MEMORIAL RESOLUTIONS
ADOPTED UNANIMOUSLY

William T. Bradley, MD
Introduced by the American Academy of Neurology

Whereas, On November 30, 2013, a dedicated member of this American Medical Association, Dr. William Texas Bradley unexpectedly passed away at the age of 46; and

Whereas, Dr. Bradley served as a delegate and alternate delegate to the AMA House of Delegates from the American Academy of Neurology since 2006; and

Whereas, Dr. Bradley served in many capacities within the Texas Medical Association, including as a delegate to the AMA Young Physicians Section; and

Whereas, Dr. Bradley started in organized medicine through the Tarrant County Medical Society, ultimately serving as society President in 2011-2012; and

Whereas Dr. Bradley devoted himself to the service of his patients and his community in Arlington and Mansfield, Texas as a multiple sclerosis specialist since 1998, exemplifying humility and graciousness in his everyday life; and

Whereas, Dr. Bradley leaves behind three minor children, Austin, Jake, and Leah, their mother, Baronda, and his brother and parents; therefore be it

RESOLVED, That our American Medical Association recognize the service and dedication of Dr. William T. Bradley to his profession, to patient care, and to organized medicine; and be it further

RESOLVED, That this resolution be forwarded to Dr. Bradley's family and to his practice partners at Neurology Associates, P.A., with the expression of deepest sympathy as well as for appreciation of his distinguished life and medical career.

Harvey L. Neiman, MD, FACR
Introduced by American College of Radiology

Whereas, Harvey L. Neiman, MD, FACR, chief executive officer of the American College of Radiology (ACR) from 2002-2014, died (June 5, 2014) following a long illness, and

Whereas, Dr. Neiman was widely considered a medical visionary who dedicated his professional life to improving patient care, and

Whereas, Under Dr. Neiman's leadership, the ACR rose to be one of the world's largest and most influential medical specialty societies, and

Whereas, Ardis Dee Hoven, M.D., president of the American Medical Association, once stated "Dr. Neiman helped make health care better and safer. The steps he championed enabled dramatic improvements in patient care and helped shape modern medicine," and

Whereas, Dr. Neiman was committed to improving the quality and safety of imaging care nationwide, taking historic steps to promote health care quality, safety and efficiency, by spearheading the co-founding the Image Wisely® and Image Gently® initiatives to raise awareness of opportunities to lower radiation dose used in medical imaging; and by guiding the development of the Dose Index Registry®, which helps imaging practices track, optimize and benchmark radiation dose used in patient scans, and

Whereas, Dr. Neiman helped plan and create the ACR Education Center to train physicians in advanced medical imaging and image-guided techniques, and helped spearhead the creation of the American Institute for Radiologic

Pathology (AIRP®), preserving nearly a century of knowledge and enabled current and future radiology residents to continue to receive a vital part of their medical training, and under whose direction the Radiology Leadership Institute (RLI), was formed, providing radiologists with business and leadership training to help make them better administrators and leaders in the changing health care environment, and

Whereas, He is remembered as a dedicated physician, a dear friend and colleague, an exceptional leader, a mentor and a luminary, and

Whereas, Dr. Neiman treasured his family and is survived by his devoted wife Ellie, daughters Jennifer and Hillary, and grandson William, to whom he was a loving and involved husband, father and grandfather; therefore be it

RESOLVED, That our American Medical Association recognize the lifelong service and dedication of Dr. Harvey L. Neiman to organized medicine and especially the field of Radiology; and be it further

RESOLVED, That our AMA express its deepest sympathy to the family members of Dr. Harvey L. Neiman.

Tom Edward Nesbitt, Sr., MD
Introduced by: Tennessee Medical Association

Whereas, Tom Edward Nesbitt, Sr., MD died on February 12, 2014; and

Whereas, Dr. Nesbitt practiced urological surgery in Nashville for almost 50 years; and

Whereas, Dr. Nesbitt dedicated his time and knowledge to a number of organizations, achieving the highest role as President of both the Tennessee Medical Association, 1970-1971, and the American Medical Association, 1978-1979; and

Whereas, Dr. Nesbitt remains the only TMA president who has also served as president of the AMA; and

Whereas, Dr. Nesbitt also led TMA advocacy efforts as Legislative Committee chair in the late 1960s, developing and implementing strategies still used by TMA today, including home district meetings with state lawmakers, annual trips to Washington, DC, to meet with members of Congress, editorial board and news media meetings; and

Whereas, Dr. Nesbitt in 1971 debated with US Senator Ted Kennedy over national health insurance, when the Senator brought a nationwide tour on his HR-1 bill to Nashville; and

Whereas, In 2011, Dr. Nesbitt won the TMA Outstanding Physician award for his lifetime of exemplary achievements both in his practice and in his advocacy and leadership roles; and

Whereas, TMA recognizes Dr. Nesbitt's historic contributions to healthcare, to organized medicine, and specifically to our Association; therefore be it

RESOLVED, That our American Medical Association convey through this resolution its deepest sympathy to the family of Dr. Tom Nesbitt, Sr.

Robert T.M. Phillips, MD, PhD
Introduced by American Academy of Psychiatry and the Law, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Association for Geriatric Psychiatry, Maryland State Medical Society

Whereas, Robert T.M. Phillips, MD, PhD, served as Delegate from the American Academy of Psychiatry and the Law in the AMA House of Delegates since 2003; and

Whereas, Dr. Phillips served as President of the American Academy of Psychiatry and The Law from 2004 to 2005; and
Whereas, Dr. Phillips was an esteemed staff member of the American Psychiatric Association from 1993 to 1998, serving as Deputy Medical Director, as Director of the APA Offices of Psychiatric Services, Minority and National Affairs and as Clinical Director of the Office of Economic Affairs and Practice Management; and

Whereas, Dr. Phillips was Adjunct Associate Professor of Psychiatry and Adjunct Professor of Law at the University of Maryland Schools of Medicine and Law, and lecturer and former Assistant Clinical Professor of Psychiatry in the Law and Psychiatry Division of the Yale University School of Medicine; and

Whereas, Dr. Phillips was Vice Chair of the AMA Section Council on Psychiatry; and

Whereas. Dr. Phillips was a member of MedChi, the Maryland State Medical Association, and a member of its Council on Ethical and Judicial Affairs since 2011; and

Whereas, His colleagues fondly remember not only his sharp intellect, but his warm personality and compassion, and his valuable contributions in psychiatry, forensic psychiatry and ethics to the AMA House of Delegates; therefore be it

RESOLVED, That our American Medical Association convey this resolution and its deepest sympathy to the family members of Dr. Robert Phillips.

RESOLUTIONS

Note: Testimony on each item is summarized in the reference committee reports. Items considered on the reaffirmation calendar do not appear in the reference committee reports and were handled as part of the Committee on Rules and Credentials Supplementary Report on Sunday, June 8. The following resolutions were handled on the reaffirmation calendar: 116, 119, 121, 122, 123, 128, 214, 216, 221, 402, 404, 405, 406, 407, 417, 418, 419, 720, 722, 726, 728, 729 and 731.

1. ORGAN DONATION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED AS FOLLOWS
WITH CHANGE IN TITLE
See Policy D-370.985.

RESOLVED, That our American Medical Association study potential models for increasing the United States organ donor pool.

2. MODERNIZATION OF HIV SPECIFIC CRIMINAL LAWS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
POLICY H-20.914 AMENDED

RESOLVED, That American Medical Association 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.

3. SOCIAL MEDIA GUIDANCE
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: POLICY E-9.124 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association collaborate with other medical organizations and interested parties to develop guidance for physicians on social media that includes benefits, pitfalls and recommended safeguards.

4. SOCIAL MEDIA
Introduced by Washington

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: POLICY E-9.124 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That the Council on Ethical and Judicial Affairs undertake a study to chart the course for the ethical and HIPAA compliant use of social media for the physicians of the United States.

5. AMERICAN BOARD OF MEDICAL SPECIALTIES SHOULD ADHERE TO ITS MISSION
Introduced by New York

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association make clear to the American Board of Medical Specialties (ABMS) our AMA's opposition to the establishment of scope of practice limitations through the use of board certifications by the ABMS and its member organizations.

6. AMERICAN MEDICAL ASSOCIATION SUPPORT FOR PATIENTS' ACCESS
Introduced by Texas

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: POLICY D-165.940 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That the Council on Ethical and Judicial Affairs (CEJA) exercise its authority to make public its opinions as to whether the American Medical Association's continuing support for issues outlined in the Affordable Care Act that impede patients' access to appropriate health care services violates the AMA's Code of Medical Ethics; and be it further

RESOLVED, That CEJA render its opinion on any future positions adopted by the AMA that could impede patients' access to appropriate health care services under the council's authority to interpret the AMA's Code of Medical Ethics.

