Memo to: Delegates, Alternate Delegates
Executive Directors, Member Organizations of the House of Delegates

From: Susan R. Bailey, MD, Speaker, House of Delegates
Bruce A. Scott, MD, Vice Speaker, House of Delegates

Date: May 19, 2017

Subject: Handbook Addendum - Supplemental Business and Information (A-17)

We are pleased to provide the attached report and resolutions that were received after the Delegates’ Handbook resolution deadline:

Each of these items also appears in the online member forum (ama-assn.org/forums/house-delegates, login required). Additional items will be posted there as they are processed for the Sunday tote.

Reports

- BOT Report 23 – Anti-Harassment Policy (Reference Committee F)
- CMS Report 06 – Expansion of US Veterans’ Health Care Choices (Reference Committee A)
- Report of the HOD Committee on Compensation of the Officers (Reference Committee F)

Resolutions

- 012 Promoting the AMA Model Medical Staff Code of Conduct and its Application to Employed Physicians
- 013 Gender Identity Inclusion and Accountability in REMS
- 014 The Need to Distinguish Between Physician Assisted Suicide and Aid in Dying
- 015 Appropriate Placement of Transgender Prisoners
- 122 Reimbursement for Pre-Colonoscopy Visit
- 123 Improving the Prevention of Colon Cancer by Insuring the Waiver of the Co-Payment in all Cases
- 124 Emergency Medical Services Reimbursement for On-Site Treatment and Transport to Non-Traditional Destinations
- 125 Medicaid Substance Use Disorder Coverage
- 126 Insurance Coverage for Compression Stockings
- 127 Balance Billing State Regulation
- 229 Medicare's Appropriate Use Criteria Program
- 230 CMS Reimbursement Guidelines for Teaching Physician Supervision
- 231 Naloxone Price Increase
- 232 Create MACRA Opt-Out Option
- 233 Regulation of Physician Assistants
- 234 Protections for Patients with Genetic Conditions
- 235 Towards Eliminating ERISA State Preemption of Health Plan Liability
- 236 Retail Price of Drugs Displayed in Direct-to-Consumer Pharmaceutical Advertising
• 237 Protection of Clinician-Patient Privilege
• 238 Limitation on Reports to the National Practitioner Data Bank Unrelated to Patient Care
• 239 AMA Support for Texting as Approved HIPAA Communication
• 240 Minimum Federal Standards for Interstate Sale of Health Insurance
• 317 Immigration
• 318 Oppose Direct-to-Consumer Advertising of the ABMS MOC Product
• 319 Public Access to Initial Board Certification Status of Time Limited ABMS Diplomates
• 320 Cultural Competence in Standardized Patient Programs Within Medical Education
• 321 Continued Support of H-1B Visa Programs for International Medical Graduates
• 322 Ending Maintenance of Certification Examinations
• 323 Exceptions to Medicare GME Cap-Setting Deadlines for Residency Programs in Medically Underserved / Economically Depressed Areas
• 415 Food Bank and Pantry Distribution of Nutrient-Dense Foods
• 416 Policy and Economic Support for Early Child Care
• 417 Mandatory Public Health Reporting of Law Enforcement Related Injuries and Death
• 519 Liquid Medication Dosing
• 520 Combination Clotrimazole/Betamethasone Diproprionate Cream Warning
• 521 Retail Prescription Bottle Label Privacy
• 606 Add Patients to the AMA Mission Statement
• 712 Pay-for-Performance Incentives
• 713 Urge AMA to Release a White Paper on ACOs
• 714 Timely Referral to Pain Management Specialist
• 715 Prescription Availability for Weekend Discharges
• 716 Understanding and Correcting Imbalances in Physician Work Attributable to Electronic Health Records
• 717 Allowing Exceptions to the Centers for Medicare & Medicaid Services' Locum Tenens 60-Day Limit

Please note: Resolution 204, Balance Billing State Regulation, has been reassigned to Reference Committee A and is now numbered Resolution 127.

In addition, the charts listing actions taken in follow-up to resolutions and report recommendations from the 2016 Annual and Interim Meetings will be posted on the Annual Meeting website.
Though the American Medical Association has in place a comprehensive anti-harassment policy regarding AMA employees, the Board of Trustees has recently become aware that no such policy exists regarding the House of Delegates, AMA sections, AMA councils, or other AMA governance entities (collectively, the “AMA Entities”). To ensure consistency throughout our AMA, the Board has reviewed this issue and presents the following report and recommendations to the HOD.

DISCUSSION

Our AMA has strong policies against discrimination and harassment in all forms. In particular, Human Resources Policy 015 (Anti-Harassment Policy) provides in pertinent part:

It is the policy of the AMA that any type of harassment of employees or applicants for employment by managers, supervisors, co-workers, other employees, or agents of AMA or non-employees (including vendors, customers or members) in the workplace is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance environment for unlawful conduct at all locations where AMA employees are conducting AMA business.

This policy includes the following definitions:

Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or other protected group status, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive work environment; (2) has the purpose or effect of unreasonably interfering with an individual’s work performance; or (3) otherwise adversely affects an individual’s employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA’s premises or circulated in the workplace.

Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:

- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature an explicit or implicit condition of continued employment;
• making submission to, or rejection of, such conduct the basis for employment decisions; and
• creating an intimidating, hostile or offensive work environment or otherwise unreasonably interfering with an individual’s work performance by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual’s physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and physical contact such as pinching or brushing against another person.

Consistent with the above Human Resources Policy 015 and the AMA’s zero tolerance policy regarding harassment, all members of the Board of Trustees are required to complete the same anti-harassment training that AMA staff are asked to complete, namely, the AMA’s “Preventing Harassment for Members of AMA Leadership Bodies” training, which is conducted by means of an online training module.

Additionally, at the first session of each HOD meeting, as provided in the HOD Reference Manual, delegates are asked to ratify a code of conduct that reaffirms a commitment to be courteous, respectful and collegial in the conduct of HOD business, and delegates are reminded of their personal responsibility regarding courteous and respectful dealings in all interactions with other delegates and with AMA staff at HOD meetings, including social events apart from HOD meetings themselves.

While the above code of conduct and commitment to be courteous, respectful and collegial in the conduct of HOD business implicitly forbids any type of harassment of other delegates or AMA staff at meetings of any AMA Entity, the Board notes that neither the HOD Reference Manual nor any other existing AMA Policy includes an explicit anti-harassment policy regarding the AMA Entities. The Board further notes that AMA Human Resources Policy 015 (Anti-Harassment Policy) does not explicitly apply to the AMA Entities (see also Appendix for AMA policy and guidelines). The Board’s recommendations in this report address this issue.

Upon adoption of the Anti-Harassment Policy, the Board will establish a formal process by which any delegate, AMA Entity member or AMA staff member who feels he/she has experienced or witnessed conduct in violation of this policy may report such incident. Additionally, the Board will consider and prepare for future consideration by the HOD, potential corrective action and/or discipline for conduct in violation of this policy, which may include, but shall not be limited to, referral of the matter to the applicable delegation, expulsion from AMA meetings, or expulsion from the HOD.

RECOMMENDATION

Therefore, the Board of Trustees recommends that the House of Delegates adopt the following recommendations, and that the remainder of this report be filed:

1. That our American Medical Association adopt the following policy:

Anti-Harassment Policy Applicable to AMA Entities

It is the policy of the American Medical Association that any type of harassment of AMA staff, fellow delegates or others by members of the House of Delegates or other attendees at or in connection with HOD meetings, or otherwise, including but not limited to dinners, receptions and social gatherings held in conjunction with HOD meetings, is prohibited conduct and is not
tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where
AMA delegates and staff are conducting AMA business. This zero tolerance policy also applies to
meetings of all AMA sections, councils, committees, task forces, and other leadership entities
(each, an “AMA Entity”), as well as other AMA-sponsored events.

Definition

Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or
shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual
orientation, gender identity, national origin, age, disability, marital status, citizenship or other
protected group status, and that: (1) has the purpose or effect of creating an intimidating, hostile or
offensive environment; (2) has the purpose or effect of unreasonably interfering with an
individual’s participation in meetings or proceedings of the HOD or any AMA Entity; or
(3) otherwise adversely affects an individual’s participation in such meetings or proceedings or, in
the case of AMA staff, such individual’s employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping;
threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic
material that denigrates or shows hostility or aversion toward an individual or group and that is
placed on walls or elsewhere on the AMA’s premises or at the site of any AMA meeting or
circulated in connection with any AMA meeting.

Sexual Harassment

Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For
the purposes of this policy, sexual harassment includes:

- making unwelcome sexual advances or requests for sexual favors or other verbal, physical,
or visual conduct of a sexual nature; and
- creating an intimidating, hostile or offensive environment or otherwise unreasonably
interfering with an individual’s participation in meetings or proceedings of the HOD or any
AMA Entity or, in the case of AMA staff, such individual’s work performance, by
instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo,
suggestive comments or gestures, descriptive comments about an individual’s physical appearance,
electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any
unwelcome physical contact.

Retaliation against anyone who has reported harassment, submits a complaint, reports an incident
witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each
complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest
extent possible, the AMA will keep complaints and the terms of their resolution confidential.
(New HOD Policy)

2. That the Board of Trustees establish a formal process by which any delegate, AMA Entity
member or AMA staff member who feels he/she has experienced or witnessed conduct in
violation of this policy may report such incident; and consider and prepare for future
consideration by the House of Delegates, potential corrective action and/or discipline for
conduct in violation of this policy, with report back at the 2017 Interim Meeting. (Directive to
Take Action)

Fiscal Note: Less than $500
Appendix

AMA Policy:
H-65.987 Gender Exploitation in the Workplace
H-295.955 Teacher-Learner Relationship in Medical Education
H-295-964 Enforcement of AMA Policy on Sexual Exploitation and Harassment
H-295-970 Sexual Harassment and Exploitation between Medical Supervisors and Trainees
H-525.998 Women in Organized Medicine
E-3.08 Sexual Harassment and Exploitation between Medical Supervisors and Trainees
D-295-962 Prevention of Harassment and Discrimination of Women in Medicine
D-525.996 Prevention of Harassment and Discrimination of Women in Medicine

AMA Guidelines:
American Medical Association Guidelines for Preventing and Addressing Harassment in the Medical Profession
EXECUTIVE SUMMARY

This report responds to referred Resolution 229-A-16, “Expansion of US Veterans’ Health Care Choices,” which asked the American Medical Association (AMA) to: (1) adopt policy that the Veterans Health Administration (VHA) expand all eligible veterans’ health care choices by permitting them to use funds currently spent on them through the Veterans Affairs (VA) system, through a mechanism known as premium support, to purchase private health care coverage, and for veterans over age 65 to use these funds to defray the costs of Medicare premiums and supplemental coverage; and (2) actively support federal legislation to achieve this reform of veterans’ health care choices.

In 2014, it was discovered that thousands of veterans were waiting excessive amounts of time to access health care through the US Department of Veteran Affairs (VA). To address access issues, the Veterans Access, Choice and Accountability Act of 2014 created the Veterans Choice Program (VCP), which authorized the VA to contract with physicians in private practice to provide care to veterans who either live too far away from a VA facility or cannot access care in a VA facility in a timely manner. The VCP was set to expire in August 2017. Implementation of the VCP was challenging. The VA was given just 90 days to fully implement the nationwide program. The VA recognized continued access issues early in the implementation stage and has been working with stakeholders, including the American Medical Association (AMA), to make needed changes.

Suggesting premium support for veterans to purchase health care in the private sector is not a new concept. However, the VHA is not a health insurance plan with a tangible amount of money to give veterans to purchase private health care. The VHA is the largest integrated health care system in the US and provides highly specialized and comprehensive care that is not available to the same extent in the private sector. Importantly, feedback from veterans on the care they receive through the VHA is mostly positive and some veterans have expressed gratitude for the camaraderie they experience while receiving treatment alongside fellow veterans.

The Administration, Congress and the VA are now working together to reform the VCP rather than let it expire or privatize it. Recent legislation was enacted into law to extend the VCP beyond the sunset date of August 2017. The extension allows the program to use the remaining appropriated funds and give Congress and the VA time to work on a comprehensive reform plan.

This report provides background on the creation of the VCP; outlines efforts to redesign the VA health care delivery system; highlights stakeholder input; explains the difficulty of providing premium support to veterans; summarizes legislative activity; explains how to become a VA provider; summarizes AMA policy, advocacy and resources; discusses avenues to improve access to care for veterans; and proposes recommendations.
At the 2016 Annual Meeting, the House of Delegates referred Resolution 229, “Expansion of US Veterans’ Health Care Choices,” which was sponsored by the Ohio Delegation. Resolution 229-A-16 asked the American Medical Association (AMA) to:

1. adopt policy that the Veterans Health Administration (VHA) expand all eligible veterans’ health care choices by permitting them to use funds currently spent on them through the Veterans Affairs (VA) system, through a mechanism known as premium support, to purchase private health care coverage, and for veterans over age 65, to use these funds to defray the costs of Medicare premiums and supplemental coverage; and
2. actively support federal legislation to achieve this reform of veterans’ health care choices.

The majority of testimony on Resolution 229-A-16 requested referral for study to review the implications of allowing veterans to access health care outside of the VA through premium support, which was viewed as complicated and controversial with implications not only for the VA, but also for Medicare, the private health insurance market and the entire health care system.

This report provides background on the creation of the Veterans Choice Program (VCP); outlines efforts to redesign the veterans’ health care delivery system; highlights stakeholder input; explains the difficulty of providing premium support to veterans; summarizes legislative activity; explains how to become a VA provider; summarizes AMA policy, advocacy and resources; discusses avenues to improve access to care for veterans; and proposes a series of recommendations.

BACKGROUND

In 2014, it was discovered that thousands of veterans were waiting excessive amounts of time to access health care through the VA. To address access issues, the Veterans Access, Choice and Accountability Act of 2014 (Public Law 113-146, “Choice Act”) created the VCP, which authorized the VA to contract with physicians in private practice to provide care to veterans who either live too far away from a VA facility or cannot access care in a VA facility in a timely manner. The VCP was set to expire in August 2017.

Implementation of the VCP was challenging. The VA was given just 90 days to fully implement the nationwide program. To achieve this short timeline, the VA modified existing purchased care contracts that were not designed to handle the scope of the VCP. In addition, the VA distributed nine million choice cards, mostly to veterans who were not immediately eligible for the VCP. The
VA recognized these problems early in the implementation stage and has been working with stakeholders, including the AMA, to make needed changes.

REDESIGNING THE VETERANS’ HEALTH CARE DELIVERY SYSTEM

Blueprint for Excellence

In 2014, the VA issued a “Blueprint for Excellence,” which identified strategies to improve the performance of VHA health care, develop a positive service culture, transition from a focus on “sick care” to “health care,” and develop business systems and management processes that are efficient, transparent and accountable. In addition to the VCP, the VA maintains the following community care programs: Emergency Care, Preauthorized Care, Patient-Centered Community Care, State Veterans Home, Indian Health Services/Tribal Health Program and other benefits and services.

The Blueprint for Excellence includes a recommendation to consolidate all of the community care programs into one streamlined program and make improvements to information and billing systems. The VA has decided that maintaining all of the community care programs is unsustainable given the following challenges: varied eligibility criteria; multiple referral and authorization requirements; lack of standard care coordination model; multiple local provider contracting approaches; variable payment rates and structures; and multiple programs that result in confusion for veterans and providers. In 2015, the VA submitted a plan to Congress to consolidate the community care programs into a community care network, which is expected to be fully operational in June 2018.

Veterans Choice Act Independent Assessment

The Choice Act called for an independent assessment of 12 areas of the VA’s health care delivery system and management processes. The “Veterans Choice Act Independent Assessment,” issued in 2015, identified the following four systemic problems: a disconnect in the alignment of demand, resources and authorities; uneven bureaucratic operations and processes; non-integrated variations in clinical and business data and tools; and leaders not fully empowered due to a lack of clear authority, priorities and goals. To address these issues, the independent assessment developed recommendations to improve the VHA system. A subsequent review found that the VHA is making progress on implementing the suggested changes.

