in lieu of Resolution 710.**

Resolution 710 asks that our AMA develop a methodology for physician reimbursement from insurance companies to compensate for the medical practice expenses of completing audits.

There was mixed testimony on this resolution. Your Reference Committee agrees that health plan audits present an often frustrating interruption in physicians' time that would otherwise be spent caring for patients. Accordingly, physician time spent conducting the administrative tasks related to audits should be fairly compensated by health plans, as is currently recommended in AMA Policies H-285.943, H-335.980, and H-315.992. Additionally, Current Procedural Terminology code 99080 is a methodology of billing for such tasks. However, as expressed by the Chair of the CPT Editorial Panel, insurance companies often do not recognize some codes. Additionally, your Reference Committee notes that ongoing AMA efforts, including a model bill currently under development and testimony provided at the National Committee on Vital Health Statistics have focused on standardizing the format and limiting the circumstances in which plans can audit providers ([ama-assn.org/resources/doc/psa/x-pub/ncvhs-audit-forms-testimony-2011.pdf](http://ama-assn.org/resources/doc/psa/x-pub/ncvhs-audit-forms-testimony-2011.pdf)).

Ultimately, your Reference Committee believes that AMA Policies H-285.943, H-335.980, and H-315.992 sufficiently addresses the concerns raised in the resolution and therefore recommend reaffirmation in lieu of Resolution 710.

**H-285.943 Payment for Managed Care Administrative Services**

Our AMA: (1) opposes managed care contract provisions that prohibit physician payment for the provision of administrative services; (2) encourages physicians entering into: (a) capitated arrangements with managed care plans to seek the inclusion of a separate capitation rate (per member per month payment) for the provision of administrative services, and (b) fee-for-service arrangements with managed care plans to seek a separate case management fee or higher level of payment to account for the provision of administrative services; and (3) supports the concept of a time-based charge for administrative duties (such as phone precertification, utilization review activities, formulary review, etc.), to be assessed to the various insurers. (CMS Rep. 13, I-97; Appended: Res. 806, I-99; Reaffirmation A-04; Reaffirmation I-08; Reaffirmation I-09; Reaffirmed in lieu of Res. 912, I-09; Reaffirmation A-10)

**H-335.980 Payment For Copying Medical Records**

It is the policy of the AMA to seek legislation under which Medicare will be required to reimburse physicians and hospitals for the reasonable cost of copying medical records which are required for the purpose of postpayment audit. A reasonable charge will be paid by the patient or requesting entity for each copy (in any form) of the medical record provided. (Res. 161, I-90; Appended by Res. 819, A-98; Reaffirmation A-08)

**H-315.992 Copying Records for Audits**

Our AMA supports taking appropriate action to ensure that the financial responsibility for producing or copying patient records at the request of any regulatory agency having the authority to do so shall be borne entirely by the requesting agency and the request for said records shall be made at least 30 days in advance of any deadline. (Res. 75, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)

(34) **RESOLUTION 711 - REIMBURSEMENT FOR PRIOR APPROVAL REQUIREMENTS**

**RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends that AMA Policies H-385.951, H-285.943, and H-385.948 be reaffirmed in lieu of Resolution 711.

**HOD ACTION: AMA Policies H-385.951, H-285.943, and H-385.948 reaffirmed in lieu of Resolution 711.**

Resolution 711 asks that our AMA develop a methodology for physician reimbursement from insurance companies to compensate for the medical practice expenses of completing prior approval requirements.

There was mixed testimony on this resolution. Your Reference Committee notes that Resolution 711 was originally placed on the Reaffirmation Consent Calendar, and the committee continues to believe existing policy adequately supports ongoing efforts in this area. Physician time spent conducting the administrative tasks related to prior authorization should be fairly compensated by health plans, as is currently recommended in AMA Policies H-385.951, H-285.943, and H-385.948. As with audit charges, the development of a methodology does not necessarily beget payment, as insurance contracts often do not allow payment for prior authorization.