7. ESTABLISH A MORATORIUM ON THE MEDICALIZATION OF CAPITAL PUNISHMENT
Introduced by American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: POLICY H-140.950 AND OPINION E-2.06 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association request that all states with active capital punishment statutes enforce a moratorium on all future executions until the legion problems associated with the medicalization of the death penalty be resolved or until such time as a non-medical method of capital punishment that is not cruel or unusual is adopted.

101. PROVIDING COMPLETE MATERNITY CARE UNDER THE AFFORDABLE CARE ACT
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-185.997.

RESOLVED, That our American Medical Association advocate for expanding coverage of maternity care to dependent women under the age of 26 on their parents' large group plans; and be it further

RESOLVED, That our AMA advocate that individual, small and large group health plans provide 60 days of newborn coverage for all newborns born to participants in the plan.

102. CRITICAL ACCESS HOSPITAL NECESSARY PROVIDER DESIGNATION
Introduced by South Dakota, North Dakota, Nebraska, Iowa, Wisconsin, Minnesota

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED
See Policy D-465.999.

RESOLVED, That our American Medical Association call on the Centers for Medicare & Medicaid Services to support individual states in their development of rural health networks; and be it further

RESOLVED, That our AMA oppose the elimination of the state-designated Critical Access Hospital (CAH) "necessary provider" designation; and be it further

RESOLVED, That our AMA pursue steps to require the federal government to fully fund its obligations under the Medicare Rural Hospital Flexibility Program.

103. CONTINUATION OF FEDERAL AUGMENTATION OF PRIMARY CARE MEDICAID PAYMENTS
Introduced by Washington

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association advocate strongly for Congress to continue the federal augmentation of primary care Medicaid payments to Medicare rates in perpetuity.

104. PHYSICIAN PAYMENT BY MEDICARE
Introduced by Louisiana

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policies H-330.925, H-400.956, H-400.959, H-400.969, D-285.964 and D-330.997.

RESOLVED, that our American Medical Association reaffirm Policies H-400.956, H-400.959, H-400.969, H-330.925 and D-330.997; 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.

105. SENIORS' SLEEP
Introduced by American Academy of Sleep Medicine

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association 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.

106. ENDORSE MEDICARE PART D EDUCATIONAL WEBSITE
Introduced by Georgia

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy D-330.912.

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.

107. SLEEP ILLNESS
Introduced by American Academy of Sleep Medicine

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: POLICIES H-160.949 AND D-440.943 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED That our American Medical Association 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.

108. MODERNIZING TRICARE PAYMENT POLICIES
Introduced by Virginia, West Virginia, Kentucky, South Carolina, Maryland, California

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association 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; and be it further

RESOLVED, 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.

109. STANDARDIZATION OF ADVANCE BENEFICIARY NOTIFICATION OF NON-COVERAGE FORMS FOR MEDICARE ADVANTAGE PLANS AND ORIGINAL FEE-FOR-SERVICE MEDICARE
Introduced by Ohio

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED
See Policy D-70.950.

RESOLVED, That our American Medical Association request the Centers for Medicare & Medicaid Services (CMS) 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; and be it further

RESOLVED, That Medicare Advantage Plan requirements for carrier specific advance beneficiary notice of non-coverage and similar forms be eliminated.

110. SUPPORT A NATIONAL POLL OF PHYSICIAN'S OPINION REGARDING A SINGLE PAYER NATIONAL HEALTH PROGRAM, IMPROVED MEDICARE FOR ALL
Introduced by American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association 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?"; and be it further

RESOLVED, That our AMA disseminate the survey results to physicians and the public.

111. INCLUDING BARIATRIC SURGERY AS PART OF THE ESSENTIAL BENEFITS PLAN
Introduced by American College of Surgeons, Society for Vascular Surgery

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy D-440.954.

RESOLVED, That our American Medical Association, consistent with Policy 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, psychological, nutritional and surgical interventions).

112. MINIMUM INSURANCE BENEFITS FOR PATIENTS WITH CHRONIC PAIN
Introduced by American Academy of Pain Medicine

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association and interested stakeholders advocate for a minimum set of health insurance benefits for people in pain severe enough to require ongoing therapy. At minimum, a proposed program of treatment categories should include:

1) Medical management
2) Evidence- or consensus-based interventional/procedural therapies
3) Ongoing behavioral/psychological/psychiatric therapies
4) Interdisciplinary care
5) Evidence-based complementary and integrative medicine (CIM - e.g., yoga, massage therapy, acupuncture, manipulation); and be it further

RESOLVED, That our AMA advocate for parity in coverage for people with pain, similar to that accorded people with mental-health disorders [MHPAEA 2008]; and be it further

RESOLVED, That our AMA and interested stakeholders advocate for an interdisciplinary clinical approach that recognizes the interdependency of treatment methods in the treatment of chronic pain; and be it further

RESOLVED, That our AMA and interested stakeholders 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.

113. NETWORK ADEQUACY
Introduced by American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association 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; and be it further

RESOLVED, That our AMA 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 be it further

RESOLVED, That our AMA support the right of patients and physicians to seek appropriate recourse when and if harmed by inadequate networks.

114. LUNG CANCER SCREENING TO BE CONSIDERED STANDARD CARE
Introduced by Florida

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy H-185.936.

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.

115. OPPOSITION TO GENETIC TESTING RESTRICTIONS BASED ON SPECIALTY
Introduced by American Society of Clinical Oncology,
American Congress of Obstetricians and Gynecologists

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-460.902.

RESOLVED, That our American Medical Association oppose limiting the ordering of genetic testing based solely on physician specialty or other non-medical care based criteria; and be it further

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; and be it further

RESOLVED, 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; and be it further

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.

116. SITE OF SERVICE DIFFERENTIAL
Introduced by Illinois

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-240.979, H-330.925 AND D-330.997 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association adopt as policy a statement that the value of a physician-provided service is the same regardless of the location where the service is provided or the entity which submits the claim for service; and be it further

RESOLVED, That our AMA advocate that Medicare and other third party payers not create or maintain payment policies that produce a financial advantage for facilities, such as hospitals, to be reimbursed at a higher rate than independent physicians for providing the same evaluation and management service.

117. METHADONE SHOULD NOT BE DESIGNATED AS THE SOLE PREFERRED ANALGESIC
Introduced by American Academy of Pain Medicine

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
WITH CHANGE IN TITLE
See Policy H-120.937.

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.

118. FACILITATING STATE LICENSURE FOR TELEMEDICINE SERVICES
Introduced by Illinois

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-480.971.

RESOLVED, That our American Medical Association study issues associated with state-based licensure and portability of state licensure for telemedicine services and report back at I-14.

119. COUNTER EFFORTS BY INSURANCE COMPANIES TO DROP PHYSICIANS FROM PLANS
Introduced by Michigan

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-285.991 AND D-285.972 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association educate and inform physicians regarding the trends, consequences, and remedial actions to be taken in the event of an insurance carrier dropping a physician or a group of physicians based on questionable or unknown parameters.

120. USING NASCENT TECHNOLOGY IN LIEU OF FACE-TO-FACE INTERACTION
Introduced by Michigan

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-330.914.

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 to satisfy the face-to-face requirement in certifying eligibility for Medicare home health services.

121. MULTIPLE MAIL-ORDER PRESCRIPTION CO-PAYS
Introduced by Michigan

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-120.962 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association reaffirm Policy H-120.962 that opposes charging patients more than one co-pay for multiple prescriptions of the same or varying doses of medication.

122. FAIRNESS IN PHARMACEUTICAL PRICING
Introduced by Michigan

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-285.965, D-110.993 AND D-330.933 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association work with pharmaceutical companies and pharmacy benefit managers to develop programs such as discounts for patients who pay out-of-pocket for their ophthalmic and other medications and encourage third party payers to expand their formularies to ensure appropriate and affordable medications are available to their contracted patients/members.

123. ATTESTATION STATEMENT
Introduced by Oklahoma

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-160.907 AND D-160.932 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association adopt policy stating that the admission attestation statement required by the Centers for Medicare & Medicaid Services is redundant and provides no relevant data in rendering care to a patient; therefore, our AMA opposes the CMS attestation statement policy requirement.

124. GENERIC CHANGES IN MEDICARE (PART D) PLANS
Introduced by Georgia

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED
See Policy D-330.911.

RESOLVED, That our American Medical Association investigate the incidence and reasoning behind the conversion of one generic drug to another generic drug of the same class in Medicare Advantage drug plans; and be it further

RESOLVED, That our AMA 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.

125. EXPANDING PATIENTS' CHOICE IN THE EXERCISE OF HEALTH INSURANCE BENEFITS
Introduced by Kansas

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association study the growing problem of restrictions on a patient's ability to use their health insurance benefits with the providers of their choice; and be it further

RESOLVED, That our AMA 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.