Commission on Care

In accordance with the Choice Act, a “Commission on Care” (the Commission) was also established to evaluate the health care that veterans had been receiving. Released in 2016, the Commission’s final report concluded that although care delivered by the VA is in many ways comparable or better in clinical quality to that generally available in the private sector, it is inconsistent from facility to facility. The Commission outlined a series of recommendations, many of which are already being implemented as part of the ongoing “MyVA initiative.”

MyVA Initiative

The “MyVA initiative” is considered the largest department-wide transformation in the VA’s history and has reportedly been very successful. In 2016, the VHA scheduled about 58 million appointments, which accounts for 1.2 million more than were scheduled in 2015 and almost 3.2 million more than in 2014. In September 2016, about 96 percent of appointments were completed.
within 30 days of the clinically indicated or veteran’s preferred date. About 91 percent of these
appointments were scheduled within 14 days, about 85 percent within 7 days and about 22 percent
on the same day. The average wait time for primary care appointments was reportedly about five
days, for specialty care about six days and for mental health care about two days.7

VHA and VCP contractors authorized appointments for more than 3 million veterans to receive
care in the private sector from February 1, 2015, through January 31, 2016. The number of
authorized appointments represents a 12 percent increase compared to the same time period a year
earlier.8

STAKEHOLDER INPUT

Many veterans’ organizations (i.e., Disabled American Veterans, The American Legion, Military
Order of the Purple Heart, Vietnam Veterans of America, Veterans of Foreign Wars, Paralyzed
Veterans of America, AMVETS, and Iraq and Afghanistan Veterans of America) have emphasized
that reform efforts should focus on strengthening the VA health care system, not dismantling it.
These organizations specifically called for reform efforts to be based on veterans’ health care needs
and preferences, and have voiced concerns about coordination of care, the quality of medical
services and the health outcomes for veterans receiving health care in the private sector. The
organizations concluded in a statement that “we are confident that any objective, unbiased analysis
of all the relevant data and evidence about the VA health care system compared to private sector
health care will demonstrate the benefits of maintaining and strengthening a dedicated veterans’
health care system.”9

PREMIUM SUPPORT FOR VETERANS

Suggesting premium support for veterans to purchase health care in the private sector is not a new
concept. Proponents have suggested providing veterans with a choice of accessing private health
care regardless of the distance from their residence to the nearest VA facility or how long it takes
to make an appointment within the VA. Opponents have argued that premium support for veterans
would essentially be a voucher and may not cover all necessary services. One proposal has
suggested privatizing health care for all veterans by phasing out VA health care facilities over the
next 20 years.10

The VHA is not a health insurance plan with a tangible amount of money to give veterans to
purchase private health care. The VHA is the largest integrated health care system in the US,
consisting of 150 medical centers, and approximately 1,400 community-based outpatient clinics,
community living centers, vet centers and domiciliaries. The VHA medical centers provide a wide
range of services including traditional hospital-based services, medical and surgical specialty
services, and advanced services such as organ transplants and plastic surgery.

In addition, the VHA provides unique, highly specialized care for many medical conditions, such
as spinal cord and traumatic brain injuries, which are not available to the same extent outside of the
VHA. The VHA provides a comprehensive, multidisciplinary approach that allows providers to
address the full spectrum of veteran needs beyond physical medical care, such as behavioral health
care, rehabilitation, vocational training and educational assistance. Some veterans have expressed
gratitude for the camaraderie they experience while receiving treatment alongside fellow veterans.

Veterans provided input on privatizing the VHA during the Commission’s evaluation. The majority
opposed privatizing the VHA, with a minority wanting more access to non-VA providers. The
Disabled American Veterans shared with the Commission a compilation of more than 4,000
verbatim comments on veterans’ health care experiences, which indicated that approximately 82 percent reported overall positive experiences.\textsuperscript{11}

LEGISLATIVE ACTIVITY

The Administration, Congress and the VA are working together to reform the VCP rather than let it expire or privatize it. Recent legislation was enacted into law to extend the VCP beyond the sunset date of August 2017. The extension allows the program to use the remaining appropriated funds and give Congress and the VA time to work on a comprehensive reform plan.

BECOMING A VA PROVIDER

The AMA encourages physicians to become VA providers. Physicians can sign up on the following website: \url{https://www.hnfs.com/content/hnfs/home/va/provider/options-for-providers.html}

Interested physicians can register to become a provider for just the VCP or for all the community care programs. Physicians can download a non-VA provider fact sheet at \url{https://www.ama-assn.org/sites/default/files/media-browser/public/washington/veterans-affairs-fact-sheet-for-non-va-medical-care-program_1.pdf} for a summary of the conditions of participation and other requirements that are included in the VCP application process.

Adequate and prompt payments by the VA have been long-standing problems, which can deter physicians from providing services to veterans. The VCP pays Medicare rates, but the other community care programs pay less. To address payment delays, in 2012 the Veterans Benefits Administration created a new electronic claims processing system, the Veterans Benefits Management System, to process claims faster, more efficiently and more accurately. From 2013-2016, the new system allowed the VA to reduce the backlog of disability claims by 87 percent.\textsuperscript{12}

RELEVANT AMA POLICY

The AMA supports providing full health benefits to eligible veterans to ensure they can access the medical care they need outside the VA in a timely manner (Policy H-510.986[2,3]). AMA Policy H-510.990 encourages the VA to continue exploring alternative mechanisms for providing quality health care coverage for veterans.

The AMA supports approaches that increase the flexibility of the VA to provide all veterans with improved access to health care services (Policy H-510.991). Policy H-510.985[1] calls on the AMA to continue advocating for improvements to legislation regarding veterans’ health care to ensure timely access to primary and specialty health care within close proximity to a veteran’s residence within the VA health care system. Policy H-510.985[2] calls on the AMA to monitor implementation of and support necessary changes to the VCP “Choice Card” to ensure timely access to primary and specialty health care within close proximity to a veteran’s residence outside of the VA health care system.

The AMA urges all physicians to participate, when needed, in providing health care to veterans (Policy H-510.986). AMA Policy H-510.985[4] advocates that the VA pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician. The AMA has long advocated that payers should pay for clean claims submitted electronically within 14 days and paper claims within 30 days (Policy H-190.981).
The AMA urges the VA to hire additional primary and specialty physicians as needed and to
enhance its loan forgiveness efforts to help with physician recruitment and retention, and to

The AMA supports improved access to health care for veterans, including in the civilian sector, for
returning military personnel when their needs are not being met by locally available resources
through the Department of Defense or the VA (Policies H-510.985, H-510.990, H-510.991 and
D-510.994). Policy H-510.986 encourages state and local medical societies to create a registry of
physicians who are willing to provide health care to veterans in their community.

AMA ADVOCACY AND RESOURCES

The AMA strongly supported passage of the Choice Act, which created the VCP, and supports
bipartisan efforts to make the VCP permanent, and to streamline the registration process for non-
VA providers. The AMA has been actively involved in helping to shape and monitor
implementation of the VCP. For example, the AMA sent a letter to the VA in March 2015, urging
it to change the way it calculated the 40 mile distance criteria from a straight line to the time it
takes for a veteran to travel to the nearest VA medical facility.13 AMA advocacy efforts were
instrumental in influencing the VA to change the distance criteria in April 2015, which expanded
eligibility for the VCP.14

In addition to meetings and other communications with VA officials, the AMA submitted
statements on proposed legislation to improve the VCP to the Senate Committee on Veterans’
Affairs in March 2016, and to the House Committee on Veterans’ Affairs in May 2016.15,16 The
AMA continues to work with the Committees on Veterans’ Affairs to streamline programs,
improve access to care and encourage participation by non-VA physicians and other providers. The
AMA has communicated the following to the committees:

Consolidation of Programs: The AMA strongly supports the improvement and consolidation of the
VCP to streamline and eliminate confusion and duplication between community care programs.
The AMA believes that creating efficiencies and reducing administrative costs will benefit both
veterans and physicians and encourage greater participation.

Access to Specialty Care: The AMA recognizes that a lack of access to specialty care in VA-based
facilities is further complicated by provisions that require a minimum 40 mile driving distance, in
addition to the lack of necessary specialists at VA community-based outpatient clinics.

Agreements/Contracts with Providers: The AMA supports using provider agreements between the
VA and private physicians, similar to those for Medicare and Medicaid, which could help alleviate
some of the burdensome compliance issues associated with federal contractors.

Billing and Payment: The AMA supports efforts to reform billing and reimbursement, such as to
standardize provider payment rates using Medicare rates as a “floor” and not a “ceiling” (especially
in regions with high demand and low supply of care specialists). Improving the VA’s
reimbursement processes would alleviate complaints that physicians and other providers have tied
to the VCP in terms of administrative hassles and payment delays.

Electronic Billing: The AMA does not advocate for the strict mandate that all claims should be
submitted electronically. Rather, it encourages a system similar to Medicare that allows certain
exceptions, especially for smaller practices.
Tiered Networks: The AMA is very concerned about proposed plans to create tiered networks, especially in the absence of clear guidelines about differentiations in “high-value care.” The AMA urges extreme caution that the VCP doesn’t experience problems similar to those sometimes resulting from the Affordable Care Act, in which tiering narrowed networks and reduced access.

Value-Based Payment Modifier: The AMA is strongly opposed to the use of a value-based payment modifier (VBM). Because the VBM was developed to measure hospital populations, it may be inadequate for accurately measuring services provided by physicians’ offices. Reports suggest that practices with the sickest patients fare poorly under the VBM. The AMA believes that more analysis of the VBM and its results are needed before it is applied to programs like the VCP.

The AMA has resources and advocacy materials located at: https://www.ama-assn.org/search/ama-assn/veterans. The AMA also has veterans’ health resources for medical professionals located at: https://www.ama-assn.org/delivering-care/veterans-health-resources-medical-professionals.

DISCUSSION

Since the access issues in 2014, the VA has made concerted efforts to improve the care it provides to veterans and has made substantial strides, but improvements are still necessary. Given the extensive input the AMA has been providing, and the progress that is being made by the VA, the Council recommends that the AMA continue to work with the VA to provide quality care, support efforts to improve the VCP, and make it a permanent program.

The VA is aware that veterans need to be able to access medical care in the private sector when it is not available through the VHA. The Council suggests reaffirming Policy H-510.985, which supports necessary changes to the VCP to ensure timely access to primary and specialty health care within close proximity to a veteran’s residence outside of the VA health care system. In addition, the Council believes the AMA should encourage the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care.

The Council suggests supporting consolidation of all the VA community care programs to streamline and eliminate confusion and duplication. Creating efficiencies and reducing administrative costs will benefit both veterans and physicians and encourage greater participation.

The VCP has been reviewed by numerous external agencies since implementation. The Council suggests the VA use external assessments as necessary to identify and address systemic barriers to care. The Council also suggests that the AMA support interventions to mitigate barriers to the VA from being able to achieve its mission.

The lack of adequate and prompt payments by the VA has been a long-standing problem that can deter physician participation. The VCP pays Medicare rates, but lower payment rates have been negotiated for the other community care programs by third party administrators based on regional/local trends. Other local contracts between VA medical centers and individual practices have also been negotiated at lower rates. The Council’s recommended reaffirmation of Policy H-510.985 reiterates AMA support for the VA to pay private physicians a minimum of 100 percent of Medicare rates.

While the VA has demonstrated progress in making prompt payments, there is room for improvement. The AMA has long advocated that payers should pay for clean claims submitted
electronically within 14 days and paper claims within 30 days (Policy H-190.981). The Council recommends that the VA provide payments within the same timeframe.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 229-A-16 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) continue to work with the Veterans Administration (VA) to provide quality care to veterans. (New HOD Policy)

2. That our AMA continue to support efforts to improve the Veterans Choice Program (VCP) and make it a permanent program. (New HOD Policy)

3. That our AMA reaffirm Policy H-510.985, which supports changes to the VCP to ensure timely access to primary and specialty health care within close proximity to a veteran’s residence outside of the VA health care system and advocates that the VA pay private physicians a minimum of 100 percent of Medicare rates. (Reaffirm HOD Policy)

4. That our AMA encourage the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care, and that the VA develop criteria by which individual veterans may request alternative pathways. (New HOD Policy)

5. That our AMA support consolidation of all the VA community care programs. (New HOD Policy)

6. That our AMA encourage the VA to use external assessments as necessary to identify and address systemic barriers to care. (New HOD Policy)

7. That our AMA support interventions to mitigate barriers to the VA from being able to achieve its mission. (New HOD Policy)

8. That our AMA advocate that clean claims submitted electronically to the VA should be paid within 14 days and that clean paper claims should be paid within 30 days. (New HOD Policy)

Fiscal Note: Less than $500
REFERENCES

1 Department of Veterans Affairs Blueprint for Excellence. Veterans Health Administration. 2014. Available at: https://www.va.gov/health/docs/vha_blueprint_for_excellence.pdf
3 Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs. 2014. Available at: https://www.va.gov/opач/Publications/Assessments/integrated_report.pdf
7 Secretary Robert McDonald. US Department of Veterans Affairs. Caring for Those who Have Borne the Battle. 2017. Available at: https://www.va.gov/opач/Publications/docs/VA-Exit-Memo.pdf
12 VBA improves the Veterans experience: goes electronic on claims, reduces backlog and improves accuracy Available at: http://www.blogs.va.gov/VAntage/28401/vba-improves-the-veterans-experience-goes-electronic-on-claims-reduces-backlog-and-improves-accuracy/
13 AMA letter to the VA. Re: Expanded Access to Non-VA Care through the Veterans Choice Program. 2015.
This report by the Committee at the 2017 Annual Meeting presents two recommendations.

BACKGROUND

At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on Trustee Compensation, currently named the Committee on Compensation of the Officers, (the “Committee”). The Officers are defined in the American Medical Association’s (AMA) Constitution and Bylaws. (Note: under changes to the Constitution previously approved by the HOD, Article V refers simply to “Officer,” which includes all 21 members of the Board among whom are President, President-Elect, Immediate Past President, Secretary, Speaker of the HOD and Vice Speaker of the HOD, collectively referred to in this report as Officers). The composition, appointment, tenure, vacancy process and reporting requirements for the Committee are covered under the AMA Bylaws. Bylaws 2.645 provides:

The Committee shall present an annual report to the House of Delegates recommending the level of total compensation for the Officers for the following year. The recommendations of the report may be adopted, not adopted or referred back to the Committee, and may be amended for clarification only with the concurrence of the Committee.

At A-00, the Committee and the Board jointly adopted the American Compensation Association’s definition of total compensation which was added to the Glossary of the AMA Constitution and Bylaws. Total compensation is defined as the complete reward/recognition package awarded to an individual for work performance including: (a) all forms of money or cash compensation; (b) benefits; (c) perquisites; (d) services; and (e) in-kind payments.

Since the inception of this Committee, its reports document the process the Committee follows to ensure that current or recommended Officer compensation is based on sound, fair, cost-effective compensation practices as derived from research and use of independent external consultants, expert in Board compensation. Reports beginning in December 2002 documented the principles the Committee followed in creating its recommendations for Officer compensation.

At A-08, the HOD approved changes that simplified compensation practices with increased transparency and consistency. At A-10, Reference Committee F requested that this Committee recommend that the HOD affirm a codification of the current compensation principle, which occurred at I-10. At that time, the HOD affirmed that this Committee has and will continue to base its recommendations for Officer compensation on the principle of the value of the work performed, © 2017 American Medical Association. All rights reserved.
consistent with IRS guidance and best practices as recommended by the Committee’s external
independent consultant, who is expert in Board compensation.

At A-11, the HOD approved the alignment of Medical Student and Resident Officer compensation
with that of all other Officers (excluding Presidents and Chair) because these positions perform
comparable work.