Your Reference Committee notes ongoing AMA efforts to reduce the burden that prior authorizations place on physicians. The AMA has created a whitepaper outlining the costs and workflow inefficiencies of the current process ([ama-assn.org/resources/doc/psa/x-pub/standardization-prior-auth-whitepaper.pdf](http://ama-assn.org/resources/doc/psa/x-pub/standardization-prior-auth-whitepaper.pdf)), has created a model workflow to promote efficiency ([ama-assn.org/resources/doc/psa/x-pub/pa-approach-summary.pdf](http://ama-assn.org/resources/doc/psa/x-pub/pa-approach-summary.pdf)), and has advocated extensively on this issue, including a recent presentation given to the National Committee for Vital and Health Statistics ([ama-assn.org/resources/doc/psa/x-pub/ncvhs-prior-authorization.pdf](http://ama-assn.org/resources/doc/psa/x-pub/ncvhs-prior-authorization.pdf)). Additionally, the AMA has developed model legislation that aims to reduce the administrative burdens and increase insurer transparency in the prior authorization process.



Ultimately, your Reference Committee believes that AMA policies H-385.951, H-285.943, and H-385.948 sufficiently addresses the concerns raised in the resolution and therefore recommend reaffirmation in lieu of Resolution 711.

#### H-385.951 Remuneration for Physician Services

1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols. 2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work. 3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly. (Sub. Res. 814, A-96; Reaffirmation A-02; Reaffirmation I-08; Reaffirmation I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmation A-11; Reaffirmed in lieu of Res. 822, I-11)

#### H-285.943 Payment for Managed Care Administrative Services

Our AMA: (1) opposes managed care contract provisions that prohibit physician payment for the provision of administrative services; (2) encourages physicians entering into: (a) capitated arrangements with managed care plans to seek the inclusion of a separate capitation rate (per member per month payment) for the provision of administrative services, and (b) fee-for-service arrangements with managed care plans to seek a separate case management fee or higher level of payment to account for the provision of administrative services; and (3) supports the concept of a time-based charge for administrative duties (such as phone precertification, utilization review activities, formulary review, etc.), to be assessed to the various insurers. (CMS Rep. 13, I-97; Appended: Res. 806, I-99; Reaffirmation A-04; Reaffirmation I-08; Reaffirmation I-09; Reaffirmed in lieu of Res. 912, I-09; Reaffirmation A-10)

#### H-385.948 Reasonable Charge for Preauthorization

The AMA strongly supports and advocates fair compensation for a physician's administrative costs when providing service to managed care patients. (Res. 815, A-97; Reaffirmation A-04; Reaffirmation A-10; Reaffirmed: CMS Rep. 4, I-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11)

### (35) RESOLUTION 714 - HARMONIZING QUALITY METRIC EFFORTS WITH ELECTRONIC MEDICAL RECORDS

#### RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-450.946 and H-450.966 be reaffirmed in lieu of Resolution 714.

#### **HOD ACTION: Policies H-450.946 and H-450.966 reaffirmed in lieu of Resolution 714.**

Resolution 714 asks that our AMA work with agencies to explore and validate a uniform set of data metrics, including quality, payment and utilization data, and publish guidelines associated with these findings and report back to the House of Delegates.

There was supportive testimony on this resolution and the need to streamline and align quality metrics and reporting requirements to help increase their utility for physicians and reduce administrative burdens associated with meeting multiple quality reporting requirements. A member of the Council on Legislation testified that our AMA's advocacy with the Centers for Medicare and Medicaid Services and the Office of the National Coordinator for Health Information Technology emphasizes the importance of alignment across quality reporting programs and the need for standards that facilitate the capture and exchange of quality data information in electronic medical records. Your Reference Committee notes that this resolution was originally placed on the Reaffirmation Consent Calendar, and

believes that existing policy provides a strong foundation for continued AMA advocacy in this area. Accordingly, your Reference Committee recommends that the following policies be reaffirmed in lieu of Resolution 714:

#### H-450.946 Ensuring Quality in Health System Reform

Our AMA: (1) will discuss quality of care in each of its presentations on health system reform; (2) will advocate for effective quality management programs in health system reform that: (a) incorporate substantial input by actively practicing physicians and physician organizations at the national, regional and local levels; (b) recognize and include key quality management initiatives that have been developed in the private sector, especially those established by the medical profession; and (c) are streamlined, less intrusive, and result in real reduced administrative burdens to physicians and patients; and (3) will take a leadership role in coordinating private and public sector efforts to evaluate and enhance quality of care by maintaining a working group of representatives of private and public sector entities that will: (a) provide for an exchange of information among public and private sector quality entities; (b) oversee the establishment of a clearinghouse of performance measurement systems and outcomes studies; (c) develop principles for the development, testing, and use of performance/outcomes measures; and (d) analyze and evaluate performance/outcomes measures for their conformance to agreed upon principles. (Sub. Res. 703, I-93; Reaffirmation A-01; Renumbered: CMS Rep. 7, I-05; Reaffirmed in lieu of Res. 704, A-12)

#### H-450.966 Quality Management

The AMA: (1) continues to advocate for quality management provisions that are consistent with AMA policy; (2) seeks an active role in any public or private sector efforts to develop national medical quality and performance standards and measures; (3) continues to facilitate meetings of public and private sector organizations as a means of coordinating public and private sector efforts to develop and evaluate quality and performance standards and measures; (4) emphasizes the importance of all organizations developing, or planning to develop, quality and performance standards and measures to include actively practicing physicians and physician organizations in the development, implementation, and evaluation of such efforts; (5) urges national medical specialty societies and state medical associations to participate in relevant public and private sector efforts to develop, implement, and evaluate quality and performance standards and measures; and (6) advocates that the following principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts: (a) Standards and measures shall have demonstrated validity and reliability. (b) Standards and measures shall reflect current professional knowledge and available medical technologies. (c) Standards and measures shall be linked to health outcomes and/or access to care. (d) Standards and measures shall be representative of the range of health care services commonly provided by those being measured. (e) Standards and measures shall be representative of episodes of care, as well as team-based care. (f) Standards and measures shall account for the range of settings and practitioners involved in health care delivery. (g) Standards and measures shall recognize the informational needs of patients and physicians. (h) Standards and measures shall recognize variations in the local and regional health care needs of different patient populations. (i) Standards and measures shall recognize the importance and implications of patient choice and preference. (j) Standards and measures shall recognize and adjust for factors that are not within the direct control of those being measured. (k) Data collection needs related to standards and measures shall not result in undue administrative burden for those being measured. (BOT Rep. 35, A-94; Reaffirmed: CMS Rep. 10, I-95; Reaf: CMS Rep. 7, A-05; Modified: CMS Rep. 6, A-13)

#### (36) RESOLUTION 715 - OVER-REGULATION OF PROVIDER-PERFORMED MICROSCOPY PROCEDURES FOR AMBULATORY HEALTH CARE

##### RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-220.946 and H-180.973 be reaffirmed in lieu of Resolution 715.

**HOD ACTION: Resolution 715 referred for report back at I-14.**

Resolution 715 asks that our AMA demand recognition of current certification systems that are in place without placing financial and temporal barriers to care and oppose overregulation of professional practitioners without clear demonstration of harm under current regulations or policies.

There was limited testimony on this resolution. Your Reference Committee notes that the resolve clauses express general statements calling for our AMA to oppose duplicative certification requirements and overregulation of professional practitioners. Policies H-220.946 and H-180.773 address these issues. These broad statements would apply to the over-regulation of provider-performed microscopy procedures, as well as other clinical procedures or situations in which physicians may be burdened by over regulation. Accordingly, your Reference Committee recommends reaffirmation of the following policies in lieu of Resolution 715:

H-220.946 Unreasonable Burden of The Joint Commission Standards and Surveys

The AMA requests The Joint Commission to study and consider the ability of small hospitals, particularly in rural areas, to bear the burden of the increasing demands on staff and financial resources in the implementation of the current and proposed standards; and urges The Joint Commission to eliminate standards that increase health care costs without demonstrably improving the quality of care. (Res. 834, A-93; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)

H-180.973 The "Hassle Factor"

Our AMA will greatly intensify its efforts (including support of HR 2695) to reduce the burden of government and third party regulation on medical practice and its intrusion into the physician-patient relationship and doctor patient time. (Res. 276, A-92; Reaffirmation A-00; Reaffirmation A-01; Modified: CLRPD Rep. 1, A-03; Reaffirmation I-07; Reaffirmation I-09)