126. MEDICARE COVERAGE OF CONTINUOUS GLUCOSE MONITORING DEVICES FOR PATIENTS WITH INSULIN-DEPENDENT DIABETES
Introduced by The Endocrine Society, American Association of Clinical Endocrinologists

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy H-330.885.

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

127. OBSERVATION STATUS
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Resolution 127 was considered with Council on Medical Service Report 4.
See Council on Medical Service Report 4.

RESOLVED, That our American Medical Association 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; and be it further

RESOLVED, 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.

128. INSURANCE COVERAGE FOR INTERPRETER SERVICES FOR HEARING IMPAIRED PATIENTS
Introduced by New Jersey

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-385.928, D-90.999 AND D-160.992 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association petition Congress to amend the language of the Americans with Disabilities Act to require that health plans cover sign language interpreter expenses.

129. CMS "TWO MIDNIGHT" POLICY
Introduced by New York

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-160.931.

RESOLVED, That our American Medical Association encourage the Centers for Medicare & Medicaid Services to educate the public and develop tools for physicians and patients that outline the financial impact of the "two midnight" policy.

130. ENSURING AFFORDABLE CARE
Introduced by New York

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association 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.

131. ALTERNATIVES TO VALUE BASED MODIFIERS
Introduced by College of American Pathologists, American Society of Anesthesiologists, American Society for Cytopathology, National Association of Medical Examiners

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: POLICIES D-390.954 AND D-450.961 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association 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; and be it further

RESOLVED, 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.

132. DELAYS IN MEDICAID PAYMENT FOR PROVIDER SERVICES
Introduced by New Mexico

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: POLICIES H-190.959, H-190.981, H-385.921 AND H-390.976 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association 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; and be it further

RESOLVED, That our AMA assist states in investigating and resolving delays in payment for services provided under Medicaid; and be it further

RESOLVED, That our AMA 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 be it further

RESOLVED, That our AMA 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.

133. ECONOMIC VIABILITY OF RURAL SOLE COMMUNITY HOSPITALS
Introduced by New Mexico

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association 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.

134. PRESCRIPTION OF DURABLE MEDICAL EQUIPMENT
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED
See Policy H-330.955.

RESOLVED, That our American Medical Association amend AMA Policy H-330.955, Prescription of Durable Medical Equipment, by insertion and deletion as follows:

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.

135. PRESCRIPTION DRUG PLANS AND PATIENT ACCESS
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED
See Policy D-330.910.

RESOLVED, That our American Medical Association explore problems with prescription drug plans, including issues related to continuity of care, prior authorization, and formularies, and work with the Centers for Medicare and Medicaid Services and other appropriate organizations to resolve them.

201. MEDICATION MANAGEMENT IN ASSISTED LIVING FACILITIES
Introduced by Illinois

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, 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

RESOLVED, 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.

202. BANNING SMOKING WHILE DRIVING IN VEHICLES IN WHICH MINORS ARE PRESENT
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy H-490.910.

RESOLVED, That our American Medical Association support legislation that prohibits smoking while operating or riding in a vehicle that contains children.

203. E-PRESCRIBING AND MEANINGFUL USE
Introduced by Virginia, Kentucky, Mississippi, North Carolina

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-120.958.

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.

204. MEDICARE CLAIMS DATA RELEASE
Introduced by Oklahoma

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED IN LIEU OF RESOLUTIONS 204, 211 AND 226
See Policy D-406.993.

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; 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.

205. PAY FOR PERFORMANCE
Introduced by Oklahoma

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: NOT ADOPTED

RESOLVED, 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.

206. STOP THE IMPLEMENTATION OF ICD-10
Introduced by Oklahoma

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS WITH REFERRAL OF INDICATED CLAUSE
See Policy D-70.949.

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; 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; and be it further

RESOLVED, That the Comptroller General's report at least address these issues: 1) decreasing the massive number of codes down to a reasonable number such as Canada did; 2) putting 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 3) 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.

HOUSE ACTION: REFERRED: RESOLVED, That the Comptroller General's report address uncoupling the ICD code system from the CPT system.

207. ICD-10 TRANSPARENCY AND CONVERSION
Introduced by Louisiana

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-70.948.

RESOLVED, 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

RESOLVED, That during the delay in implementation of the ICD-10 transition, our AMA will seek and support efforts to ensure that any health plan (commercial, Medicare, Medicaid or other) operating in the United States shall provide to their provider network sufficient and timely information apprising providers of all planned changes, including coverage, guidelines, authorizations, 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.

208. COMPLETING THE ELECTRONIC PRESCRIPTION LOOP FOR CONTROLLED SUBSTANCES
Introduced by Martin D. Trichtinger, MD, Delegate, Pennsylvania

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy D-120.945.

RESOLVED; 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-scribing.

209. IMPROVEMENT OF ELECTRONIC PRESCRIPTION SOFTWARE
Introduced by Utah

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-120.944.

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; and be it further

RESOLVED, That our AMA work with pharmacies, vendors and other appropriate entities to encourage the use of standards 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.

210. MEDICAL TEXTBOOKS AND PEER-REVIEWED JOURNAL REPRINTS PER THE SUNSHINE ACT
Introduced by American Medical Group Association

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy D-140.958.

RESOLVED, That 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

RESOLVED, 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.

211. RELEASE OF PROVIDER-SPECIFIC MEDICARE PART B PAYMENT DATA BY CMS
Introduced by American Academy of Ophthalmology, American Society of Cataract and Refractive Surgery, American Association of Neurological Surgeons, Congress of Neurological Surgeons, California

Resolution 211 considered with Resolutions 204 and 226. See Resolution 204.

RESOLVED, 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.

212. SPECIAL INSPECTOR GENERAL TO OVERSEE IMPLEMENTATION OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT
Introduced by Illinois

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: NOT ADOPTED

RESOLVED, 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).

213. MEDICAL INFORMATION AND ITS USES
Introduced by Illinois

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, 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.

214. REGULATION AND TAXATION OF AMMUNITION
Introduced by California

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-145.985 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support the regulation and taxation of ammunition to improve public safety, with funds from such a tax to be earmarked to help fund health care.

215. REDUCING GUN VIOLENCE
Introduced by Illinois

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED INCLUDING PROPOSED SUBSTITUTE

RESOLVED, That our American Medical Association support Congressional passage of legislation requiring criminal background checks for all gun sales, public and private.

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

216. INCREASING THE CURRENT J-1 VISA WAIVER ALLOTMENT
Introduced by Illinois

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES D-200.980, D-255.985, D-255.993 AND D-310.992 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association work to increase the national allotment and state distributions of J-1 Visa Waivers.

217. LIABILITY RELATED TO REFERRALS FROM FREE CLINICS
Introduced by Michigan

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, 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 their work at the free clinic per the Free Clinic Federal Tort Claims Act (FTCA) Medical Malpractice Program at both the state and federal levels.

218. IMPROVEMENTS TO THE VALUE-BASED MODIFIER
Introduced by Michigan

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy D-450.959.

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

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.

219. PATIENT PROTECTION FROM FORCED SWITCHING OF PATENT-PROTECTED DRUGS
Introduced by Hawaii

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, 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

RESOLVED, 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

RESOLVED, 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.

220. TRANSPARENCY, PARTICIPATION, AND ACCOUNTABILITY IN CMS' PAYMENT DETERMINATION PROCESS
Introduced by American College of Gastroenterology, American Gastroenterological Association, American Society for Gastrointestinal Endoscopy

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-400.984.

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; and be it further

RESOLVED, 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.

221. THE CONTINUED FUNDING OF THE CHILDREN'S HEALTH INSURANCE PROGRAM
Introduced by American Academy of Pediatrics

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-290.969, H-290.971, D-290.982 AND D-290.985 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association strongly support the continued funding of the Children's Insurance Program through 2019.

222. SUNSHINE ACT AMENDMENT TO LIMIT EXPENSE REPORTING TO TRANSFERRED VALUE GREATER THAN $100
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy H-140.848.

RESOLVED, 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.

223. PHYSICIAN LIABILITY AND PATIENT PROTECTION UNDER THE FALSE CLAIMS ACT
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: POLICIES H-175.984 AND H-330.974 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, 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.

224. FIREARM VIOLENCE
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, 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.

225. 911 GOOD SAMARITAN LAWS
Introduced by American College of Emergency Physicians, American College of Radiology, College of American Pathologists, Connecticut, Kentucky, Oklahoma

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy D-95.977.

RESOLVED, That 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

RESOLVED, That our AMA promote 911 Good Samaritan policies through legislative or regulatory advocacy at the local, state, and national level.

226. RELEASE OF PHYSICIAN MEDICARE CLAIMS DATA
Introduced by American College of Rheumatology

Resolution 226 considered with Resolutions 204 and 211. See Resolution 204.

RESOLVED, 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

RESOLVED, 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.

227. OPPOSITION TO LABORATORY REPORTING PROVISIONS OF HR 4302
Introduced by Texas

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, 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.