Immediately following A-11, the Committee retained Mr. Don Delves, founder of the Delves
Group, to update his 2007 research by providing the Committee with comprehensive advice and
counsel on Officer compensation. The Committee asked for this update because it had been four
years since the last comprehensive review and because the Committee wanted to continue refining
its compensation practices to improve simplification and transparency. The updated compensation
structure was presented and approved by the HOD at I-11 with an effective date of July 1, 2012.

At I-11, Reference Committee F requested that the Committee list the specific benefits, perquisites
and in-kind payments provided to the Officers and to document annually the taxable value of these
benefits. The Committee first reported this information, as reported to the IRS, in its A-12 report.

The Committee’s I-12 report referenced discussion and research concerning Presidents’ travel on
regional airlines. The A-13 report expanded the travel discussion to include travel on airlines
without preferred status. The HOD approved the Committee’s recommendation to provide a travel
allowance for each President to be used for upgrades, primarily on non-preferred status airlines,
because of the significant volume of travel by the Presidents in representing our AMA.

At A-16 the Committee reported that they had commissioned a comprehensive compensation
review with their new consultant, Becky Glantz Huddleston, of Willis Towers Watson. Ms.
Huddleston is an expert in Board compensation and the firm she works for is one of the largest,
most prestigious and well-respected compensation firms. At I-16, based on this review, the
Committee made five recommendations for Officer compensation which were approved by the
HOD. These changes, effective July 1, 2017, provided modest increases to the Governance
Honorarium and Per Diems (representation and telephonic representation) for Officer
Compensation (excluding the Presidents and Chairs) and no changes to the definitions or other
changes.

The recommendations in this report focus on the definitions based on the same data used to arrive
at the I-16 recommendations.

METHODOLOGY

Early in 2016, the Committee commissioned a comprehensive compensation review with an
outside consultant expert in Board compensation. The purpose of the review was to ensure the
Officers are compensated appropriately for the work performed on behalf of the AMA and to
review how the Officer compensation is structured to ensure continued alignment with current
trends in for-profit Board compensation which had been to move away from paying for each
individual Board or Board committee meeting to one annual fee.

The Committee’s review and subsequent recommendations for Officer compensation are based on
the principle of the value of the work performed, as affirmed by the HOD. In addition, the
following additional guidelines were followed:

• Compensation should be based on the value expected by the AMA from its Officers.
Compensation should take into account that the AMA is a complex organization when comparing compensation provided to Board members by for-profit organizations and by complex not-for-profit organizations of similar size and activities.

Compensation should be aligned with the long-term interests of AMA members and the fulfillment of the fiduciary responsibilities of the Officers.

Officers should be adequately compensated for their value, time, and effort.

Compensation should reinforce choices and behaviors that enhance effectiveness.

Compensation should be approached on a comprehensive basis, rather than as an array of separate elements.

The process the Committee followed along with the aforementioned principles is consistent with the guidelines recommended by the IRS for determining reasonable and competitive levels of Officer compensation.

Ms. Huddleston and the Committee developed their recommendations based on:

- The current compensation structure.
- Interviews with certain Board members to gain an understanding of their insights related to the current Officer compensation program.
- Review and analysis of Officer compensation data for the past three terms.
- Pay practices for Board of Directors at for-profit and not-for-profit organizations similar to the AMA who pay their Board members.
- A collaborative, deliberative and objective review process.

FINDINGS

The Committee notes that Officers continue to make significant time commitments in supporting our AMA in governance and representation functions. Given the amount of time required of Board members, it is important that individuals seeking a position on the Board be aware of the scope of the commitment and the related compensation.

As noted in its I-16 report, the Committee balanced simplicity, transparency and comparability with Board feedback, internal and external compensation data and the total cost of governance to the AMA when recommending the modest increases to the Governance Honorarium and Per Diems. One of the results of the review, as noted in the I-16 report, was that Chair-assigned External Representation, compensated by a per diem, had the greatest variability in the number of representation days by Officer, followed by Chair-assigned Internal Representation. Internal Representation is defined as any representation within AMA groups (e.g., council and section liaisons) that does not relate to currently scheduled Board meetings, special Board or Board committee, subcommittee and task force meetings, Board orientation, Board development, media training, and Board conference calls.

All Internal Representation work, by definition, is included as part of the Governance Honorarium, which also compensated Officers for Board meetings, so Internal Representation days do not receive a per diem. The variability in the number of Internal Representation days by Officer was a concern expressed by Board leadership during their interviews about Officer compensation.

Subsequent Committee discussions about the variability in the number of Internal Representation days resulted in the Committee and their external consultant, Ms. Huddleston, again reviewing the data previously gathered along with its related analysis. This review focused on internal AMA data from the past three terms, specifically the number of Internal Representation days per Officer per
term. This review showed that for each term there were several Officers with assigned Internal
Representation days significantly above each year’s Internal Representation day average. While
comparability and simplicity remain important in determining appropriate compensation based on
the value of the work performed, in some cases, these variances were outside the scope of
comparability.

Analysis of the data for the 3 terms calculated the average number of Internal Representation days
at eleven (11). To better align Officer compensation, the Committee recommends that Internal
Representation days exceeding eleven (11) days per term be compensated by a per diem for each
day or teleconference meetings as defined in the current definitions of Per Diems used for External
Representation effective July 1, 2017. The Committee views this recommendation as a fiscally
responsible solution.

The Committee will also incorporate this more detailed review of Internal Representation days into
its future reviews of board compensation which typically takes place every 3 to 5 years.

RECOMMENDATIONS

The Committee on Compensation of the Officers recommends the following recommendations be
adopted and the remainder of this report be filed:

1. That there be changes to the current Definitions as they appear in the Travel and Expenses
Standing Rules for AMA Officers for the Governance Honorarium, Per Diem for External
Representation and Telephonic Per Diem for External Representation and that the changes
become effective July 1, 2017, as noted below.

• Definition of Governance Honorarium effective July 1, 2012:
The purpose of this payment is to compensate Officers for all Chair-assigned internal
AMA work and related travel. This payment is intended to cover all currently scheduled
Board meetings, special Board or Board committee meetings, task forces, subcommittees,
Board orientation, development and media training, Board calls, sections, councils or other
internal representation meetings or calls, and any associated review or preparatory work,
and all travel days related to all meetings as noted above.

• Definition of Governance Honorarium effective July 1, 2017:
The purpose of this payment is to compensate Officers, excluding Board Chair, Chair-Elect
and Presidents, for all Chair-assigned internal AMA work and related travel. This payment
is intended to cover all currently scheduled Board meetings, special Board or Board
committee, subcommittee and task force meetings, Board orientation, Board development
and media training, and Board conference calls, and any associated review or preparatory
work, and all travel days related to all such meetings. The Governance Honorarium also
covers Internal Representation, such as section and council liaison meetings (and
associated travel) or calls, up to eleven (11) Internal Representation days.

• Definition of Per Diem for Representation effective July 1, 2017:
The purpose of this payment is to compensate for Board Chair-assigned representation
day(s) and related travel for Officers, excluding Board Chair, Chair-Elect and Presidents.
Representation is either external to the AMA, or for participation in a group or
organization with which the AMA has a key role in creating/partnering/facilitating
achievement of the respective organization goals such as the AMA Foundation, PCPI,
etc., or for Internal Representation days above eleven (11). The Board Chair may also
approve a per diem for special circumstances that cannot be anticipated such as weather related travel delays. Per Diem for Chair-assigned representation and related travel is $1,300 per day.

- Definition of Telephonic Per Diem for Representation effective July 1, 2017:
  Officers, excluding the Board Chair, Chair-Elect and Presidents, who are assigned as the AMA representative to outside groups as one of their specific Board assignments or assigned Internal Representation days above eleven (11), receive a per diem rate for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for these meetings would require approval of the Chair of the Board. The amount of the Telephonic Per Diem will be ½ of the full Per Diem or $650.

2. Except as noted above, there be no other changes to the Officers’ compensation for the period beginning July 1, 2017. (Directive to Take Action)

Fiscal Note: Estimated annual cost of Recommendation 1 is $42,000 based on the three-year average of Internal Representation days.

APPENDIX

<table>
<thead>
<tr>
<th>POSITION</th>
<th>GOVERNANCE HONORARIUM</th>
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<tbody>
<tr>
<td>President</td>
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<tr>
<td>Immediate Past President &amp; President-Elect</td>
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<tr>
<td>Chair</td>
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<tr>
<td>Chair-Elect</td>
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<tr>
<td>Other Officers</td>
<td>$65,000</td>
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Definition of Governance Honorarium Effective July 1, 2012:

The purpose of this payment is to compensate Officers for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board Committee meetings, task forces, subcommittees, Board orientation, development and media training, Board calls, sections, councils or other internal representation meetings or calls, and any associated review or preparatory work, and all travel days related to all meetings as noted above.

Definition of Per Diem for Representation effective July 1, 2017:

The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel. Representation is either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating achievement of the respective organization goals such as the AMA Foundation, PCPI, etc. The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather related travel delays. Per Diem for Chair-assigned representation and related travel is $1,300 per day.

Definition of Telephonic Per Diem for External Representation effective July 1, 2017:

Officers, excluding the Board Chair and the Presidents, who are assigned as the AMA representative to outside groups as one of their specific Board assignments, receive a per diem rate
for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer
during a calendar day equal 2 or more hours. Payment for these meetings would require approval of
the Chair of the Board. The amount of the Telephonic Per Diem will be ½ of the full Per Diem or
$650.
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 012
(A-17)

Introduced by: American Association of Neurological Surgeons
Congress of Neurological Surgeons

Subject: Promoting the AMA Model Medical Staff Code of Conduct\(^1\) and its Application to Employed Physicians

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Michael B. Hoover, MD, Chair)

Whereas, The reliable, safe, high quality and efficient practice of medicine requires the highest ethical and professional standards of physicians; and

Whereas, In some circumstances, these goals can be undermined by physician conduct asserted to be “disruptive, intimidating or inappropriate”; and

Whereas, Such behavior results in detrimental effects on patient care and the collegiality of the healthcare team; and

Whereas, Without appropriate investigation or process, such conduct cannot be concluded to be per se unethical, unprofessional and require sanction; and

Whereas, The valid concerns of a physician’s conduct or behavior, without appropriate review, can be misinterpreted, causing he/she to be mischaracterized as “disruptive, intimidating or inappropriate”; and

Whereas, Our AMA\(^2\) and The Joint Commission\(^3\) have published reports describing and defining the “disruptive physician” as well as model bylaws describing an investigative process to assure a fair hearing before a physician’s behavior may be affirmed or sanctioned; and

Whereas, The “employed physician,” although a member of the medical staff and is otherwise compliant with hospital bylaws, such as credentialing, committee service, continuing education programs, etc., may not be eligible to have “disruptive conduct” investigated or reviewed through such process; and

Whereas, He/she may be dismissed from employment “for cause” as being a “disruptive physician” which carries a stigma and possible effect with future employment considerations; therefore be it

RESOLVED, That our American Medical Association actively educate state and specialty medical societies about the AMA Medical Staff Code of Conduct and promote its use (Directive to Take Action); and be it further

\(^2\) AMA CEJA Report 3-1-09. Physicians with Disruptive Behavior.
\(^3\) Joint Commission Sentinel Event Alert, Issue 40, July 9, 2008.
RESOLVED, That our AMA advocate that, as participating members of their medical staffs, “employed physicians” be afforded the same right of review as non-employed physicians as regards an accusation that their conduct has been characterized as “disruptive, intimidating or inappropriate. (New HOD Policy)

Fiscal Note: Not yet determined

Received: 05/09/17
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 013
(A-17)

Introduced by: American Academy of Dermatology
American Society for Dermatologic Surgery Association
American College of Mohs Surgery
American Society of Dermatopathology
GLMA
Society for Investigative Dermatology
Wisconsin

Subject: Gender Identity Inclusion and Accountability in REMS

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Michael B. Hoover, MD, Chair)

Whereas, The United States Food and Drug Administration (FDA) Risk Evaluation and
Mitigation Strategies (REMS) are mandatory risk management plans that use risk minimization
strategies beyond the professional labeling to ensure that the benefits of certain prescription
drugs outweigh their risks;¹ and

Whereas, Many REMS programs are designed to prevent fetal exposure to highly teratogenic
drugs, including, but not limited to, isotretinoin, mycophenolate mofetil, thalidomide, macitentan,
bosentan, lenalidomide, riociguat, and pomalidomide. For many of these drugs, enrollment in
the respective REMS program is mandatory in order to access the drug;² and

Whereas, Many of these REMS programs mandate the classification of patients as one of the
following: females of child-bearing potential (FCBPs), females not of child-bearing potential
(FnCBPs), or males;¹,³,⁴ and

Whereas, A female of childbearing potential is defined as “a nonmenopausal female who has
not had a hysterectomy, bilateral oophorectomy, or medically documented ovarian failure”
进一步 characterized by “permanent cessation of previously occurring menses… with
documentation of hormonal deficiency;”³ and

Whereas, The transgender population is increasing with an estimated 1.4 million people in the
United States (0.6% of the population) identifying as transgender;⁵ and

Whereas, The results of gender-affirming hormonal therapies in transgender men may be
reversible and do not guarantee ovarian failure, and as such transgender men with retained
uterus and ovaries may continue to have the ability to become pregnant;⁶ and

Whereas, REMS provider and patient information do not specifically mention the care or
accommodation of transgender individuals;³,⁴ and

Whereas, Transgender individuals are effectively excluded from the classification system,
particularly transgender men who possess the reproductive anatomy capable of producing a
pregnancy, given that the current classification associates child-bearing potential exclusively
with a designation of female gender identity;⁹-¹¹ and
Whereas, The inability of transgender individuals to register in REMS programs in a manner commensurate with their gender identity while also accurately stating their childbearing potential creates a barrier to care with perpetuation of cultural insensitivity, in many cases resulting in deferral of otherwise indicated treatment;9-11 and 

Whereas, The current categorization scheme poses an ethical conflict for physicians caring for transgender patients, necessitating a choice between affirming a patient’s gender identity and providing an accurate evaluation of childbearing potential;9-11 and 

Whereas, Both the Institute of Medicine and The Joint Commission have called for increased awareness of healthcare disparities in the gender minority community as well as stigma reduction;12,13 therefore be it 

RESOLVED, That our American Medical Association work with the United States Food and Drug Administration to develop a gender-neutral patient categorization model in Risk Evaluation and Mitigation Strategies programs, focusing exclusively on childbearing potential rather than gender identity. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 05/11/17

References:

RELEVANT AMA POLICY

H-295.878 Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education
D-65.995 Health Disparities Among Gay, Lesbian, Bisexual and Transgender Families
H160.991 Health Care Needs of Lesbian, Gay, Bisexual, and Transgender Populations
D-100.971 Physician Awareness and Education About Pharmaceutical and Biological Risk Evaluation and Mitigation
H-100.961 The Evolving Culture of Drug Safety in the United States: Risk Evaluation and Mitigation Strategies (REMS)
Whereas, Existing AMA Policy H-270.965, “Physician-Assisted Suicide.” is clear that “our AMA strongly opposes any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician’s role as healer” and H-140.952, “Physician Assisted Suicide,” which states that “Physician Assisted Suicide is fundamentally inconsistent with the physician’s professional role; and

Whereas, A review of all AMA policy yields no results for the phrase ‘aid in dying’, especially in any way meant to be synonymous with ‘physician assisted suicide’; and

Whereas, The replacement of the use of the known phrase ‘physician assisted suicide’ with the new phrase ‘aid in dying’ will have and is having the effect of concealing the reality of the fact that both these phrases are being used interchangeably to refer to the same specific defined procedure long established and defined already to be ‘physician assisted suicide’; and

Whereas, ‘Physician assisted suicide’ is clearly defined to be a situation where a physician is asked to and agrees to prescribe a lethal dose of medication to a patient known to be terminally ill so that the patient can self-administer that lethal dose and bring about the immediate end of their own life; and

Whereas, There is no more clear and appropriate phrase to define this procedure than “Physician Assisted Suicide”; and

Whereas, AMA policy is often operationally meted out in the public sector and daily through the terms it endorses and advertises making its selection of terms and phrases like ‘physician assisted suicide’ or ‘aid in dying’ very important with regards to how we maintain transparency and clarity with regards to AMA policy positions; and

Whereas, Any attempt to re-brand what is clearly “physician assistance in the act of suicide” to what is felt to be a softer, less ‘inflammatory’, ‘aid in dying’, can be well-intended but can also have many unintended consequences; and

Whereas, Physicians may either agree or disagree on the ethics and propriety of assisted suicide, the change in terminology creates an insidious misrepresentation if not confusion about the reality of the ‘physician assisted suicide’ process and act which does not hold true to the transparency of the AMA’s current policy position; therefore be it
RESOLVED, That our American Medical Association, as a matter of organizational policy, when referring to what it currently defines as ‘Physician Assisted Suicide’ avoid any replacement with the phrase ‘Aid in Dying’ when describing what has long been understood by the AMA to specifically be ‘Physician Assisted Suicide’ (New HOD Policy); and be it further

RESOLVED, That our AMA develop definitions and a clear distinction between what is meant when the AMA uses the phrase ‘Physician Assisted Suicide’ and the phrase ‘Aid in Dying’ (Directive to Take Action); and be it further

RESOLVED, That these definitions and distinction be fully utilized by our AMA in organizational policy, discussions, and position statements regarding both ‘Physician Assisted Suicide’ and ‘Aid in Dying.’ (New HOD Policy)

Fiscal Note: Not yet determined

Received: 05/11/17

RELEVANT AMA POLICY

Physician Assisted Suicide H-140.952
It is the policy of the AMA that: (1) Physician assisted suicide is fundamentally inconsistent with the physician’s professional role. (2) It is critical that the medical profession redouble its efforts to ensure that dying patients are provided optimal treatment for their pain and other discomfort. The use of more aggressive comfort care measures, including greater reliance on hospice care, can alleviate the physical and emotional suffering that dying patients experience. Evaluation and treatment by a health professional with expertise in the psychiatric aspects of terminal illness can often alleviate the suffering that leads a patient to desire assisted suicide. (3) Physicians must resist the natural tendency to withdraw physically and emotionally from their terminally ill patients. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease. (4) Requests for physician assisted suicide should be a signal to the physician that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary. Multidisciplinary intervention, including specialty consultation, pastoral care, family counseling and other modalities, should be sought as clinically indicated. (5) Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area. Physicians should recognize that courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations.


Physician-Assisted Suicide H-270.965
Our AMA strongly opposes any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician's role as healer.

Whereas, Transgender individuals sentenced to jail or prison time are often placed in facilities based on birth gender, unless they have undergone complete surgical transition. However, a 2012 report by the Department of Justice confirmed that transgender individuals placed in prisons inconsistent with their gender identity experience rape, harassment, and physical violence at higher levels than non-transgender prisoners (34% experienced sexual violence vs 10% for the overall population). Another study by UC-Irvine looking at assault in California prisons confirmed this increased risk with 59% of transgender prisoners experiencing sexual assault vs 4.4% of prisoners overall; and

Whereas, Transgender prisoners are often placed in “administrative segregation” for “protection” from violence but this separation also excludes these prisoners from recreation, educational and occupational opportunities which may violate their constitutional rights. Additionally, transgender inmates are often denied hormonal therapy in prison, which can result in gender dysphoria and depression; and

Whereas, A Bureau of Justice Statistics survey from Spring 2015 estimates that there were at least 3,209 transgender prisoners in state and federal facilities in 2011–2012, or about 0.22% of the national prison population, according to the National Center for Transgender Equality calculations. The Justice Bureau estimated there were 1,709 transgender inmates in local jails, or about 0.23% of the national jail population; and

Whereas, More significantly, nearly one in six transgender Americans and nearly half of all transgender black Americans have been to prison so that transgender people as a population are significantly impacted by prison policies; and

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1 Transsexual people who have not had genital surgery are generally classified according to their birth sex for purposes of prison housing, regardless of how long they may have lived as a member of the other gender, and regardless of how much other medical treatment they may have undergone”, Farmer v. Brennan, 511 U.S. 825, 829 (1994); Farmer v. Haas, 990 F.2d 319, 320 (7th Cir. 1993)
2 Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-2012; Department of Justice, Office of Justice Programs, Bureau of Justice Statistics; Allen Beck, Ph.D., statistician.
3 Violence in California Correctional Facilities: an Empirical Examination of Sexual Assault; Criminology, Law and Society, University of California-Irvine, Center for Evidence Based Corrections; April 27, 2007.
6 RH reality check, “Sentenced to Abuse: Trans People in Prison Suffer Rape, Coercion, Denial of Medical Treatment”, May 12, 2015
Whereas, The Department of Justice issued a statement in April 2015 stating that all prisoners should be treated adequately for any gender dysphoria, and current AMA policy exists to support gender affirmation of transgender individuals regardless of surgical status (AMA Policy H-65.967). All prisoners, regardless of gender identity, deserve access to health care and safety while incarcerated; therefore be it

RESOLVED That our American Medical Association establish policy supporting the ability of transgender prisoners to be placed in facilities that are reflective of their affirmed gender status regardless of surgical status, if they so choose. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 05/11/17

RELEVANT AMA POLICY

Conforming Birth Certificate Policies to Current Medical Standards for Transgender Patients H-65.967

1. Our AMA supports policies that allow for a change of sex designation on birth certificates for transgender individuals based upon verification by a physician (MD or DO) that the individual has undergone gender transition according to applicable medical standards of care.

2. Our AMA: (a) supports elimination of any requirement that individuals undergo gender affirmation surgery in order to change their sex designation on birth certificates and supports modernizing state vital statistics statutes to ensure accurate gender markers on birth certificates; and (b) supports that any change of sex designation on an individual's birth certificate not hinder access to medically appropriate preventive care.


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Whereas, It has been our AMA policy since 2004 that the pre-colonoscopy visit should be reimbursable by Medicare and other insurers, but there has been no action to bring this policy to fruition; and

Whereas, Colonoscopy is an invasive procedure which has been demonstrated to save lives by preventing colon cancer and by finding lesions in an early stage so that endoscopic procedures can be curative; and

Whereas, Due to this benefit, colonoscopy was approved by the Centers for Medicare & Medicaid Services for prevention of colon cancer in average risk individuals beginning on July 1, 2001; and

Whereas, Patients should see the doctor who is performing an invasive procedure prior to preparing for an elective procedure; and

Whereas, The doctor should have the opportunity to evaluate the patient for an invasive procedure if he feels that it is necessary; and

Whereas, The preparation of the colon is a vital part of the procedure in that good preparation enables the endoscopist the ability to detect small polyps and flat lesions; and

Whereas, The preparation of the colon is a quality issue for the doctor performing the colonoscopy; and

Whereas, The interval of ten years between colonoscopies has been demonstrated to be safe and cost effective in patients with good preparation; and

Whereas, The Secretary of Health and Human Services has been granted extraordinary powers under the Affordable Care Act; and

Whereas, The current Secretary of Health and Human Services has a strong understanding of the deliberative processes of our AMA; and

Whereas, In the State of South Carolina, the state insurance fund already pays for this pre-colonoscopy visit; therefore be it
RESOLVED, That our American Medical Association request that the Secretary of Health and Human Services consider allowing Medicare to pay for the pre-colonoscopy consultation to ensure that patients are well chosen, well informed about their choices and well versed in preparation for their colonoscopies. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 05/08/17
Whereas, It has been our AMA policy since 2004 that all methods for prevention of colon cancer that are approved by the United States Preventive Services Task Force should be included in all health plans; and

Whereas, Colonoscopy is an invasive procedure which has been demonstrated to save lives by preventing colon cancer and by finding lesions in an early stage so that endoscopic procedures can be both preventative and curative; and

Whereas, Due to this benefit, colonoscopy was approved by the Centers for Medicare & Medicaid Services for prevention of colon cancer in average risk individuals beginning on July 1, 2001; and

Whereas, Current reimbursement practice is that the copay is waived for preventive services such as colonoscopy; and

Whereas, There are proposals to not include all approved services in insurance plans; and

Whereas, For Medicare patients, when a polyp is removed as part of the procedure to prevent the development of colon cancer, the patient is charged a co-payment; therefore be it

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

RESOLVED, That our AMA strongly urge members of the Congress and the President to support legislation to correct the oversight in the original legislation providing the benefit of colonoscopy screening with the inducement that the copay would not be required when a polyp or other lesion is found as part of the screening process. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/08/17
Whereas, The Centers for Medicare and Medicaid Services (CMS) will only cover the costs of emergency medical services (EMS) transport of patients, not treatment without transport, and such ambulance transports are further restricted to defined locations, not necessarily to the most appropriate and beneficial location for the patient; and

Whereas, Paramedics and other EMS personnel can often provide on-site, community-based evaluation, and triage health care services in a more cost-effective manner than the emergency room setting or traditional CMS defined transport destinations; and

Whereas, EMS could transport patients directly to the appropriate next site of care such as a psychiatric hospital, a detoxification unit, or other site, thus providing more cost-effective care; and

Whereas, EMS companies providing transportation of patients to the appropriate next site of care, other than to CMS approved destinations, incur the expense of the care and the transport with no opportunity to recoup this revenue loss; therefore be it

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

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

RESOLVED, That our AMA work with the Centers for Medicare & Medicaid Services (CMS) to reimburse emergency medical services providers for the evaluation and transport of patients to the appropriate next site of care rather than only to CMS defined and limited transport locations.

(Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17
RELEVANT AMA POLICY

Medicare's Ambulance Service Regulations H-240.978
The AMA supports changes in Medicare regulations governing ambulance service coverage guidelines that would expand the term "appropriate facility" to allow full payment for transport to facilities other than the closest based upon the physician's judgment.

On-Site Emergency Care H-130.976
(1) The AMA reaffirms its policy endorsing the concept of appropriate medical direction of all prehospital emergency medical services. (2) The following factors should be considered by prehospital personnel in making the decision either to provide extended care in the field or to evacuate the trauma victim rapidly: (a) the type, severity and anatomic location of the injury; (b) the proximity and capabilities of the receiving hospital; (c) the efficiency and skill of the paramedic team; and (d) the nature of the environment (e.g., rural or urban). (3) Because of the variability of these factors, no single methodology or standard can be applied to all accident situations. Trauma management differs markedly between locales, settings, and types of patients receiving care. For these reasons, physician supervision of prehospital services is essential to ensure that the critical decision to resuscitate in the field or to transfer the patient rapidly is made swiftly and correctly.

Reference
Whereas, The Centers for Disease Control and Prevention (CDC) has declared an opioid misuse epidemic in the United States; and

Whereas, The need for medical management and treatment of substance use disorders (SUD), including opioid misuse and alcohol misuse, far exceeds the current availability of Addiction Medicine specialty physicians; and

Whereas, On January 1, 2016, Medicaid began allowing physicians and non-physician practitioners providing medical management of SUD to use an Opioid Use Disorder code for relevant office visits, thus providing payment coverage for these services (known as Office-Based Opioid Treatment or OBOT); and

Whereas, Medicaid currently covers payment for naltrexone (Vivitrol, a monthly injectable medication) for the treatment of both Alcohol Use Disorder and Opioid Use Disorder; and

Whereas, Medicaid does not cover payments for office visits related to the medical management of other substance use disorders, including Alcohol Use Disorder; and

Whereas, Access to medical treatment for SUD for persons with Medicaid coverage is already very limited; and

Whereas, The limited payment coverage for medical management of SUD to OBOT serves as a deterrent to primary care physicians who might consider improving access by providing SUD services for their patients; and

Whereas, The appropriate billing and coding processes for medical management and treatment of SUD is unclear for both addiction medicine specialty physicians and primary care physicians, leading to poor payment coverage for these services, again limiting access; therefore be it

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

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

Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs H-185.974
Our AMA supports parity of coverage for mental illness, alcoholism, substance use, and eating disorders.

Advocating for Reform in Payment of Mental Health and Substance Use Disorder Services H-345.980
Our AMA advocates that funding levels for public sector mental health and substance use disorder services not be decreased in the face of governmental budgetary pressures, especially because private sector payment systems are not in place to provide accessibility and affordability for mental health and substance use disorder services to our citizens.
Res. 205, A-06 Modified: CMS Rep. 01, A-16

Substance Use and Substance Use Disorders D-95.984
Our AMA:
(1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders;
(2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and
(3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.
CSAPH Rep. 8, A-08

Fiscal Note: Modest – between $1,000 - $5,000
Received: 05/11/17
Whereas, Venous disorders of the leg constitute a large financial burden ($2.5-$3.5 billion annually for venous stasis ulcers alone\(^1\)) on the health care system and produce substantial morbidity rates; and

Whereas, Compression stockings have been shown to prevent deep vein thrombosis, to reduce symptoms of various venous disorders including varicose veins and phlebitis, and to prevent venous stasis ulcers\(^2\); and

Whereas, Medicare currently covers compression stockings only when open venous stasis ulcers are already present\(^3\); and

Whereas, The over-the-counter cost of gradient compression stockings can be up to or exceeding sixty-five dollars; and

Whereas, Patient non-compliance with compression stockings for chronic venous disease may be as high as 63 percent due to factors such as cost and difficulty or lack of knowledge of how to apply the stockings\(^4\); and

Whereas, Existing research suggests patient compliance with compression stocking therapy increases when physicians offer education regarding venous disease and the use of compression stockings\(^5\); and

Whereas, Michigan Medicaid currently covers compression stockings, if deemed medically necessary by a physician for lymphedema, chronic venous insufficiency, thrombophlebitis, burns or post-surgical care\(^6\); therefore be it

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

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17

RELEVANT AMA POLICY

Appropriateness of National Coverage Decisions D-330.918
1. Our AMA will work with the national medical specialty societies and the Centers for Medicare
   and Medicaid Services (CMS) and their intermediaries to identify outdated coverage decisions
   that create obstacles to clinically appropriate patient care.
2. Our AMA will work with CMS to suspend recovery actions for technologies and treatments for
   which sufficient comparative effectiveness research or other quality evidence exists to update a
   National Coverage Determination (NCD) or Local Coverage Determination (LCD) to reflect the
   available scientific evidence and contemporary practice.
Sub. Res. 120, A-11 Reaffirmed in lieu of Res. 125, A-12
Whereas, Balance billing occurs when an out-of-network physician bills a patient for the outstanding balance of the entire charge after the insurance company submits its portion of the bill; and

Whereas, Median physician charges have been recently reported to vary greatly across the nation and average 2.5 times higher than what Medicare pays (JAMA;317(3):315-317); and

Whereas, Nearly 7 in 10 of individuals with unaffordable out-of-network medical bills did not know the health care provider was not in their plan’s network at the time they received care; and

Whereas, The ACA requires health plans to provide coverage for out-of-network emergency care services and apply in-network levels of cost sharing for emergency services, even if the plan otherwise provides no out-of-network coverage; and

Whereas, CMS has issued rules to begin to address surprise medical bills for non-emergency services for individuals covered by qualified health plans offered through the Health Insurance Marketplace; and

Whereas, The National Association of Insurance Commissioners has proposed changes to its health plan network adequacy model act to address surprise medical bills; and

Whereas, Most states are either contemplating or have passed balance billing limits or mandatory dispute resolution processes between payers and providers in balance billing cases; therefore be it

RESOLVED, That our American Medical Association report on the status of the various current efforts across the country, including the many state legislative efforts, to limit non-Medicare balance billing (Directive to Take Action); and be it further

RESOLVED, That our AMA develop model state legislation to assist its component members in their advocacy efforts against current efforts to regulate balance billing (Directive to Take Action); and be it further

RESOLVED, That the Board of Trustees report back to the House of Delegates at the 2017 Interim Meeting according to AMA Policy D-380.996. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 04/25/17
RELEVANT AMA POLICY

Balance Billing for All Physicians D-380.996
1. Our AMA will devote the necessary political and financial resources to introduce national legislation at the appropriate time to bring about implementation of Medicare balance billing and to introduce legislation to end the budget neutral restrictions inherent in the current Medicare physician payment structure that interferes with patient access to care.
2. This national legislation will be designed to pre-empt state laws that prohibit balance billing and prohibit inappropriate inclusion of balance billing bans in insurance-physician contracts.
3. Our AMA will develop model language for physicians to incorporate into any insurance contracts that attempt to restrict a physician's right to balance bill any insured patient.
4. Our AMA Board of Trustees will report back to our AMA House of Delegates electronically by March 15, 2008 and at every HOD meeting its progress toward the completion of all of these goals.
Res. 925, I-07

Medicare Balance Billing D-390.985
Our AMA will work on behalf of physicians to regain the right to balance bill Medicare patients for the full reasonable fees as they determine appropriate.