228. PROPOSED CHANGE IN MEDICAL REQUIREMENTS FOR 3RD CLASS PILOTS' LICENSES
Introduced by Aerospace Medical Association

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy H-45.975.

RESOLVED, That our American Medical Association oppose efforts to substitute the third class medical certificate with a driver's license; and be it further

RESOLVED, That our AMA write a letter encouraging the Federal Aviation Administration to retain the third class medical certification process.

229. ADVANCE APPROPRIATIONS FOR THE INDIAN HEALTH SERVICE
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy D-350.987.

RESOLVED, That our American Medical Association request that Congress amend the Indian Health Care Improvement Act to authorize Advanced Appropriations; and be it further

RESOLVED, That our AMA request that Congress include our recommendation for the Indian Health Service (HIS) Advanced Appropriations in the Budget Resolution; and be it further

RESOLVED, That our AMA request that Congress include in the enacted appropriations bill IHS Advanced Appropriations.

230. DEVELOPMENT AND PROMOTION OF USE OF SINGLE NATIONAL PRESCRIPTION DRUG MONITORING PROGRAM
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association 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

RESOLVED, That our AMA oppose requirements that physicians must consult prescription drug monitoring programs before prescribing medications; and be it further

RESOLVED, That a national PDMP not add undue burden onto patients who need chronic controlled substance treatments or the physicians who prescribe them.

231. ENSURING ACCESS TO CARE FOR OUR VETERANS
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED IN LIEU OF RESOLUTIONS 231 AND 233
See Policy H-510.986.

RESOLVED, That our American Medical Association encourage all physicians to participate, when needed, in the health care of veterans; 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; 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; 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.

232. COMPLIANCE WITH "MEANINGFUL USE" REQUIREMENTS AS A CONDITION OF MEDICAL LICENSURE
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-478.987.

RESOLVED, 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

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.

233. IMMEDIATE RESOLUTION OF VETERANS ADMINISTRATION WAITING LISTS FOR VETERAN ACCESS TO CARE
Introduced by Florida, Texas

Resolution 233 was considered with Resolution 231. See Resolution 231.

RESOLVED, 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.

301. SHARED DECISION MAKING IN MEDICAL EDUCATION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
POLICY D-373.999 AMENDED

RESOLVED, That our American Medical Association amend Policy D-373.999 by insertion as follows:

> D-373.999 Informed Patient Choice and Shared Decision Making
> 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 be it further

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.

302. PROVIDING RESIDENCY APPLICANTS A TIMELY RESPONSE TO RESIDENCY APPLICATION OUTCOME
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
POLICY H-310.998 AMENDED

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

Our ~~The~~ AMA encourages ~~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 ~~about their interview status and provide a time frame of notification dates in the application materials~~.

303. PROTECTING RESIDENTS AGAINST AVOIDABLE FINANCIAL CONSTRAINT RELATED TO REIMBURSED WORK-RELATED EXPENSES
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-310.912.

RESOLVED, That our American Medical Association 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; and be it further

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); and be it further

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 is strongly recommended.

304. GRADUATE MEDICAL EDUCATION FUNDING AND QUALITY OF RESIDENT EDUCATION
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED
See Policy D-305.967.

RESOLVED, That our American Medical Association 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.

305. TRANSPARENCY ON MATERNITY AND PATERNITY LEAVE POLICIES FOR TRAINEES
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
POLICY H-405.960 AMENDED AND TITLE CHANGED

RESOLVED, That American Medical Association House of Delegates Policy H-405.960, Policies for Maternity, Paternity, Family and Medical Necessity Leave, be amended by insertion and deletion as below:

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

306. INCLUDING DISABILITY RELATED COMPETENCIES AND OBJECTIVES IN MEDICAL SCHOOL CURRICULUM
Introduced by American Academy of Physical Medicine and Rehabilitation, American Academy of Neuromuscular and Electrodiagnostic Medicine

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS WITH CHANGE IN TITLE
See Policy H-90.968.

RESOLVED, That our American Medical Association continue to work with medical schools and their accrediting/licensing bodies to encourage 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.

307. PRACTICAL USE OF ADVANCE DIRECTIVES IN MEDICAL EDUCATION
Introduced by Wisconsin

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-85.956.

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; and be it further

RESOLVED, That our AMA encourage development of a model educational module for the teaching of advance directives and advance care planning.

308. COMPETENCY AND THE AGING PHYSICIAN
Introduced by Senior Physicians Section, Section on Medical Schools, International Medical Graduates Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-275.959.

RESOLVED, That our American Medical Association 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 care for their patients; and be it further

RESOLVED, That there be a report back to the House of Delegates.

309. EXPANSION OF GRADUATE MEDICAL EDUCATION POSITIONS THROUGH ALTERNATIVE FUNDING
Introduced by International Medical Graduates Section

Resolution 309 was considered with Council on Medical Education Report 7.
See Council on Medical Education Report 7.

RESOLVED, That our American Medical Association 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 be it further

RESOLVED, That our AMA, 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.

310. PHYSICIAN REENTRY AND LICENSURE
Introduced by Women Physicians Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-300.984.

RESOLVED, That our AMA 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.

311. IMPACT OF COMPETENCY-BASED MEDICAL EDUCATION PROGRAMS AS OPPOSED TO TIME-BASED PROGRAMS
Introduced by Donald Eckhoff, MD, Delegate, Section on Medical Schools

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED
See Policy D-295.318.

RESOLVED, That our American Medical Association 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 be it further

RESOLVED, That our AMA 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.

312. ASSESSING THE IMPACT OF LIMITED GME RESIDENCY POSITIONS IN THE MATCH
Introduced by Donald Eckhoff, MD, Delegate, Section on Medical Schools

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-310.977.

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; and be it further

RESOLVED, That our AMA 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 be it further

RESOLVED, That our AMA 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.

313. OPPOSITION TO THE FSMB MAINTENANCE OF LICENSURE PROGRAM
Introduced by Florida

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: POLICY H-275.920 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association oppose any efforts by the Federation of State Medical Boards, Inc., (FSMB) to implement a "maintenance of licensure (MOL)" program in any state; and be it further

RESOLVED, That our AMA oppose any maintenance of certification (MOC) or recertification by a specialty medical board as a condition of licensure in any state.

314. COMPROMISING LIFETIME CERTIFICATIONS RETROACTIVELY
Introduced by Illinois

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED
See Policy H-405.974.

RESOLVED, That our American Medical Association adopt policy stating that no qualifiers or restrictions should be placed on lifetime certifications recognized by the American Board of Medical Specialties.

315. CERTIFICATION OF METHADONE EDUCATION
Introduced by American Academy of Pain Medicine

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association 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; and be it further

RESOLVED, 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; and be it further

RESOLVED, That our AMA work with the DEA or other regulatory bodies to require providers to have this certification starting by June 2016; and be it further

RESOLVED, 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.

316. MORATORIUM ON MAINTENANCE OF CERTIFICATION
Introduced by Michigan

Resolution 316 was considered with Council on Medical Education Report 6.
See Council on Medical Education Report 6.

RESOLVED, That our American Medical Association 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.

317. ABOLISH DISCRIMINATION AGAINST IMGs IN MEDICAL LICENSING REQUIREMENTS
Introduced by Michigan

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association 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 be it further

RESOLVED, That our AMA lobby the Federation of State Medical Boards (FSMB) to vigorously promote its policy of equal requirements for IMGs and LCME graduates and to ask the FSMB to seek changes in laws in each state to eliminate unequal graduate medical education requirements that discriminate against IMGs.

318. ASSISTING MEDICAL STUDENTS APPLYING FOR AWAY ROTATIONS
Introduced by American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-225.959.

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

319. MAINTENANCE OF LICENSURE
Introduced by New York

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-275.923.

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 above physician competence; and be it further

RESOLVED, That Policy H-275.923 be reaffirmed.

320. MANDATORY BOARD RECERTIFICATION
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: POLICY H-275.996 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association urge mandatory recertification be replaced with a specialty-specific continuing medical education alternative.

321. ALTERNATE FINANCING OF POST GRADUATE EDUCATION FOR PHYSICIANS
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association work with the Congress to earmark funds from the federal higher education budget to increase graduate medical education (GME) training positions; and be it further

RESOLVED, That our AMA explore funding from private sources for GME training positions and prepare a report for the House of Delegates.

322. MAINTAINING AND DEVELOPING HIGH QUALITY HOSPICE AND PALLIATIVE CARE PHYSICIAN WORKFORCE IN THE NEW MILLENNIUM
Introduced by New York

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy H-295.875.

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.

323. PRESERVATION OF THE CURRENT FEDERAL STUDENT AID LOAN FORGIVENESS FOR PUBLIC SERVICE EMPLOYEES PROGRAM
Introduced by South Carolina

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-305.993.

RESOLVED, That our American Medical Association advocate against putting a monetary cap on federal loan forgiveness programs.

324. USE OF UNMATCHED MEDICAL STUDENTS AS "ASSISTANT PHYSICIANS"
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED
See Policy H-160.949.

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

401. PUBLIC HEALTH: "HEADING IN SOCCER"
Introduced by Indiana

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association 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; and be it further

RESOLVED, That our AMA recommend that individuals trained in heading the ball similarly train athletes when they are old enough; and be it further

RESOLVED, That our AMA encourage continued investigation by our local sports medicine, pediatric and neurological colleagues, into the potential consequences of nonconcussive heading involved with soccer participation.

402. LIMITING ACCESS TO TOBACCO PRODUCTS
Introduced by American College of Cardiology

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-495.986 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association congratulate CVS/Caremark Pharmacies for its voluntary action to stop selling tobacco products; and be it further

RESOLVED, That our AMA call on all pharmacies and providers of health services and products to similarly stop selling tobacco products.

403. SUNSCREEN AND SUN PROTECTION COUNSELING BY PHYSICIANS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED
See Policy H-440.839.

RESOLVED, That our American Medical Association encourage physicians to counsel their patients on sun-protective behavior.

404. PREVENTION OF MOSQUITO TRANSMITTED DISEASES
Introduced by Medical Student Section

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-135.938 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association encourage physicians to discuss and promote protective practices specific for mosquitos, such as those developed by the Centers for Disease Control and Prevention, with patients when clinically appropriate.

405. ELIMINATION OF TOBACCO PRODUCTS SOLD BY NATIONAL RETAILERS
Introduced by Minority Affairs Section

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-495.986 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association publicly support all pharmacies or retailers that discontinue the sale of tobacco products.

406. AIR POLLUTION
Introduced by International College of Surgeons - US Section

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-135.984, H-135.991, H-135.998, D-135.985 AND D-135.996 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support (1) anti-idling technology should be installed and maintained to modern standards for all diesel trucks and engines, (2) all new vehicles and equipment meet federal air pollution guidelines, (3) appropriate air testing be conducted on a regular basis for (a) fine particle content (soot); (b) lead; (c) N_2O and (d) other noxious contaminants; and (4) appropriate laws are developed and enforced to maintain legally accepted clean air standards.

407. TOXIC MERCURY IN THE WATER SUPPLY
Introduced by International College of Surgeons - US Section

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY D-135.992 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support minimal standards for pollutant discharge into lakes and other bodies of water by industry; and be it further

RESOLVED, That our AMA encourage the US Environmental Protection Agency to set deadlines and enforce such established standards.

408. GLOBAL WARMING
Introduced by International College of Surgeons - US Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: POLICY H-135.977 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support that all fuels as well as their utilization should be evaluated to determine their relative impact on CO_2 increase and global warming; and be it further

RESOLVED, That our AMA support higher pricing and taxation on environmentally harmful fuels such as gasoline and coal.

409. FEDERAL RESOURCES TO PROTECT THE PUBLIC AND THE MEDICAL PROFESSION FROM AND DURING A COMMUNICABLE DISEASE OUTBREAK
Introduced by American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association 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 be it further

RESOLVED, That our AMA, no later than the 2015 Annual Meeting, present a report, recommendations and an action plan (including legislative proposals), to the House of Delegates whereby our AMA will advocate action to address this serious resource deficiency.

410. EVALUATING AND REDUCING THE RISK OF YOUTH SPORTS CONCUSSIONS
Introduced by American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Academy of Psychiatry and the Law, American Academy of Family Physicians, American Academy of Neurology, American College of Preventive Medicine

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association ask our Council on Science and Public Health to prepare a report summarizing the existing data on the risk of concussion in youth sports; and be it further

RESOLVED, that our AMA ask 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; and be it further

RESOLVED, That our AMA 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 be it further

RESOLVED, That our AMA 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.

411. BAN ON SUPER MAGNETIC TOYS AS A CHOKING AND GASTROINTESTINAL HAZARD TO CHILDREN
Introduced by American Medical Group Association

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED

RESOLVED, 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.

412. MANAGEMENT OF CONCUSSION GUIDELINES
Introduced by California

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED

RESOLVED, 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."

413. NATIONAL NUTRITIONAL GUIDELINES FOR FOOD BANKS AND PANTRIES
Introduced by Illinois

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED
See Policy H-150.930.

RESOLVED, That our American Medical Association adopt policy in support of the use of existing national nutritional guidelines for food banks and food pantries.

414. MENINGOCOCCAL VACCINATION FOR SCHOOL CHILDREN
Introduced by California

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED
See Policy H-60.923.

RESOLVED, That our American Medical Association support efforts to require that school children receive meningococcal vaccine per the Advisory Committee on Immunization Practices guidelines.

415. SAFER CHEMICAL POLICIES
Introduced by Illinois

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED
See Policy D-135.973.

RESOLVED, That our American Medical Association review the recommendations of the National Academies of Sciences with respect to chemical policy reform.

416. GUN VIOLENCE PREVENTION AS A CONTINUING MEDICAL EDUCATION TOPIC
Introduced by Michigan

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-145.975.

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.

417. NUTRITION LITERACY AND IMPROVING OUTCOMES
Introduced by Michigan

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-150.937, D-150.975 AND D-150.983 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support incentives for Supplemental Nutrition Assistance Program (SNAP), Electronic Benefit Transfer (EBT), and Women, Infants, and Children (WIC) program participants to purchase fruits, vegetables, and whole grains in grocery markets; and be it further

RESOLVED, That our AMA advocate for the participation of authorized retailers in programs that qualify for grants and other initiatives that aim to increase the purchase of fruits and vegetables by Supplemental Nutrition Assistance Program (SNAP) participants by providing incentives at the point of purchase to promote healthy food choices in their businesses; and be it further

RESOLVED, That our AMA support the inclusion of literature about nutrition education, healthy affordable recipes, and the knowledge of healthier meal choices targeted to Supplemental Nutrition Assistance Program (SNAP), Electronic Benefit Transfer (EBT), and Women, Infants, and Children (WIC) program participants.

418. CONDOM USE IN FILMS
Introduced by Nevada

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-365.978 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association recommend that for films made in the US, actors in sexually explicit scenes be required to wear condoms.

419. RAISING THE PURCHASE AGE OF ALL TOBACCO PRODUCTS
Introduced by New York

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-495.984 AND H-495.986 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support legislation which would (a) limit the promotion of tobacco and cigar products, smokeless tobacco products, electronic cigarettes or other unregulated nicotine delivery devices in any state; (b) prohibit the sale of tobacco and cigar products, smokeless tobacco products, electronic cigarettes or other unregulated nicotine delivery devices to anyone under 21 years of age; and (c) increase the penalties for the sale of any of these products to persons under 21 years of age.

420. SUPPORT FDA REGULATION OF ALL TOBACCO PRODUCTS
Introduced by American Thoracic Society, American College of Preventive Medicine, American College of Chest Physicians

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-495.988.

RESOLVED, That our American Medical Association support the US Food and Drug Administration (FDA) as it takes an important first step in establishing basic regulations of all tobacco products; and be if further

RESOLVED, That our AMA strongly oppose any FDA rule that exempts any tobacco or nicotine-containing product, including all cigars, from FDA regulation; and be if further

RESOLVED, That our AMA join with physician and public health organizations in submitting comments on FDA proposed rule to regulate all tobacco products.

421. SUPPORT EPA REGULATION OF CARBON POLLUTION
Introduced by American Thoracic Society, American College of Preventive Medicine, American College of Chest Physicians

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
POLICIES H-135.934 AND H-135.949 REAFFIRMED
See Policy D-135.972.

RESOLVED, That our American Medical Association submit comments to the US Environmental Protection Agency 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.

422. SUPPORT FOR NUTRITION LABEL REVISION AND FDA REVIEW OF ADDED SUGARS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED
See Policy D-150.974.

RESOLVED, That our American Medical Association issue a statement of support for the newly proposed nutrition labeling by the Food and Drug Administration (FDA) during the public comment period; and be it further

RESOLVED, That our AMA 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 WHO and AHA); and be it further

RESOLVED, That our AMA encourage further research into studies of sugars as addictive through epidemiological, observational, and clinical studies in humans.

501. DEVELOPMENT OF A STANDARDIZED POST-CONDUCTED ELECTRICAL DEVICE EXPOSURE MEDICAL PROTOCOL AND EDUCATIONAL CAMPAIGN
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: POLICY H-145.977 AMENDED IN LIEU OF RESOLUTION 501

Policy H-145.977 amended by addition and deletion to read as follows:

H-145.977 Use of ~~Tasers~~ 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.

502. BREAST DENSITY NOTIFICATION
Introduced by Washington

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-525.977.

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 requirements for mandatory notification of breast tissue density to patients.