Medicare Balance Billing D-390.986
Our American Medical Association: (1) advocate that physicians be allowed to balance bill Medicare recipients to the full amount of their normal charge with the patient responsible for the difference between the Medicare payment and the physician charges; (2) seek introduction of national legislation to bring about implementation of balance billing of Medicare recipients; and (3) further advocate that such federal laws and regulations pre-empt state laws that prohibit balance billing.

Balance Billing H-385.991
Our AMA supports the right of the physician to balance bill a patient for any care given, regardless of method of payment, where permissible by law or contractual agreement.
Whereas, The Protecting Access to Medicare Act (PAMA) of 2014 (P.L. 113-93) requires clinicians to consult Appropriate Use Criteria (AUC) prior to ordering certain advanced diagnostic imaging services; and

Whereas, The RAND evaluated the Medicare appropriate use criteria (AUC) imaging demonstration conducted by the Centers for Medicare and Medicaid Services (CMS) from October 2011 through September 2013 and found a large proportion of orders could not be linked to any criteria when providers entered patient characteristics into Clinical Decision Support Mechanisms (CDSMs);\(^1\) and

Whereas, The RAND recommended against expanding the use of AUC for imaging services to a broader population of Medicare beneficiaries;\(^2\) and

Whereas, The Government Accountability Office (GAO) identified several issues that are key to the effective implementation of the imaging AUC program or any future expansion of the program, including, but not limited to, designing CDSMs for ease of use; ensuring provider confidence in appropriateness ratings and their underlying evidence; and allowing sufficient preparation time for implementation,\(^3\) and

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\(^{2}\) Id.

Whereas, The GAO reported that providers who participated in the AUC imaging demonstration noted that all phases of the demonstration were too short to address the large number of challenges related to successfully engaging providers and staff, aligning existing and new workflow patterns, and introducing providers and staff to the CDSM software and guidelines. The GAO furthermore reported that efforts to move forward rapidly during the demonstration were confounded by CDSM software challenges beyond the control of participants and their practices.\(^4\) and

Whereas, CMS has stated that qualification of CDSMs before June 30, 2017 is not feasible\(^5\); and

Whereas, CMS has stated that it expects to implement the AUC consultation and reporting requirements under section 1834(q)(4)(A) and (B) of the PAMA on January 1, 2018\(^6\), allowing six months for clinicians to acquire and implement in their practices a CDSM; and

Whereas, Section 1834(q)(1)(C) of PAMA defines the applicable imaging services for which AUC consultation is required as those for which there is at least one free mechanism available for AUC consultation; and

Whereas, CMS recognizes it is more likely that CDSMs available free of charge may initially begin as web-based tools\(^7\); and

Whereas, The GAO notes that in the AUC imaging demonstration, providers using web-based or stand-alone software applications experienced frustration with the lack of integration between the CDSM and their electronic health record (EHR) system and experienced workflow inefficiencies\(^8\); and

Whereas, The acquisition and implementation of a CDSM that integrates with the clinician’s EHR system may be cost prohibitive or hampered by EHR vendor readiness, thereby increasing administrative burden on clinicians who must use a free web-based tool to consult AUC; and

Whereas, CMS has acknowledged the number of clinicians affected by the program is “massive,” crossing almost every medical specialty and having a particular impact on primary care physicians since their scope of practice can be vast\(^9\); and

Whereas, The PAMA directs CMS to require, beginning Jan. 1, 2020, prior authorization for ordering professionals who are identified as outliers in AUC adherence; and

Whereas, Prior authorization for advanced imaging services is a contradiction to established AMA policy against the use of prior authorization in other parts of the Medicare program\(^10\); and

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\(^5\) Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule. CMS-1654-F. Federal Register/Vol. 81, No. 220; pg. 80419

\(^6\) Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule. CMS-1654-F. Federal Register/Vol. 81, No. 220; pg. 80419; pg. 80425

\(^7\) Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule. CMS-1654-F. Federal Register/Vol. 81, No. 220; pg. 80425.


\(^9\) Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule. CMS-1654-F. Federal Register/Vol. 81, No. 220; pg. 80424

Whereas, The Medicare AUC Program is expected to be implemented in 2018 during the continued transition to the new Quality Payment Program, which requires significant clinician practice resources; and

Whereas, The AUC Program is an independent, stand-alone program that is largely unnecessary since AUC consultation is inherent within the Merit-Based Incentive Payment System and alternative payment models, both which hold clinicians accountable for quality and patient outcomes, as well as for resource use, including the use of diagnostic tests and procedures; and

Whereas, The Medicare AUC Program lacks a patient outcomes or quality component; therefore be it

RESOLVED, That our American Medical Association advocate to delay the effective date of the Medicare AUC Program until the Centers for Medicare & Medicaid can adequately assess how the Quality Payment Program affects the use of advanced diagnostic imaging (Directive to Take Action); and be it further

RESOLVED, That our AMA call upon Congress and the Administration to revisit the necessity and value of the Medicare AUC Program given the establishment of the Quality Payment Program. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/09/17

RELEVANT AMA POLICY

Restoring High Quality Care to the Medicare Part D Prescription Drug Program D-330.933

Our AMA will:

a. work to eliminate prior authorizations under the Medicare Part D Prescription Drug Program which undermine a physician’s best medical judgment;
b. work with the Centers for Medicare and Medicaid Services (CMS) to enforce the Medicare Part D Prescription Drug Program statutory requirement that all Part D plans include at least two drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients;
c. work with CMS to place reasonable copays in the Medicare Part D Prescription Drug Program;
d. work with other interested parties to simplify the CMS prior authorization process such that a diagnosis or reason written on the prescription should be accepted as documentation for non formulary request; and

e. work with CMS to develop a one-page form for physicians and patients to utilize in appealing a prescription coverage denial.

Res. 106, A-07 Reaffirmation A-08 Reaffirmation A-14
Whereas, To submit a claim for a minor procedure, defined as requiring less than five minutes, the Centers for Medicare and Medicaid Services (CMS) requires the supervising physician to be present in the room for the entire procedure when performed by a resident; and
Whereas, For longer, major procedures, CMS requires the supervising physician to be present only for key portions of the procedure, not the entire procedure; and
Whereas, The Accreditation Council for Graduate Medical Education Common Program Requirements call for graduated supervision of residents with progressive authority and responsibility and conditional independence in order to ensure that resident supervision is optimized to provide both high quality patient care and resident training; therefore be it

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

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17

RELEVANT AMA POLICY

Payments to Physicians in Teaching Setting by Medicare Fiscal Intermediaries H-390.999
When a physician assumes responsibility for the services rendered to a patient by a resident or an intern, the physician may ethically bill the patient for services which were performed under the physician’s personal observation, direction, and supervision.


CMS Documentation Guidelines for Teaching Physicians H-315.982
The AMA will work with the CMS to: (1) reduce the redundant and burdensome documentation for teaching physicians; (2) accept documentation by the physician team under the supervision of a teaching physician if it collectively meets all CMS documentation requirements; and (3) accept a statement of the teaching physician's level of participation in patient care as sufficient or adequate documentation.


1 CMS Manual System. Pub 100-04 Medicare Claims Processing. Transmittal 2303. 100.1.2 Surgical Procedures
2 ACGME Common Program Requirements. VI. D. Supervision of Residents, http://www.acgme.org/Portals/0/PPAssets/ProgramRequirements/CPRs_07012016.pdf
Whereas, Naloxone is an opioid antagonist available as a reversal agent for opioid overdoses\(^1\); and

Whereas, States have worked extremely hard to increase access to naloxone by passing legislation in 40 states that offer clinicians various levels of immunity from criminal or civil prosecution for third-party prescriptions; and

Whereas, In 42 states, criminal or civil immunity is granted to bystanders who possess or use illegal drugs when they provide emergency services to someone who has overdosed, including administering naloxone or calling emergency responders\(^2\); and

Whereas, 40 states have passed legislation allowing access to naloxone via standing prescription orders at pharmacies, pharmacist prescription authority, or collaborative practice agreements\(^3\); and

Whereas, The price of naloxone products has increased significantly since 2009: Injectable or intranasal, 1 mg-per-milliliter vial (2 mL) manufactured by Amphastar increased from $20.34 (2009) to $39.60 (2016); 0.4 mg-per-milliliter vial (10 mL) manufactured by Hospira increased from $62.29 (2012) to $142.49 (2016); and the auto-injector, two-pack of single-use prefilled auto-injectors (Evzio) manufactured by Kaleo increased from $690.00 (2014) to $4,687.50 (2017)\(^4\); and

Whereas, Naloxone bulk purchasing programs -- modeled after federal government purchasing of vaccines -- could help reduce the price of naloxone for communities, as seen with the Massachusetts bulk purchasing program that reduced the price for both first-responders and municipalities; and

Whereas, Wisconsin, New York, and Ohio also have negotiated rebate programs with the pharmaceutical manufacturers\(^2,3,4\); and

Whereas, The US federal government could use federal law 28 U.S.C. section 1498, which permits contracts with manufacturers to produce cheaper generic formulations of patented products for federal use during public health emergencies, to negotiate for lower drug prices as done with ciprofloxacin during the 2001 anthrax threat\(^2,5\); and

\(^1\) https://www.samhsa.gov/medication-assisted-treatment/treatment/naloxone
\(^3\) http://www.sciencedirect.com/science/article/pii/S0749379700002105
\(^5\) http://content.healthaffairs.org/content/35/5/791.full
Whereas, Increased competition through introduction of generic options could lower drug prices and could be accomplished by incentivizing generic development with accelerated approval and waived fees or importing international generic drugs that meet US Food and Drug Administration (FDA) standards; and

Whereas, Making naloxone an over-the-counter drug (as discussed by the FDA previously) would attract additional manufacturers, due to easier FDA authorization, which could reduce prices; therefore be it

RESOLVED, That our American Medical Association amend existing AMA Policy, H-95.932, “Increasing Availability of Naloxone,” by addition and deletion as follows:

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

Fiscal Note: Minimal – less than $1,000

Received: 05/11/17

RELEVANT AMA POLICY

Study OTC Availability of Naloxone D-95.974
1. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.
2. Our AMA will study and report back at the 2016 Annual Meeting on ways to expand the access and use of naloxone to prevent opioid-related overdose deaths.
Res. 909, I-15

Increasing Availability of Naloxone H-95.932
1. Our AMA supports legislative and regulatory efforts that increase access to naloxone, including collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.
3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
BOT Rep. 22, A-16

See also:
Prevention of Opioid Overdose D-95.987

6 http://www.ajhp.org.proxy.lib.wayne.edu/content/72/17/1426.1.long
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 232
(A-17)

Introduced by: Michigan

Subject: Create MACRA Opt-Out Option

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

Whereas, The Centers for Medicare and Medicaid Services has instituted provisions of the Medicare Access and CHIP Reauthorization Act (MACRA) for quality payment for physicians; and

Whereas, MACRA by design will produce winners and losers with practices that could lose up to 9 percent in 2022; and

Whereas, Small practices do not have the infrastructure or the budget to spend on a complicated program such as MACRA; therefore be it

RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services to permit solo practitioners and small practices to opt-out of the Medicare Access and CHIP Reauthorization Act completely in order to protect their financial viability.

(Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17

RELEVANT AMA POLICY

MIPS and MACRA Exemption H-390.838
Our AMA will advocate for an exemption from the Merit-Based Incentive Payment System (MIPS) and Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for small practices.

Res. 208, I-16

1. Our AMA will urge the Centers for Medicare and Medicaid Services to protect access to care by significantly increasing the low volume threshold to expand the MACRA MIPS exemptions for small practices (on a voluntary basis), and to further reduce the MACRA requirements for ALL physicians’ practices to provide additional flexibility, reduce the reporting burdens and administrative hassles and costs.
2. Our AMA will advocate for additional exemptions or flexibilities for physicians who practice in health professional shortage areas.
3. Our AMA will determine if there are other fragile practices that are threatened by MACRA and seek additional exemptions or flexibilities for those practices.

Res. 243, A-16
Whereas, The physician assistant profession was originally created in the mid 1960’s to serve as a support role to physicians to help alleviate primary care shortages; and

Whereas, The physician assistant profession was designed to function under the direction of a duly qualified licensed physician; and

Whereas, Existing AMA Policy H-160.947, “Physician Assistants and Nurse Practitioners,” states that the extent of the involvement of a physician assistant in the assessment and implementation of treatment should be determined by the supervising physician; and

Whereas, Additional AMA Policy H-35.989, “Physician Assistants,” states that a physician assistant’s utilization should be approved by the medical licensing board; and

Whereas, Physicians are ultimately responsible for the scope of the physician assistant’s duties; and

Whereas, Physicians are licensed, regulated, and disciplined by state medical licensing and regulatory bodies; and

Whereas, Currently, the majority of states authorize medical licensing and regulatory bodies to license, regulate, and discipline physician assistants; therefore be it

RESOLVED, That our American Medical Association advocate in support of maintaining the authority of medical licensing and regulatory boards to regulate the practice of medicine through oversight of physicians, physician assistants and related medical personnel (New HOD Policy); and be it further

RESOLVED, That our AMA oppose legislative efforts to establish autonomous regulatory boards meant to license, regulate, and discipline physician assistants outside of the existing state medical licensing and regulatory bodies’ authority and purview. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000
Received: 05/11/17
RELEVANT AMA POLICY

Physician Assistants H-35.989
(1) The AMA opposes legislation to increase public funding for programs to train physician assistants and supports a careful reevaluation of the need for public funding at the time that present legislative authorities expire.
(2) A physician assistant should provide patient care services only in accord with the medical practice act and other applicable state law, and such law should provide that the physician assistant's utilization by a physician or group of physicians be approved by the medical licensing board. A licensed physician or group of physicians seeking to utilize a physician assistant should submit to the medical licensing board an application for utilization that identifies: the qualifications and experience of the physician assistant, the qualifications and experience of the supervising physician and a description of his or her practice, and a description of the manner and the health care settings in which the assistant will be utilized, and the arrangements for supervision by the responsible physician. Such an application should also specify the number of physician assistants that the physician or group of physicians plans to employ and supervise. A physician assistant should be authorized to provide patient care services only so long as the assistant is functioning under the direction and supervision of a physician or group of physicians whose application for utilization has been approved by the medical licensing board. State medical licensing boards, in their review of applications for utilization of a physician assistant, should take special care to insure that the proposed physician assistant functions not be of a type which: (a) would unreasonably expand the professional scope of practice of the supervising physician, (b) cannot be performed safely and effectively by the physician assistant, or (c) would authorize the unlicensed practice of medicine.
(3) The physician assistant should function under the direction of and supervision by a duly qualified licensed physician. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise that amount of control or supervision over a physician assistant which is appropriate for the maintenance of quality medical care and in accord with existing state law and the rules and regulations of the medical licensing authority. Such supervision in most settings includes the personal presence or participation of the physician. In certain instances, such as remote practice settings, where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, frequent site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times. The physician assistant may serve the patients of the supervising physician in all types of health care settings, including but not limited to: physician's office, ambulatory or outpatient facility, clinic, hospital, patient's home, long-term care facility or nursing home. The state medical licensing board should determine on an individual basis the number of physician assistants that a particular physician may supervise or a group of physicians may employ.
(4) While it is preferable and desirable that the physician assistant be employed by a physician or group of physicians so as to ensure appropriate physician supervision in the interests of the patient, where a physician assistant is employed by a hospital, the physician assistant must provide patient care services in accordance with the rules and procedures established by the organized medical staff for utilization of physician-employed physician assistants functioning in that institution, and under the direction and supervision of a designated physician who has been approved by the state medical licensing board to supervise that physician assistant in accordance with a specific utilization plan and who shall be directly responsible as the attending physician for the patient care services delegated to his physician assistant.
(5) The AMA opposes legislation or proposed regulations authorizing physician assistants to
make independent medical judgments as to the drug of choice for an individual patient.
(6) In view of an announced interest by HHS in considering national legislation which would
devise state regulatory systems for health manpower, the AMA recommends that present
Association policy supporting state prerogatives in this area be strongly reaffirmed.