503. ACCESS TO CLINICAL TRIAL DATA
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS WITH CHANGE IN TITLE
See Policy D-460.970.

RESOLVED, That our American Medical Association urge the Food and Drug Administration to investigate and develop means by which scientific investigators can access original source safety data from industry-sponsored trials upon request; and be it further

RESOLVED, That our AMA support the adoption of universal policy by medical journals requiring participating investigators to have independent access to all study data from industry-sponsored trials.

504. ARSENIC IN FOOD
Introduced by International College of Surgeons - US Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association endorse the establishment of guidelines for minimally acceptable levels of arsenic content in food; and be it further

RESOLVED, That our AMA 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.

505. COMMUNITY PEANUT ALLERGY SAFETY
Introduced by International College of Surgeons - US Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: NOT ADOPTED

RESOLVED, 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.

506. REDUCING SALMONELLA OUTBREAKS
Introduced by International College of Surgeons - US Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy H-440.837.

RESOLVED, That our American Medical Association 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.

507. OTC INSULIN
Introduced by Indiana

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: REFERRED

RESOLVED, 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.

508. US PREVENTIVE SERVICES TASK FORCE REFORM
Introduced by American Urological Association, Association of Clinical Urologists

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
POLICY H-330.896 AMENDED

RESOLVED, That our American Medical Association amend existing Policy H-330.896 to read as follows:

H-330.896 Strategies to Strengthen the Medicare Program
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; and be it further

509. IMPACT OF PHARMACEUTICAL ADVERTISING ON WOMEN'S HEALTH
Introduced by Women Physicians Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-105.996.

RESOLVED, That our American Medical Association 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; and be it further

RESOLVED, That our AMA 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.

510. LABELING OF FOODS AND PACKAGING CONTAINING ENGINEERED NANOPARTICLES
Introduced by California

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: POLICY H-480.949 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED; That our American Medical Association endorse labeling of foods and packaging containing engineered nanoparticles including nanoparticle specifications, as reasonable, to allow public health monitoring.

511. REGULATION OF ELECTRONIC NICOTINE DELIVERY SYSTEMS
Introduced by Illinois

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: POLICY H-495.973 AMENDED
IN LIEU OF RESOLUTIONS 511, 518, 519 AND 521

Policy H-495.973 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 US 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 emissions 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; and (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.

512. RISK EVALUATION AND MITIGATION STRATEGIES FOR METHADONE
Introduced by American Academy of Pain Medicine

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association 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 be it further

RESOLVED, That our AMA advocate that the manufacturer deemed responsible for developing a methadone-specific REMS consult experts in pain medicine in designing the program.

513. ANTIBIOTIC USE IN FOOD-PRODUCING ANIMALS
Introduced by Infectious Diseases Society of America

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED
POLICY H-440.895 RESCINDED
See Policy H-440.846.

RESOLVED, That our American Medical Association support federal efforts to ban antibiotic use in food-producing animals for growth promotion purposes, including through regulatory and legislative measures; and be it further

RESOLVED, That our AMA 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 be it further

RESOLVED, That our AMA support efforts to expand FDA surveillance and data collection of antibiotic use in agriculture.

514. IMPROVING FAMILIARITY WITH AND UTILIZATION OF MOBILE MEDICAL TECHNOLOGY
Introduced by Illinois

Resolution 514 was considered with Council on Science and Public Health Report 5.
See Council on Science and Public Health Report 5.

RESOLVED, That our American Medical Association 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; and be it further

RESOLVED, That our AMA 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; and be it further

RESOLVED, That our AMA educate physicians on discerning between useful, evidence-based apps and apps that are inaccurate; and be it further

RESOLVED, That our AMA 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.

515. EDUCATION TO PROMOTE RESPONSIBLE USE OF METHADONE FOR PAIN MANAGEMENT
Introduced by American Academy of Pain Medicine

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy D-120.985.

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.

516. STEM UNDERGRADUATE EDUCATION
Introduced by Michigan

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
POLICY H-170.985 AMENDED

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
Our ~~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~~ literacy in the nation, and to increase interest in STEM ~~science and education~~ on the part of the nation's youth, particularly underrepresented minorities.

517. GENETICALLY MODIFIED ORGANISMS LABELING
Introduced by Michigan

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association 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 be it further

RESOLVED, That our AMA pursue and endorse a national law requiring the clear labeling of all genetically modified organisms (GMOs) or foods containing genetically modified ingredients.

518. TREATING E-CIGARETTES AS TOBACCO PRODUCTS
Introduced by AMDA - The Society for Post-Acute and Long-Term Care Medicine

Resolution 518 considered with Resolutions 511, 519 and 521. See Resolution 511.

RESOLVED, 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.

519. SALES AND MARKETING OF E-CIGARETTES TO MINORS
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Resolution 519 considered with Resolutions 511, 518 and 521. See Resolution 511.

RESOLVED, That our American Medical Association oppose the marketing, sales, and use of e-cigarettes and other nicotine delivery products to minors; and be it further

RESOLVED, That our AMA 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.

520. MODIFICATION TO THE USP CHAPTER 797 GUIDELINES AS CURRENTLY WRITTEN
Introduced by Texas

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-120.946.

RESOLVED, That our American Medical Association inform physicians on the far-reaching effects of the immediate-use exception to practice and patient safety; 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; 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; and be it further

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; and be it further

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.

521. E-CIGARETTES TO BE TREATED THE SAME AS TOBACCO PRODUCTS
Introduced by New York

Resolution 521 considered with Resolutions 511, 518 and 519. See Resolution 511.

RESOLVED, 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.

522. DRUG SHORTAGES – FEDERAL AGENCY ASSESSMENT OF REIMBURSEMENT & PRICING POLICY ON SHORTAGES
Introduced by New Jersey

Resolution 522 was considered with Council on Science and Public Health Report 3.
See Council on Science and Public Health Report 3.

RESOLVED, That our American Medical Association 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 be it further

RESOLVED, That our AMA 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.

523. PRESIDENT'S COUNCIL ON SCIENCE AND TECHNOLOGY REPORT
Introduced by Ralph Schmeltz, MD, Delegate, Pennsylvania

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-480.973.

RESOLVED, That our American Medical Association analyze the President's Council on Science and Technology Report entitled "Better Health Care and Lower Costs: Accelerating Improvement through Systems Engineering" and respond as appropriate.

601. A VIRTUAL MEDICAL ASSOCIATION
Introduced by Indiana

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association allow future virtual live attendance of our House of Delegates meetings, with virtual attendees having the full ability to vote and communicate with the House leadership and the delegates; and be it further

RESOLVED, That our AMA allow live virtual attendance of reference committees with full ability to communicate with the committee members and the attendees of the reference committees; and be it further

RESOLVED, That our AMA determine when virtual live attendance of association meetings would begin with the goal that the House of Delegates sessions be virtually available by 2016 and that all reference committees would be virtually available by 2020.

602. AMA ELECTION ACTIVITIES
Introduced by Alabama, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, New Jersey, North Carolina, Puerto Rico, South Carolina, Tennessee, Virginia, West Virginia

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
POLICY G-610.020 AMENDED

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.

603. MEDICAL MALPRACTICE RATE DISCOUNTS
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy G-620.045.

RESOLVED, That our American Medical Association encourage member organizations of the Federation to offer access to discounted medical liability insurance premiums where legally permissible.

604. EXAMINING THE COMPOSITION OF THE AMA GOVERNANCE STRUCTURE
Introduced by California

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association convene a committee to research and develop recommendations on the composition of the 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.

605. ENCOURAGE PHYSICIANS AS LEGISLATIVE CANDIDATES
Introduced by Michigan

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy G-640.025.

RESOLVED, That our American Medical Association continue to identify, encourage and support physicians to run as state and national legislative candidates.

606. TECHNOLOGY AND THE PRACTICE OF MEDICINE
Introduced by Maryland

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED AS FOLLOWS
WITH CHANGE IN TITLE
See Policy G-615.035.

RESOLVED, That our American Medical Association encourage the collaboration of existing AMA councils and working groups on matters of new and developing technology, particularly in electronic medical records (EMR) and telemedicine.

607. MEMBER RECOGNITION
Introduced by Maryland

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED AS FOLLOWS
WITH CHANGE IN TITLE
See Policy G-635.015.

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 personal sense of connection with our AMA.

608. ONEROUS RESTRICTIONS ON TRAVEL OF GOVERNMENT SCIENTISTS
Introduced by American Academy of Allergy, Asthma and Immunology, American Academy of Neurology, American College of Rheumatology, Infectious Diseases Society of America, The Endocrine Society

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-440.934.

RESOLVED, That our American Medical Association 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.

609. AMA PARTICIPATION IN REDUCING MEDICAL SCHOOL DEBT
Introduced by Virginia, West Virginia, Kentucky, Mississippi

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED AS FOLLOWS
WITH CHANGE IN TITLE
See Policy D-305.956.

RESOLVED, That our American Medical Association explore the feasibility of the development of an affinity program in which student, resident and fellow members of our AMA could obtain new educational loans and consolidate existing loans from one or more national banks or other financial intermediaries. Membership in our AMA would be required during the life of the loan (typically 10 years or more following medical school); and be it further

RESOLVED, That such activities or program would neither result in our AMA becoming subject to regulation as a financial institution nor impair our AMA's ability to continue to be treated as a not-for-profit entity; and be it further

RESOLVED, That our AMA HOD receive a progress report on these discussions by the 2014 Interim Meeting.

610. ALTERNATIVE MAINTENANCE OF CERTIFICATION
Introduced by New York

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: POLICIES H-275.923 AND D-275.960 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association explore the feasibility of developing an alternative Maintenance of Certification program as a member benefit.

611. DUES EXEMPTION/ADJUSTMENT FOR PHYSICIANS UNABLE TO ATTAIN RESIDENCY TRAINING PROGRAM
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy G-620.065.

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.

612. FUNDING OF AMA REGION AND SECTION DELEGATES/ALTERNATES
Introduced by New York

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association provide hotel accommodations during the Annual and Interim meetings at no cost to the medical student region delegates and alternates and the resident physician section delegates and alternates; and be it further

RESOLVED, That our AMA reimburse the region and section delegates and alternates for their transportation to and from the meeting; and be it further

RESOLVED, That the state and specialty societies which have section and region delegates elected from their memberships will continue to provide meals and other miscellaneous reimbursements to these members of the AMA House of Delegates as they are financially able.

613. IDENTITY THEFT
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-80.997.

RESOLVED, That our American Medical Association request that the Internal Revenue Service (IRS) adopt policies to ensure greater security protection for electronically filed federal income tax returns, including the universal use of PINs, or personal identification numbers; and be it further

RESOLVED, That our AMA request that the IRS and the Centers for Medicare & Medicaid Services promulgate regulations to prohibit the use of Social Security numbers (SSN) by insurers, health care vendors, state agencies other than the state taxing authority and non-financial businesses.

614. VA ACES TRAVEL POLICY
Introduced by American Thoracic Society, American College of Chest Physicians

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-440.933.

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.

615. AMA ADVOCACY ANALYSIS
Introduced by Florida

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy G-640.005.

RESOLVED, That our American Medical Association Board of Trustees provide a 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.

616. IMPROVING LEADERSHIP POTENTIAL AND PREVENTING ATTRITION AMONG EARLY- AND MID-CAREER PHYSICIANS
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy G-600.035.

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.

701. MEDICAL STAFF AND HOSPITAL ENGAGEMENT OF COMMUNITY PHYSICIANS
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-225.949.

RESOLVED, That our American Medical Association encourage medical staffs to develop medical staff membership categories for physicians who provide a low volume or no volume of clinical services in the hospital ("community physicians"); and be it further

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.

702. PUTTING PRICE TRANSPARENCY INTO PRACTICE
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-155.989.

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; and be it further

RESOLVED, That our AMA support 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; and be it further

RESOLVED, That our AMA provide regular updates to its membership on the path toward enhancing the transparency of cost within the US health care system for both providers and consumers, and how our AMA can be the leading voice in this effort.

703. IMPROVING HOME HEALTH CARE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association support the establishment of state-based certification for home health care workers and regulatory oversight over home health agencies.

704. STUDYING HOSPITAL INCENTIVES FOR ADMISSION, TESTING AND PROCEDURES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
WITH CHANGE IN TITLE
See Policy D-215.989.

RESOLVED, That our American Medical Association study the extent to which US hospitals interfere in physicians' independent exercise of medical judgment, including but not limited to the use of incentives for admissions, testing and procedures.

705. PAYMENT FOR NUTRITION SUPPORT SERVICES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy H-150.931.

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.

706. HIGH RATES OF CESAREAN DELIVERIES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association support the American Congress of Obstetricians and Gynecologists' 2013 opinion that recommended vaginal delivery instead of cesarean section in the absence of maternal or fetal indications; and be it further

RESOLVED, That our AMA encourage appropriate agencies and organizations to study the indications for cesarean section in order to achieve a greater degree of standardization in their use.

707. GRACE PERIOD
Introduced by Washington

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 732
See Policy H-185.938.

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 laws and regulations to protect state 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 claims for services rendered that would otherwise be covered under the contract during a grace period. and be it further

RESOLVED, That our AMA take all possible means available to change the current federal rule permitting the pending of claims during the grace period; and be it further

RESOLVED, That our AMA vigorously support state societies in their legal attempts to enforce prompt pay statutes and rules during grace periods; and be it further

RESOLVED, That our AMA support the development of alternative financing solutions, such as reinsurance for unpaid premiums, for physician payments during the grace period.

708. PROTECTING PHYSICIANS WHO ARE PARTICIPATING IN PHYSICIAN HEALTH PROGRAMS FROM ARBITRARY DELISTING BY INSURANCE CARRIERS
Introduced by Maryland

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-285.991.

RESOLVED, That American Medical Association Policy H-285.991, Qualifications and Credentialing of Physicians in Managed Care (1)(d), be amended by addition 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. 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."

709. CHANGE OF COUMADIN REGULATION BY CMS
Introduced by Georgia

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-185.951.

RESOLVED, That our American Medical Association request a change in Centers for Medicare & 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.

710. REIMBURSEMENT FOR AUDIT REQUESTS
Introduced by Georgia

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: POLICIES H-285.943, H-315.992 AND H-335.980 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association develop a methodology for physician reimbursement from insurance companies to compensate for the medical practice expenses of completing audits.

711. REIMBURSEMENT FOR PRIOR APPROVAL REQUIREMENTS
Introduced by Georgia

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: POLICIES H-285.943, H-385.948 AND H-385.951 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association develop a methodology for physician reimbursement from insurance companies to compensate for the medical practice expenses of completing prior approval requirements.

712. VERBAL ADMISSION ORDER SIGNATURES
Introduced by Ohio

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy D-240.993.

RESOLVED, That our American Medical Association work with the Centers for Medicare & Medicaid Services to allow authentication of verbal admission orders within 30 days rather than prior to discharge.

713. DIAGNOSIS CODE FOR EXCESSIVE RELIANCE ON ALTERNATIVE THERAPY
Introduced by Utah

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association propose to the appropriate internal or external organizations or committees that determine diagnosis codes the addition of a diagnosis code(s) for excessive reliance on alternative therapy, defined as deliberate patient reliance, after adequate education, on alternative therapy to the degree it significantly hinders care or jeopardizes physician-patient trust.

714. HARMONIZING QUALITY METRIC EFFORTS WITH ELECTRONIC MEDICAL RECORDS
Introduced by Illinois

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: POLICIES H-450.946 AND H-450.966 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association work with national agencies to explore and validate a uniform set of data metrics, including quality, payment, and utilization data; and be it further

RESOLVED, That our AMA publish guidelines associated with these findings, and report back to the AMA House of Delegates.

715. OVERREGULATION OF PROVIDER-PERFORMED MICROSCOPY PROCEDURES FOR AMBULATORY HEALTH CARE
Introduced by John W. Spurlock, MD, Delegate, Pennsylvania

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association vigorously advocate for recognition of current certification systems that are in place without placing financial and temporal barriers to care; and be it further

RESOLVED, That our AMA oppose overregulation of professional practitioners without clear demonstration of harm under current regulations and/or policies.

716. PHARMACY-PHYSICIAN COMMUNICATIONS REGARDING DRUG FORMULARIES
Introduced by Illinois

Resolution 716 was considered with Resolution 724. See Resolution 724.

RESOLVED, That our American Medical Association adopt the following pharmacy-physician communication procedural policy:

> 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.

717. INCREASING PHYSICIAN EFFICIENCY
Introduced by Illinois

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association adopt policy encouraging the integration of dictation systems into present and all future electronic medical record systems; and be it further

RESOLVED, That our AMA encourage the business and technology communities to integrate dictation systems into present and all future electronic medical record systems.

718. IMPROVING THE HANDLING OF IN-FLIGHT MEDICAL EMERGENCIES
Introduced by Illinois

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-45.979.

RESOLVED, That our AMA support efforts to educate the flying physician public about in flight medical emergencies (IFMEs) to help them participate more fully and effectively when an IFME occurs; and be it further

RESOLVED, That such educational course be made available online as a webinar.

719. STUDY THE COSTS OF ADMINISTRATIVE AND REGULATORY BURDENS
Introduced by Michigan

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED IN LIEU OF RESOLUTIONS 719 AND 730
See Policy D-330.909.

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.

720. COMPENSATION FOR PRIOR AUTHORIZATION EFFORTS
Introduced by Michigan

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-320.944 AND D-190.974 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association prioritize and aggressively pursue the simplification of prior authorization processes.