Physician Assistants and Nurse Practitioners H-160.947
Our AMA will develop a plan to assist the state and local medical societies in identifying and
lobbying against laws that allow advanced practice nurses to provide medical care without the
supervision of a physician.
The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as
follows (these guidelines shall be used in their entirety):
(1) The physician is responsible for managing the health care of patients in all settings.
(2) Health care services delivered by physicians and physician assistants must be within the
scope of each practitioner's authorized practice, as defined by state law.
(3) The physician is ultimately responsible for coordinating and managing the care of patients
and, with the appropriate input of the physician assistant, ensuring the quality of health care
provided to patients.
(4) The physician is responsible for the supervision of the physician assistant in all settings.
(5) The role of the physician assistant in the delivery of care should be defined through mutually
agreed upon guidelines that are developed by the physician and the physician assistant and
based on the physician's delegatory style.
(6) The physician must be available for consultation with the physician assistant at all times,
either in person or through telecommunication systems or other means.
(7) The extent of the involvement by the physician assistant in the assessment and
implementation of treatment will depend on the complexity and acuity of the patient's condition
and the training, experience, and preparation of the physician assistant, as adjudged by the
physician.
(8) Patients should be made clearly aware at all times whether they are being cared for by a
physician or a physician assistant.
(9) The physician and physician assistant together should review all delegated patient services
on a regular basis, as well as the mutually agreed upon guidelines for practice.
(10) The physician is responsible for clarifying and familiarizing the physician assistant with
his/her supervising methods and style of delegating patient care.
BOT Rep. 6, A-95 Reaffirmed: Res 240 and Reaffirmation A-00 Reaffirmed: Res. 213, A-02
I-12 Reaffirmed: BOT Rep. 16, A-13
Whereas, The Preserving Employee Wellness Programs Act1 (H.R.1313) has been introduced in the 115th Congress; and

Whereas, The legislation would reward employees who voluntarily provide personal and family genetic information to their employers as part of workplace wellness programs by offering discounts on insurance premiums and other financial incentives; and

Whereas, Provisions of this legislation explicitly remove privacy protections of the Genetic Information Nondiscrimination Act of 2008 (GINA) and the Americans with Disabilities Act of 1990 (ADA) for genetic tests conducted as part of voluntary workplace wellness programs; and

Whereas, Employees who refuse to provide their personal genetic and health information or that of their family members will face higher costs for employer-sponsored health insurance than those who do provide this information; and

Whereas, If enacted, the Preserving Employee Wellness Programs Act would undermine existing protections for privacy and introduce unnecessary ethical dilemmas into the employer-employee relationship; therefore be it

RESOLVED, That our American Medical Association actively oppose the Preserving Employee Wellness Programs Act (Directive to Take Action); and be it further

RESOLVED, That our AMA support efforts to preserve nondiscrimination protections established by the Genetic Information Nondiscrimination Act and the Americans with Disabilities Act. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17

RELEVANT AMA POLICY

Genetic Discrimination and the Genetic Information Nondiscrimination Act H-65.969
Our AMA: (1) strongly opposes discrimination based on an individual's genetic information; (2) will pursue and support legislation intended to provide robust and comprehensive protections against genetic discrimination and misuse of genetic information; and (3) supports education for health care providers and patients on the protections against genetic discrimination currently afforded by federal and state laws. CSAPH Rep. 7, A-13

Patient Privacy and Confidentiality H-315.983

1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; and (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure. 2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law. 3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure. 4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review. 5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use. 6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained. 7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual. 8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end. 9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures. 10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the overriding good of accountability provided by an IRB. 11. Marketing and commercial uses of identifiers and identifiable information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures. 12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients" medical records, (b) The establishment of rules to prevent fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of patients' medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights. 13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned. 14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance. 15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or other provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands. 16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine. 17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing. 18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes. 19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls. 20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes. BOT Rep. 9, A-98 Reaffirmation I-98

Whereas, A strategic goal of our AMA is improving patient outcomes; and

Whereas, The Employee Retirement Income Security Act (ERISA), a comprehensive federal statute enacted in 1974 to ensure the fiscal integrity of pension plans, applies to health benefit plans as well; and

Whereas, ERISA became a pivotal piece of legislation because, to a large extent, it prevented states from regulating the activities of employee health benefit plans; and

Whereas, Empirical research has found a correlation between higher payer denial rates and profits; and

Whereas, In today’s health care delivery climate, the decision by a health plan not to cover a particular service generally means that the patient will not receive the service; adverse effects on the patient’s health may result (as noted by the Supreme Court in Pegram v Herdrich; and

Whereas, The ERISA preemption against state laws that “relate to” employee benefit plans has elicited a large volume of litigation, and 10 states have enacted laws attempting to enhance the ability of enrollees to sue health plans in state courts, but the U.S. Supreme Court has ruled that negligence claims against employer-sponsored health plans are preempted by ERISA; and

Whereas, Compensation in cases filed under ERISA is limited to that available under contract law (compensation equal to the value of the services required in the contract). Thus, even though enrollees may suffer serious medical consequences as a result of the actions of their health plans, they may sue only for the value of the services withheld or delayed; and

Whereas, Justice Ruth Bader Ginsburg, in her concurring opinion, suggested that congressional action amending ERISA may be the only mechanism available to provide patients with adequate compensation for damages incurred as a result of coverage decisions made by employer-sponsored health plans, and Justice Ginsburg and Justice Breyer characterized the current ERISA preemption regimes in the field of health care as unjust and tangled; and

Whereas, Additionally, Justice Ginsburg acknowledges that the Supreme Court has joined together “an encompassing interpretation of ERISA’s preemptive force with a cramped construction of the ‘equitable relief allowable under [section] 502(a)(3),’ to create a "regulatory vacuum" that in effect denies ERISA plan beneficiaries any tort damages against HMOs for medical malpractice; and
Whereas, The Supreme Court has afforded to managed care plans that cover enrollees through an employee benefit plan a type of immunity that will do little to deter these providers from disapproving requests to cover necessary but expensive health care services; and

Whereas, ERISA is a complicated area of the law that throws up many hurdles that stand between employees (and their attorneys) and their insurance benefits if the insurance coverage is provided as an employee benefit; and

Whereas, ERISA limits the remedy of a claim in a benefits case to the benefits that should have been paid under the plan, plus maybe attorneys’ fees, but precludes other state law remedies, such as claims for bad faith failure to pay an insurance claim, or fraud, and ERISA precludes punitive damages or other state law remedies; and

Whereas, ERISA limits discovery, limits damages to the amount due under the plan (plus possibly attorneys’ fees), often allows the insurer a deferential standard of review, limits evidence to that information that was provided during the administrative appeals process, does not allow for jury trials, and usually involves litigating in federal court; and

Whereas, Plaintiffs’ attorneys often avoid ERISA cases; and

Whereas, Payors have little incentive to comply with the regulations by accurately processing and properly approving claims in the first place by virtue of minimal to no penalties even if found at fault in federal court; and

Whereas, Proponents of ERISA in 1974 had little inkling that this law would become a major factor in shaping the US health care delivery system, since employer-sponsored health plans were a much smaller percentage of the health care system at the time; and

Whereas, Many attempts have been made to overturn ERISA preemption over many years without substantial success, and our AMA has policy supporting objections to this law (see policies listed below); and

Whereas, Legal scholars such as L. Darnell Weeden, B.A., J.D. have concluded: “Congress should adopt a Patients’ Bill of Rights (PBR) Law to wipe out the vast regulatory vacuum created by ERISA’s conflict and complete preemption rationales that leave patients without any adequate legal remedy when an HMO’s conduct is proximate. It is my sincere hope that one day Congress will enact meaningful PBR legislation to protect all Americans from the bottom-line oriented eligibility and treatment decisions made by big business HMOs and other greedy corporate actors in the managed care industry”; and

Whereas, The current constitution of the Executive and Legislative branches has opened a significant opportunity for change in the existing healthcare system; therefore be it

RESOLVED, That our American Medical Association renew active advocacy for Executive and Congressional action to amend the Employee Retirement Income Security Act (ERISA) to eliminate the state preemption clause and provide patients with a less restrictive and/or less burdensome process to seek adequate redress or compensation for damages incurred as a result of coverage decisions made by employer-sponsored health plans (Directive to Take Action); and be it further

(Reaffirm HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17

References
1 Fred J. Hellinger, PhD and Gary J. Young, PhD, JD; Am J Public Health. 2005 February; 95(2): 217–223. Health Plan Liability and ERISA: The Expanding Scope of State Legislation
4 Eric Buchanan & Associates, PLLC. Website: How to Tell if an Insurance Claim is Preempted by ERISA

RELEVANT AMA POLICY

Establishment of Liability of Managed Care Organizations H-285.945

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


AMA Policy on ERISA H-285.915

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

2. Our AMA will continue to advocate for the elimination of ERISA preemption of self insured health plans from state insurance laws consistent with current AMA policy.

ERISA Preemption and State Prompt Pay Laws D-385.984
(1) Our AMA continue to actively work with constituent societies to advocate for strong prompt payment laws, as well as full enforcement and implementation of those laws.
(2) Our AMA Advocacy Resource Center disseminate information to the Federation regarding the issue of Employee Retirement Income Security Act preemption and state prompt pay laws, including specific guidance for drafting legislation to best avoid preemption.
(3) Our AMA continue to seek legal avenues for advancing the case against ERISA preemption of state prompt pay laws.
(4) Our AMA monitor developments with regard to implementation of the U.S. Department of Labor claims processing regulation and provide information to the federation on any significant developments.

ERISA Plans and the United States Department of Labor D-385.973
1. Our AMA will seek federal legislation that would modify Employee Retirement Income Security Act law to incorporate a clause that addresses timely payment of medical claims of health care practitioners who provide treatment in good faith to the members of self-funded group employer-sponsored health plans.
2. When the federal law is amended, our AMA will work with the United States Department of Labor to devise and implement a formalized appeal process at the United States Department of Labor.
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 236
(A-17)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Retail Price of Drugs Displayed in Direct-to-Consumer Pharmaceutical Advertising

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

Whereas, Direct-to-consumer advertising of prescription pharmaceuticals is designed to cause patients to pressure physicians to prescribe certain medications\(^1\); and

Whereas, Prescription rates of those medications advertised directly to consumers have increased by 34.2% compared to a 5.1% increase in other pharmaceuticals\(^2\); and

Whereas, Direct-to-consumer advertising of prescription pharmaceuticals was illegal in the United States until 1997 and is currently legal in only one other country, New Zealand\(^3\); and

Whereas, Prescription pharmaceuticals cost more in the United States than they do in any other country\(^4\); and

Whereas, Prescription pharmaceuticals that are advertised directly to consumers tend to be the newer and more expensive ones in their classes\(^5\), such as Humira and Enbrel—each of which cost more than $4,000 per month\(^6\); and

Whereas, Efforts to ban direct-to-consumer advertising of prescription pharmaceuticals have thus far been unsuccessful\(^7\); and

Whereas, In a free enterprise system such as we have in the United States, the purchasing public should be educated; therefore be it

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

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17

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\(^3\) Lee VC. Direct-to consumer pharmaceutical advertising: therapeutic or toxic? *Pharmacy and Therapeutics*. 2011; 36(10): 669.


\(^5\) Russell J. Do drug ads help patients or lead to expensive treatments? *Chicago Tribune*. September 4, 2016.


\(^7\) AMA calls for ban on direct to consumer advertising of prescription drugs and medical devices. *AMA Newsroom*. November 17, 2015.
Whereas, A student who was gang-raped at the University of Oregon sued the university and due to loopholes in the Family Educational Rights and Privacy Act (FERPA), the university was able to access the student's treatment records from the student's counseling sessions to use against her in court, and

Whereas, These privacy loopholes in FERPA have led to 1) students being reluctant to utilize their campus health or counseling services and 2) students receiving advice from legal experts advising them not to utilize their campus health or counseling services precisely because of these privacy loopholes in FERPA, and

Whereas, The Standards for Privacy of Individually Identifiable Health Information of HIPAA do not apply to Protected Health Information (PHI) that is considered part of a student's education record, and

Whereas PHI that is considered part of a student's education record is subject to FERPA unless more rigorous state regulations apply, and

Whereas, FERPA defines education records as records that are 1) directly related to a student and 2) maintained by an educational institution or by a party acting for the institution, and

Whereas, FERPA defines treatment records as records that are made or maintained by a health care clinician employed or contracted by the educational institution and are only shared with other clinicians, and

Whereas, Under normal circumstances, treatment records are excluded from the definition of education records under FERPA and thus have additional privacy protections that education records do not have, and

Whereas, If treatment records are disclosed under one of the exceptions to written consent under 34 CFR §99.31, including when legal action is initiated by either the student or the educational institution, these additional privacy protections no longer apply and an educational institution may disclose a student's treatment records without a court order or subpoena, and

Whereas, The Department of Education has determined that educational institutions may disclose educational records to courts without a court order or consent from the parents or student; and
Whereas, Medical privacy is typically only breached when the patient sues a health care professional for malpractice in order to determine if the standard of care was met, and in such cases, the request to breach privacy would require either the patient to give written consent or the judge to issue a subpoena, as well as allowing the patient the opportunity to object to the request for a subpoena or to request that the court look at the private medical records in secret in the judge's chambers to determine which medical records are relevant; and

Whereas, The Supreme Court of the United States has ruled that psychotherapist-patient privilege exists within the Federal Rules of Evidence because "the mere possibility of disclosure may impede the confidential relationship necessary for successful treatment"; and

Whereas, The policies of both the American Counseling Association and the American Psychological Association state that a therapist's records may only be disclosed under a court order; therefore be it

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

Fiscal Note: Modest – between $1,000 – $5,000

Received: 05/11/17

9 M.G.L. ch.71, § 34H
16 603 CMR 23.00
Whereas, The legislative purpose establishing the National Practitioner Data Bank (NPDB) was to create a record of physicians whose treatment resulted in harm, but there are no empirical studies that demonstrate the NPDB produced any impact on the quality of patient care; and

Whereas, The regulations and NPDB Guidebook of reportable events now expands beyond the goal and intended purpose of the legislation to include reports by hospitals and other entities of physicians for reasons not related to patient care and who remain competent; and

Whereas, A chief purpose of the Health Care Quality Improvement Act was to protect patients from physicians prone to giving subpar healthcare services and to report on physicians and providers found to harm the public during the delivery of patient care or “health care services”. See 42 U.S.C. § 11101; and

Whereas, Hospitals improperly report on physician applicants to medical staff for reasons not related to patient care, but rather for administrative or eligibility reasons unrelated to professional performance; and

Whereas, Reports to the NPDB damage reputations, negatively affect hospital privileges and future employment opportunities and deprive wrongfully reported physicians of liberty and property interests without due process; therefore be it

RESOLVED, That our American Medical Association formally request that the Health Resources and Services Administration (HRSA) clarify that reports of medical staff appointment denial by physicians are contingent upon competency issues related to physicians’ provision of or failure to provide healthcare services that result in patient harm (Directive to Take Action); and be it further

RESOLVED, That our AMA formally petition the Secretary of HHS to direct the HRSA to remove the name of any physician from the National Practitioner Data Bank reported for reasons not related to patient care that resulted in patient harm. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17
Whereas, Despite efforts to educate patients and physicians on the topic of protected health information (PHI), some physicians and patients still choose to text PHI to each other during the course of medical care in violation of HIPAA privacy and security regulations; and

Whereas, Smartphone apps and encrypted email accounts, while meeting the HIPAA definition of safe communication, are too cumbersome, complicated, and expensive for the transfer of PHI; and

Whereas, Technological advances in areas such as two-step authentication, secured Wi-Fi, and business associate agreements with cloud businesses have substantially closed the gaps between current smartphone text communication platforms and the definition of HIPAA secured communications; and

Whereas, The AMA has a long-established history of advocacy in many areas of medicine, including technological infrastructure issues such as the development of the HCFA 1500 form; therefore be it

RESOLVED, That our American Medical Association collaborate with medical technology companies and the federal government to improve texting platforms so that more commercially available devices comply with HIPAA without having to utilize expensive and complex encryption technology (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the relaxation of HIPAA rules regulating the use of commercially available devices to transfer protected health information. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17
Whereas, The interstate sale of health insurance across state lines is being discussed at the federal level as it applies to replacing the Affordable Care Act; and

Whereas, The Affordable Care Act provides for the sale of health insurance across state lines if states form interstate compacts; and

Whereas, State legislatures and insurance departments may not have consensus on how they want domiciled insurance companies to be regulated; and

Whereas, States have different laws regarding health insurance mandated health benefits, prompt pay guidelines for claims, financial protections, and network adequacy rules to name a few; therefore be it

RESOLVED, That our American Medical Association advocate for the establishment of minimum federal standards on the interstate sale of health insurance, consistent with existing AMA policy (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that minimum federal standards should not weaken any states’ requirements on network adequacy, tort, financial protections, and other relevant insurance plan regulations. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17

RELEVANT AMA POLICY

Health Insurance Exchange Authority and Operation H-165.839
1. Our American Medical Association adopts the following principles for the operation of health insurance exchanges:

A) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features.