721. CAPTURING PHYSICIAN SENTIMENTS OF HOSPITAL QUALITY
Introduced by Michigan

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-215.988.

RESOLVED, That our American Medical Association foster the creation of quality measures and rating systems that incorporate the satisfaction and perspective of the medical staff regarding individual hospitals.

722. EHR IN POST-ACUTE AND LONG-TERM CARE SETTINGS
Introduced by AMDA - The Society for Post-Acute and Long-Term Care Medicine

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES D-478.994, D-478.995 AND D-478.996 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association investigate the current availability of and work with appropriate stakeholders to help develop interoperable exchange of information between practice settings that include post-acute and long-term care (PA/LTC); and be it further

RESOLVED, That our AMA advocate with Congress and appropriate Federal agencies to establish incentives for PA/LTC based physicians and PA/LTC facilities in order to adopt these technologies.

723. INTEGRATING PHYSICAL AND BEHAVIORAL HEALTHCARE
Introduced by Colorado

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-345.987.

RESOLVED, That our American Medical Association, with interested specialty and state societies, study and report back at the 2015 Annual Meeting on our current state of knowledge regarding integration of physical and behavioral healthcare, including pediatric and adolescent health care, and make recommendations for further study, implementation of models of physical and behavioral healthcare integration, and any other tools or policies that would benefit our patients and our healthcare system by the integration of physical and behavioral healthcare.

724. PRIVATE HEALTH INSURANCE FORMULARY TRANSPARENCY
Introduced by American Clinical Neurophysiology Society, American Academy of Neurology, American College of Rheumatology, American Academy of Allergy, Asthma & Immunology, American Academy of Ophthalmology, American Academy of Dermatology

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED IN LIEU OF RESOLUTIONS 716 AND 724
See Policy H-125.979.

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; 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; 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; and be it further

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; and be it further

RESOLVED, That drugs requiring prior authorization, shall be adjudicated by the IPBMP within 72 hours of receipt of the prescription.

725. SUPPORT FOR THE CONCEPTS OF THE "CHOOSING WISELY" PROGRAM
Introduced by New York

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
WITH CHANGE IN TITLE
See Policy D-155.988.

RESOLVED, That our American Medical Association support the concepts of the American Board of Internal Medicine Foundation's Choosing Wisely program.

726. INTERNET REVIEW OF PHYSICIANS
Introduced by New York

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY D-478.980 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association seek federal legislation and/or regulation to amend Internet privacy laws and require that websites hosting reviews of physicians obtain the name of the person posting the review, that this information will be kept on file, and that the website inform the poster that a physician requesting this information from the website in regard to a review must be provided with the name of the person writing the review; and be it further

RESOLVED, That our AMA advocate that websites hosting reviews of physicians be required to post a warning against libelous and other legally inappropriate statements.

727. POINT OF CARE AVAILABILITY FOR BLOOD GLUCOSE TESTING
Introduced by New York

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-260.994.

RESOLVED, That our American Medical Association work with the Food and Drug Administration and the Centers for Medicare & Medicaid Services to maintain the Clinical Laboratory Improvement Act exempt status of point-of-care glucose testing.

728. DEVELOPMENT OF A TRANSPARENT AND FAIR PAYMENT PROCESS FOR ERISA PLANS
Introduced by New York

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-185.975, D-385.973 AND D-385.984 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association seek legislation through the Congress or through regulation by the Department of Labor which would require ERISA Plans to develop and administer a transparent and fair process for the payment of claims to providers, similar to states' prompt payment laws and CMS regulation.

729. EXEMPTION CRITERIA FOR ELECTRONIC HEALTH RECORD ADOPTION AND CLOUD–BASED ELECTRONIC HEALTH RECORD PACKAGES
Introduced by New York

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-478.993, D-478.982, D-478.994, D-478.995 AND D-478.996 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association not give up the fight for Electronic Health Records (EHR) exemptions and continue to petition the Centers for Medicare & Medicaid Services (CMS) to:

- Grant solo physician practices and physicians nearing the age of retirement an exemption from the disincentives associated with not using Electronic Health Records (EHR); and

- Provide government EHR adoption subsidies for any small and/or solo physician practices that demonstrate a need for these subsidies, beyond the present incentive payment structure; and

- Provide cheaper alternatives to commercial EHR systems, either through a lowest–bid Request for Proposal (RFP) process with commercial vendors, or the development of a low–cost or free, CMS–based and administered, cloud–based system for physicians in solo practice and physicians nearing the age of retirement; and be it further

RESOLVED, That our AMA request that CMS grant a "temporary waiver" for physician practices that, in good faith, are in the process of obtaining and attempting to implement meaningful use of an Electronic Health Records system, but due to technical issues outside of their control will be unable to meet the October 2014 attestation deadline.

730. PAYMENT FOR CENTERS FOR MEDICARE & MEDICAID SERVICES MANDATED SERVICES
Introduced by Texas

Resolution 730 was considered with Resolution 719. See Resolution 719.

RESOLVED, That our American Medical Association perform (or commission) an analysis to compare the official Centers for Medicare & Medicaid Services' estimates of direct and indirect costs attributable to the Physician Quality Reporting System, EHR Meaningful Use, and ICD-10, then compare these estimates to the actual time and costs required by the individual and group physicians to comply with these mandates.

731. REQUIREMENT FOR MEDICAL INSURANCE COMPANIES TO PROVIDE ONLINE REAL-TIME INSURANCE CLAIM ADJUSTMENT
Introduced by Texas

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY D-185.999 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association seek changes in federal law to require health insurance companies to adjudicate claims and issue standard format benefit verifications in real-time.

732. FEDERAL ADVOCACY FOR PROTECTION OF STATE LAW UNDER THE 90-DAY GRACE PERIOD
Introduced by Texas

Resolution 732 was considered with Resolution 707. See Resolution 707.

RESOLVED, That our American Medical Association 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; and be it further

RESOLVED, That our AMA 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 be it further

RESOLVED, That our AMA support the development of alternative financing solutions, such as reinsurance for unpaid premiums, for physician payments during the grace period.

Resolution 733 was withdrawn prior to acceptance as business.

734. PUBLIC REPORTING OF QUALITY AND OUTCOMES FOR PHYSICIAN-LED TEAM-BASED CARE
Introduced by Integrated Physician Practice Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED
See Policy H-450.932.

RESOLVED, That our American Medical Association advocate that internal reporting of quality and outcomes of team-based care should be done at both the team and individual physician level; and be it further

RESOLVED, That our AMA advocate that public reporting of quality and outcomes data for team-based care should be done at the group/system/facility level, and not at the level of the individual physician; and be it further

RESOLVED, That our AMA reaffirm the intent of the codified mandate in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA 2008) that public reporting of quality and outcomes data for team-based care should be done at the group/system level, and not at the level of the individual physician; and be it further

RESOLVED, That our AMA advocate that the current regulatory framework of public reporting for Meaningful Use 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.

735. THE FUTURE OF PRIVATE PRACTICE
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-405.988.

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 at the 2015 Annual Meeting; and be it further

RESOLVED, That our AMA create and maintain a reference document establishing principles for entering into and sustaining a private practice and encourage medical schools and residency programs to present physicians in training with information regarding private practice as a viable option.

736. STUDYING PHYSICIAN ACCESS TO ACO PARTICIPATION
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-160.930.

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 deselected once they are members of an ACO;
c. The implications of such criteria and processes for patient access to care outside the ACO; and
d. The effect of evolving system alignments and integration on physician recruitment and retention.

The results of this study should be reported back to the HOD and to our AMA membership at large by the 2015 Annual Meeting.

737. AMENDMENTS TO THE AMA PRINCIPLES FOR PHYSICIAN EMPLOYMENT
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED
See Policy H-225.950.

RESOLVED, That our American Medical Association amend Section (5)(f) of AMA Policy H-225.950, Principles for Physician Employment, by insertion and deletion as follows:

(5)(f) ~~Unless specified otherwise in the employment agreement, u~~Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:

i. The agreement is for the provision of services on an exclusive basis; and
ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and
iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement; and be it further

RESOLVED, That our AMA amend Section 3 of AMA Policy H-225.950, Principles for Physician Employment, by insertion and deletion as follows:

(3)(e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due

process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.

(3)(f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.

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

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

738. PHYSICIAN LEADERSHIP OF THE PATIENT-CENTERED MEDICAL HOME
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-35.988.

RESOLVED, That our American Medical Association continue to support the concept of physician-led teams within the patient centered medical home (PCMH) as outlined in the Joint Principles of the Patient-Centered Medical Home; and be it further

RESOLVED, That our AMA respond to The Joint Commission's interpretation of its primary care medical home certification standards addressing non-physician-led PCMHs; and be it further

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 as being anything other than MD/DO physician-led.