B) Any benefits standards implemented for plans participating in the exchange and/or to determine minimum creditable coverage for an individual mandate should be designed with input from patients and actively practicing physicians.

C) Physician and patient decisions should drive the treatment of individual patients.

D) Actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options.

E) Regulations addressing physician participation in public, private or non-profit health insurance options in the exchange that impact physician practice should ensure reasonable implementation timeframes, with adequate
support available to assist physicians with the implementation process.

F) Any necessary federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices.

2. Our AMA: (A) supports using the open marketplace model for any health insurance exchange, with strong patient and physician protections in place, to increase competition and maximize patient choice of health plans, (B) will advocate for the inclusion of actively practicing physicians and patients in health insurance exchange governing structures and against the categorical exclusion of physicians based on conflict of interest provisions; (C) supports the involvement of state medical associations in the legislative and regulatory processes concerning state health insurance exchanges; and (D) will advocate that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information.


Comprehensive Health System Reform H-165.841
Our AMA supports the overall goal of ensuring that every American has access to affordable high quality health care coverage and will work with interested members of Congress to seek legislation consistent with AMA policy.
Sub. Res. 924, I-07 Reaffirmed: Res. 239, A-12

Educating the American People About Health System Reform H-165.844
Our AMA reaffirms support of pluralism, freedom of enterprise and strong opposition to a single payer system. Res. 717, I-07 Reaffirmation A-09

Adequacy of Health Insurance Coverage Options H-165.846
1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options:
   A. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose.
   B. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage.
   C. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations.
   D. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services.

2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children.

Comprehensive Health System Reform H-165.847
1. Comprehensive health system reform, which achieves access to quality health care for all Americans while improving the physician practice environment, is of the highest priority for our AMA.
2. Our AMA recognizes that as our health care delivery system evolves, direct and meaningful physician input is essential and must be present at every level of debate.
Res. 613, A-06 Reaffirmation I-07 Res. 107, A-08

Whereas, The recent Immigration Executive Order temporarily banning immigration from six countries has created chaos, fear and uncertainty among physicians and their patients; and

Whereas, This threatens the free exchange of medical ideas, experience and perspectives; and

Whereas, International Medical Graduates have a crucial impact on internal medicine, making up more than 50 percent of the residency slots in 2016, filling gaps through care provided to underserved residents and veterans and serving as faculty in top internal medicine programs across the US; and

Whereas, Twenty-four percent of all practicing physicians in the US in 2015 were international medical graduates; and

Whereas, Restrictions on immigration for physicians would adversely affect patient care in the US for years to come; and

Whereas, Over the past 50 years, the US biomedical research enterprise has benefited greatly from the ideas, creativity, ingenuity and drive of international medical graduates and other non-US nationals engaged in biomedical research; and

Whereas, An immigration policy that blocks the best and brightest from coming to work and train in the United States and blocks our trainees, physicians and faculty from traveling to other countries is a step backward that will harm our patients, our colleagues, and America’s position as a world leader in health care and innovation; therefore be it

RESOLVED, That our American Medical Association lobby the US Congress and other appropriate US government officials to exempt physicians from any current or future ban or suspension impacting immigration or the issuance of a J1 Visa or H1-B Visa. (Directive to Take Action)

The topic of this resolution is currently under study by the Council on Medical Education.

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17
RELEVANT AMA POLICY

Visa Complications for IMGs in GME D-255.991
1. Our AMA will: (A) work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice; (B) promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and (C) work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs’ inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

Conrad 30 - J-1 Visa Waivers D-255.985
1. Our AMA will: (A) lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program; (B) advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state; (C) advocate for expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages; (D) publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program; (E) advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage; (F) work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and (G) continue to communicate with the Conrad 30 administrators and IMGs members to share information and best practices in order to fully utilize and expand the Conrad 30 program.
2. Our AMA will continue to monitor legislation and provide support for improvements to the J-1 Visa Waiver program.
3. Our AMA will continue to promote its educational or other relevant resources to IMGs participating or considering participating in J-1 Visa waiver programs.
4. As a benefit of membership, our AMA will provide advice and information on Federation and other resources (but not legal opinions or representation), as appropriate to IMGs in matters pertaining to work-related abuses.
5. Our AMA encourages IMGs to consult with their state medical society and consider requesting that their state society ask for assistance by the AMA Litigation Center, if it meets the Litigation Center's established case selection criteria.


Whereas, There are no studies linking physician’s participation in the American Board of Medical Specialties (ABMS) Maintenance of Certification (MOC) product with a positive effect on the quality or cost of care; and

Whereas, Advertising medical products and processes directly to patients bypasses the critical filter of physicians who can help patients decipher complicated medical concepts; and

Whereas, There is no regulatory proof required for these direct-to-consumer advertising campaigns, making it difficult to refute these claims in the marketplace of ideas; and

Whereas, Existing AMA Policy H-105.988 opposes direct-to-consumer advertising of prescription drugs and implantable devices for the ethical concerns of misleading information and corporate interference with the doctor-patient relationship; and

Whereas, The American Board of Medical Specialties has launched a direct-to-consumer campaign at certificationmatters.org; and

Whereas, Subspecialty boards such as the American Board of Pediatrics are following suit with mycertifiedpediatrician.org; and

Whereas, These advertising campaigns contain misleading information linking quality care to the board certification product; and

Whereas, These advertising campaigns direct patients and families to search misleading databases that eliminate the names of physicians who have passed multiple board exams over decades, but choose not to participate in MOC; and

Whereas, These campaigns do not mention alternate certification boards where a physician may be certified; and

Whereas, These direct-to-consumer campaigns with misleading and incomplete information have potential to harm the physician-patient trust and relationship; therefore be it

RESOLVED, That our American Medical Association oppose direct-to-consumer marketing of the American Board of Medical Specialties Maintenance of Certification (MOC) product in the form of print media, social media, apps, and websites that specifically target patients and their families including but not limited to the promotion of false or misleading claims linking MOC participation with improved patient health outcomes and experiences where limited evidence exists (Directive to Take Action); and be it further
RESOLVED, That our AMA amend existing AMA Policy D-275.954, “Maintenance of Certification and Osteopathic Continuous Certification” by addition as follows:

36. Direct the ABMS to ensure that any publicly accessible information pertaining to maintenance of certification (MOC) available on ABMS and ABMS Member Boards’ websites or via promotional materials includes only statistically validated, evidence based, data linking MOC to patient health outcomes. (Modify Current HOD Policy)

Fiscal Note: Not yet determined

Received: 05/11/17

RELEVANT AMA POLICY

Maintenance of Certification H-275.924
AMA Principles on Maintenance of Certification (MOC)
1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant within the diplomate’s scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 CreditTM, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician’s Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. MOC should be used as a tool for continuous improvement.
15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing MOC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. MOC activities and measurement should be relevant to clinical practice.
19. The MOC process should not be cost prohibitive or present barriers to patient care.
20. Any assessment should be used to guide physicians’ self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.


Maintenance of Certification and Osteopathic Continuous Certification D-275.954
Our AMA will:
1. Continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC, and prepare a yearly report to the House of Delegates regarding the MOC and OCC process.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOC and OCC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of MOC, and encourage the ABMS to report its research findings on the issues surrounding certification and MOC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and MOC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of MOC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that MOC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that MOC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from MOC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting MOC and certifying examinations.
10. Encourage the ABMS to ensure that MOC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, particularly to ensure that MOC is specifically relevant to the physician’s current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for MOC; (b) support ABMS member board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet MOC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether MOC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from MOC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping MOC and OCC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and MOC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of MOC.
18. Encourage medical specialty societies’ leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant MOC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the MOC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the MOC process be required to participate in MOC.
22. Continue to participate in the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's MOC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the MOC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Maintenance of Certification.
28. Examine the activities that medical specialty organizations have underway to review alternative pathways for board recertification; and determine if there is a need to establish criteria and construct a tool to evaluate if alternative methods for board recertification are equivalent to established pathways.
29. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on maintenance of certification activities relevant to their practice.
30. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
31. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
32. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
33. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
34. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Maintenance of Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
35. Increase its efforts to work with the insurance industry to ensure that maintenance of certification does not become a requirement for insurance panel participation.

Whereas, Initial American Board of Medical Specialties (ABMS) board certification is a
credential of great accomplishment for many physicians; and

Whereas, Initial ABMS board certification is all that is required of time-unlimited or
“grandfathered” physicians; and

Whereas, Existing AMA Policy H-275.924, “Maintenance of Certification,” protects the status of
“grandfathered” physicians, stating “No qualifiers or restrictions should be placed on diplomates
with lifetime board certification recognized by the ABMS related to their participation in MOC;”
and

Whereas, The names of grandfathered physicians are available when verifying certification
status on ABMS credentialing websites, indicating the date of initial certification, regardless of
their participation in Maintenance of Certification (MOC); and

Whereas, Similar protections for physicians holding time-limited certificates do not exist; and

Whereas, The ABMS and ABMS member boards erase the name of time-limited physicians
when they choose not to participate in any of the four parts of MOC, regardless of how many
times the physician has passed his or her board examinations; and

Whereas, Under this punitive system that erases the name of time-limited physicians, the only
way for the public to verify initial certification is via formal inquiry and a fee; and

Whereas, This punitive system causes great harm to time-limited diplomates during professional
physician credentialing, when initial certification is not readily available; and

Whereas, This punitive system causes great harm to time-limited diplomates in terms of patient
trust under the current direct-to-consumer advertising campaigns directing patients and families
to “verify if your doctor is board certified,” when patients and families are not able to access
initial board certification status of time-limited diplomates; therefore be it
RESOLVED, That our American Medical Association amend the AMA Principles of Maintenance of Certification (MOC), AMA Policy H-275.924, "Maintenance of Certification," by addition as follows:

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

Fiscal Note: Minimal – less than $1,000

Received: 05/11/17

RELEVANT AMA POLICY

Maintenance of Certification H-275.924
AMA Principles on Maintenance of Certification (MOC)
1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 CreditTM, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise
the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.

11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.

12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.

13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.

14. MOC should be used as a tool for continuous improvement.

15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.

16. Actively practicing physicians should be well-represented on specialty boards developing MOC.

17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.

18. MOC activities and measurement should be relevant to clinical practice.

19. The MOC process should not be cost prohibitive or present barriers to patient care.

20. Any assessment should be used to guide physicians’ self-directed study.

21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.

22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.

23. Physicians with lifetime board certification should not be required to seek recertification.

24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.

25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

Whereas, Standardized patients are used throughout medical education to assess competency in communication, quality of care delivery, and for accreditation of residency programs, physician licensing and certification; and

Whereas, Medical students develop clinical, communication, and interpersonal skills through clinical scenarios with standardized patients of varied cultural and socioeconomic backgrounds; and

Whereas, The US Census Bureau’s 2014 National Projections state that the US is predicted to become more racially and ethnically diverse in the coming years, with the non-Hispanic White population comprising less than 50 percent by 2044; and

Whereas, Culture is defined as a pattern of integrated beliefs, values, behaviors, social practices of a group, including but not limited to groups characterized by race, ethnicity, gender, sexual orientation, religion, disability, etc.; and

Whereas, The Association of American Medical Colleges defined cultural competency as “a set of congruent behaviors, knowledge, attitudes, and policies that come together in a system, organization, or among professionals that enables effective work in cross-cultural situations”; and

Whereas, Cultural competency training is intended to help health care professionals avoid stereotyping, be aware of normative cultural values that can affect informed consent, and adapt more readily to cultural differences; and

Whereas, A systematic review of 34 studies have shown that cultural competency training improved the cultural knowledge, perspective, and skills of health professionals, with beneficial impacts on patient satisfaction; according to one study, families in the emergency room setting were two to three times more likely to report feeling comfortable with and respected by their physician; and

Whereas, Cultural competency training in medical education, as it is taught in the US, Canada, and the United Kingdom, is largely limited to incorporation in lectures, case studies, and mostly optional workshops; and

Whereas, Without application of cultural competency-related knowledge and skills in patient encounters during the pre-clinical years of medical school, students are more likely to perceive such training as more theoretical than useful; and
Whereas, Pilot programs in schools such as Wake Forest School of Medicine (WFSM) have shown that cultural competency can be built through immersion, allowing medical students to learn the health challenges of diverse populations through activities like community-based service learning, simulations, role-play, and demonstrations; afterwards, medical students in the WFSM pilot program reported up to two times more improvement in their knowledge, skills, and attitude with interacting with patients of different backgrounds; and

Whereas, Of those that participated in cultural competence programs in a community setting, medical students at the University of California-San Diego School of Medicine felt more prepared for their third-year clinical clerkships and beyond; and

Whereas, The standardized patient population that includes those with a diverse spectrum of intellectual and/or physical disabilities will better equip medical students to meet the unique medical needs of this patient population; and

Whereas, The American Medical Association supports efforts to continually integrate medical training with education regarding health disparities, social determinants, and cultural competencies, so that student doctors are well prepared to serve high quality and patient-centered care to all their future patients; and

Whereas, The Liaison Committee on Medical Education recognizes the necessity for cultural competence training in medical education and states, under Standard 7.6, that medical curriculum should provide opportunities for medical students to not only learn but also “appropriately address cultural biases in themselves and others, and in the process of health care delivery”; therefore be it

RESOLVED, That our American Medical Association amend existing AMA Policy H-295.897, “Enhancing the Cultural Competence of Physicians” by addition as follows:

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

Fiscal Note: Minimal – less than $1,000

Received: 05/11/17

RELEVANT AMA POLICY

Enhancing the Cultural Competence of Physicians H-295.897
1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.
2. Our AMA continues research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys and focus groups at regularly scheduled meetings.
3. Our AMA will form an expert national advisory panel (including representation from the AMA Minority Affairs Consortium and International Medical Graduate Section) to consult on all areas related to enhancing the cultural competence of physicians, including developing a list of
resources on cultural competencies for physicians and maintaining it and related resources in an electronic database.

4. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through development of an annotated resource database on the AMA home page, with information also available through postal distribution on diskette and/or CD-ROM.

5. Our AMA will seek external funding to develop a five-year program for promoting cultural competence in and through the education of physicians, including a critical review and comprehensive plan for action, in collaboration with the AMA Consortium on Minority Affairs and the medical associations that participate in the consortium (National Medical Association, National Hispanic Medical Association, and Association of American Indian Physicians,) the American Medical Women's Association, the American Public Health Association, the American Academy of Pediatrics, and other appropriate groups. The goal of the program would be to restructure the continuum of medical education and staff and faculty development programs to deliberately emphasize cultural competence as part of professional practice.

6. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health


11Beagan BL. Teaching social and cultural awareness to medical students:“It's all very nice to talk about it in theory, but ultimately it makes no difference”. Academic Medicine. 2003 Jun 1. 78(6): 605-14.


14Sopoaga F, Zaharic T, Kokaua J, Covello S. Training a medical workforce to meet the needs of diverse minority communities. BMC Medical Education. 2017. 17, 19.


20LCME® Functions and Structure of a Medical School Standards for Accreditation of Medical Education Programs Leading to the MD Degree. N.p.: Liaison Committee on Medical Education (LCME), Mar. 2016.
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 321
(A-17)

Introduced by: Minnesota

Subject: Continued Support of H-1B Visa Programs for International Medical Graduates

Referred to: Reference Committee C
(Kenneth M. Certa, MD, Chair)

Whereas, We are facing a looming shortage of physicians in this country, and international medical graduates provide access to physician care for thousands of people in rural and underserved communities; and

Whereas, The H-1B visa and the J-1 visa are the principal means by which international medical graduates train and/or work in the U.S.; and

Whereas, The H-1B visa program supports graduate medical education training for international medical graduates; and

Whereas, The H-1B visa requires an employer-employee relationship, and individuals granted H-1B visas are admitted for a period of up to three years, with an extension possible for up to six years; and

Whereas, The H-1B visa has an annual cap of 65,000 visas each fiscal year, with exemptions to the cap existing for (1) workers who are petitioned for or employed at an institution of higher education or its affiliated or related nonprofit entities or a nonprofit research organization, or a government research organization, and (2) the first 20,000 petitions filed on behalf of beneficiaries with a U.S. master’s degree or higher; and

Whereas, The Trump Administration stopped H-1B visa "premium processing" beginning April 3, 2017 for up to six months, a mechanism that cuts wait times for H-1B visas from a few months to as little as 15 days; and

Whereas, Many international medical graduates who are finishing their training in the U.S. and looking for positions in rural or urban underserved areas currently do not have the expedited premium processing option available to them, causing uncertainty with respect to their status in the U.S.; therefore be it

RESOLVED, That our American Medical Association urge the Trump Administration to immediately reinstate premium processing of H-1B visas for physicians to prevent any negative impact on patient care in underserved communities. (Directive to Take Action)

The topic of this resolution is currently under study by the Council on Medical Education.

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/09/17
Whereas, The American Board of Medical Specialties (ABMS) stated goal of Maintenance of Certification (MOC) in 2000 was to "implement a model for continuous professional development that would demonstrate to their peers and the public a commitment to lifelong learning and to staying current with medical knowledge."\(^1\); and

Whereas, There have been no well designed studies or scholarly articles that MOC has had any impact on professional development of physicians or increased confidence in physicians by the public; and

Whereas, The MOC process is costly with physicians spending approximately $2300 per physician over 10 years (varies by specialty), however, this pales in comparison to the time costs to do the MOC which is estimated at $21,000 over 10 years\(^2\); and

Whereas, MOC has not demonstrated an impact on continuous professional development or public confidence in physicians over the well-established continuing medical education system that has long existed and this low value activity is very costly; therefore be it

RESOLVED, That our American Medical Association oppose the requirement of Maintenance of Certification (MOC) as currently constituted in privileging and credentialing providers by health systems, hospitals, and payers (New HOD Policy); and be it further

RESOLVED, That our AMA call on the American Board of Medical Specialties to pursue ongoing meaningful continuing medical education as a pathway to MOC without the requirement for re-examination (Directive to Take Action); and be it further

RESOLVED, That our AMA reaffirm Policies H-275.924 and D-275.954, and report back at the 2017 Interim Meeting with an update on progress made to toward these policies. (Directive to Take Action)


RELEVANT AMA POLICY

Maintenance of Certification H-275.924
AMA Principles on Maintenance of Certification (MOC)
1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomat will be required to complete CME credits (AMA PRA Category 1 CreditTM, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. MOC should be used as a tool for continuous improvement.
15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing MOC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. MOC activities and measurement should be relevant to clinical practice.
19. The MOC process should not be cost prohibitive or present barriers to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.


Maintenance of Certification and Osteopathic Continuous Certification D-275.954

Our AMA will:
1. Continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC, and prepare a yearly report to the House of Delegates regarding the MOC and OCC process.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOC and OCC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of MOC, and encourage the ABMS to report its research findings on the issues surrounding certification and MOC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and MOC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of MOC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that MOC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that MOC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from MOC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting MOC and certifying examinations.
10. Encourage the ABMS to ensure that MOC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, particularly to ensure that MOC is specifically relevant to the physician’s current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for MOC; (b) support ABMS member board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet MOC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether MOC is an important factor in a physician’s decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from MOC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping MOC and OCC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and MOC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of MOC.
18. Encourage medical specialty societies’ leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant MOC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the MOC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the MOC process be required to participate in MOC.
22. Continue to participate in the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board’s MOC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the MOC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Maintenance of Certification.
28. Examine the activities that medical specialty organizations have underway to review alternative pathways for board recertification; and determine if there is a need to establish criteria and construct a tool to evaluate if alternative methods for board recertification are equivalent to established pathways.
29. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on maintenance of certification activities relevant to their practice.
30. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
31. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician’s practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
32. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
33. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
34. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Maintenance of Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
35. Increase its efforts to work with the insurance industry to ensure that maintenance of certification does not become a requirement for insurance panel participation.

Whereas, There is a national shortage of physicians, and the Association of American Medical Colleges projects the shortage will worsen. The shortage is projected to increase to a range of 7,300 to 43,100 for primary care physicians and 33,500 to 61,800 for physicians in specialty care by 2030; and

Whereas, U.S. medical school enrollments are projected to increase by 30 percent from 2002 to 2018; and

Whereas, Medicare remains the single largest funding source for residency training in the U.S.; and

Whereas, Hospitals that begin to sponsor residency training and become recognized as eligible for Medicare graduate medical education (GME) funding have a maximum of five years to establish all residency programs before the institution’s Medicare GME funding-cap is set. These caps are permanent in most cases; and

Whereas, New medical schools must establish GME programs in all six of the core clerkships to meet accreditation requirements, and this can be challenging to accomplish in underserved and economically depressed areas within five years. In these areas, the five-year Medicare GME cap-setting deadline is not feasible and exceptions to these deadlines should be available from the Centers for Medicare and Medicaid Services to allow medical schools sufficient time to identify qualified and willing teaching partners and establish new GME programs in underserved areas; therefore be it

RESOLVED, That our American Medical Association advocate to the Centers for Medicare & Medicaid Services for flexibility beyond the current maximum of five years for the Medicare graduate medical education cap-setting deadline for new residency programs in underserved areas and/or economically depressed areas. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17
RELEVANT AMA POLICY

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.


Proposed Revisions to AMA Policy on the Financing of Medical Education Programs H-305.929
H(I). New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.


Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy D-305.958
2. Our AMA will work with the Centers for Medicare and Medicaid Services to explore ways to increase graduate medical education slots to accommodate the need for more physicians in the US.
3. Our AMA will work actively and in collaboration with the Association of American Medical Colleges and other interested stakeholders to rescind funding caps for GME imposed by the Balanced Budget Act of 1997.
4. Our AMA will actively advocate for expanded funding for entry and continued training positions in specialties and geographic regions with documented medical workforce shortages.

Whereas, In 2004, food banks and pantries served over 960 million pounds of food to over 19 million food-insecure Americans; and

Whereas, By 2011, the total amount of food distributed skyrocketed to an excess of 2 billion pounds serving over 25 million food-insecure Americans\(^1,2\); and

Whereas, The US Department of Agriculture reported the percentage of food-insecure American households at 14.5 percent in 2012, 14.3 percent in 2013, and 14.0 percent in 2014\(^3,4,5\); and

Whereas, Food banks and pantries are increasingly shifting their focus from addressing emergent cases of food shortage towards serving chronic food insecurity as an increasing number of clients are coming to rely on food banks and pantries as their sole source of food\(^6,7,8,9\); and

Whereas, Food-insecure households tend to experience outstanding unmet health needs and inequities in access to healthcare services\(^10,11,12,13\); and

Whereas, 47.4 percent of food bank clients are uninsured in contrast to a national average uninsured rate of 13 percent; and

Whereas, 62.8 percent of clients had between one to eight unmet referral needs and 34.4 percent of clients had not seen a healthcare provider within the past 12 months\(^14,15\); and

Whereas, 37.9 percent of food bank clients either have prehypertension in contrast to an estimated national prevalence of 28 percent and 31.9 percent of food bank clients have hypertension in contrast to an estimated national prevalence of approximately 30 percent\(^14,15,16\); and

Whereas, The increasing number of Americans consistently utilizing food banks, pantries, and other emergency food distributors as their major food source highlights a need for transitioning from a system that emphasizes sufficient caloric intake to one that promotes satisfying daily nutritional needs\(^1,7,17\); and

Whereas, Food bank and pantry inventories are significantly impacted by cost-effectiveness considerations and consequentially, are pressed economically to stock food items that last longer and provide more meals which often also happen to be calorically rich and nutritionally poor\(^2,18\); and
Whereas, Food-insecure individuals often face great difficulty in meeting the Recommended Daily Allowances of certain vital nutrients and as a result, they are at significantly higher risk for nutritional deficits that are subsequently linked with immunosuppression, increased rates of infection, and altered cognition and mental performance²,⁸,¹⁵,¹⁷,¹⁹,²⁰,²¹,²²,²³; and

Whereas, Prior studies identified several barriers to healthy eating pervasive across underserved communities which include lack of knowledge on what to cook, absence of suitable ingredients, limited time, and exhaustion after work²⁴; and

Whereas, Food banks often lack sufficient staff trained in nutrition to advise and educate volunteers and clients alike on food selections that optimize both nutritional value and shopper satisfaction. In instances where proper nutritional guidance was provided, either through passive or active means, it yielded demonstrable value in helping clients better identify healthier food options⁹,²⁵; and

Whereas, Studies demonstrated food banks that proactively instituted interventions for chronic disease clients such as distributing diabetes-suitable foods, providing blood sugar monitoring, primary care referrals, and self-management resources saw improved glycemic control, increased nutrient-rich food intake, as well as enhanced self-efficacy¹⁸,²⁶; and

Whereas, Food banks are ideally positioned to positively impact the health of local community members through initiatives such as opting to reduce or cease distribution of nutrient-poor products, yet they are often stymied by obstacles including fear of reporting reduced total food distribution numbers, lack of existing structure to determine what foods to keep offering, and the potential for endangering their relationships with donors, community partners, and corporate entities²⁷; and

Whereas, The country’s food bank network, which has a significant presence in underserved communities, tends to serve the same clients repeatedly. As an entity that has privileged access to the procurement and distribution of food, it is poised to serve as society’s new health sentry for the underserved¹⁶; therefore be it

RESOLVED, That our American Medical Association advocate for programs that incentivize and provide resources for food banks and pantries to design and institute translatable nutrient-driven food distribution methodologies, initiatives that promote sustainable sourcing of healthier food options, and dissemination of user-friendly resources and education on healthier eating. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17

RELEVANT AMA POLICY

National Nutritional Guidelines for Food Banks and Pantries H-150.930
Our AMA supports of the use of existing national nutritional guidelines for food banks and food pantries.
Res. 413, A-14

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Whereas, Our AMA has no policy on family leave to care for newborns and infants; and

Whereas, Paid maternity and parental leave policies are consistently associated with improvements in child health in high-income countries1–5; and

Whereas, Increases in paid parental leave have been associated with lower infant mortality in 16 European countries3; and

Whereas, Increases in paid parental leave were associated with decreases in perinatal, neonatal, post-neonatal, infant, and child mortality in a sample of 18 Organization for Economic Co-operation and Development countries4; and

Whereas, Unpaid maternal leave provided through the Family and Medical Leave Act of 1993 in the United States was associated with decreases in neonatal, post-neonatal, and infant mortality, but only among women who were married and had graduated from college, suggesting that women of lower socioeconomic position were unable to benefit from unpaid leave5; and

Whereas, The United States is one of the few countries in the world that does not offer paid maternity leave6–8, therefore be it

RESOLVED, That our American Medical Association advocate for improved social and economic support for paid family leave to care for newborns, infants and young children (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for federal tax incentives to support early child care and unpaid child care by extended family members. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17

References
8 http://www.huffingtonpost.com/2013/02/04/maternity-leave-paid-parental-leave_n_2617284.html
Whereas, Over the past year, the United States has experienced a crisis of violence between law enforcement officers and civilians in their communities, leading to a great deal of civil unrest; and

Whereas, In 2015 the FBI reports that 41 law enforcement officers were feloniously killed and 45 were accidentally killed while performing their duties; and

Whereas, In 2015 the FBI reports an additional 50,212 officers were assaulted while performing their duties, with 28.4 percent of them injured; and

Whereas, No reliable official US data exist on the number of persons killed, assaulted, or injured during police-civilian interactions; and

Whereas, Those deaths and injuries are countable, as evidenced by “The Counted,” a website launched on June 1, 2015, by the newspaper The Guardian, published in the United Kingdom; and

Whereas, According to “The Counted,” over 500 people in the US had been killed by the police between January 1, 2015 and June 9, 2015, twice what would be expected based on estimates from the US Federal Bureau of Investigation (FBI); and

Whereas, The Department of Justice (DOJ) states “Accurate and comprehensive accounting of deaths that occur during the process of arrest is critical for law enforcement agencies to demonstrate responsiveness to the citizens and communities they serve”; and

Whereas, At a 2015 violence summit, mayors, police chiefs and state attorneys general said the lack of data was contributing to a dangerous trend in which police officers shunned aggressive tactics for fear of becoming the next officer to be caught on camera in a compromising situation; and

Whereas, Federal officials currently rely on local police to report shootings involving officers, but reporting is voluntary and typically occurs months after the fact; and

Whereas, The DOJ is piloting a new voluntary system to count civilian deaths that occur during the process of arrest around the United States; and
Whereas, The CDC and many state health departments require mandatory reporting not only of certain infectious diseases but also of occupational related injuries, cancer, certain toxicologic injuries and exposures, and dog bites, etc.\textsuperscript{vi,vii}; and

Whereas, Former Surgeon General David Satcher, MD, PhD, said, “In public health, we can’t do anything without surveillance. That’s where public health begins.”; therefore be it

RESOLVED, That our American Medical Association encourage the Centers for Disease Control and Prevention and state departments of health to collect data on serious law-enforcement-related injuries and deaths and make law-enforcement-related deaths a notifiable condition. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 05/1/17

\textsuperscript{i} https://ucr.fbi.gov/leoka/2015
\textsuperscript{ii} http://www.theguardian.com/us-news/ng-interactive/2015/jun/01/the-counted-police-kilings-us-database
\textsuperscript{iii} http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001915
\textsuperscript{iv} https://www.theguardian.com/us-news/2016/aug/08/police-officer-related-deaths-department-of-justice
\textsuperscript{v} https://www.theguardian.com/us-news/2015/oct/08/fbi-chief-says-ridiculous-guardian-washington-post-better-information-police-shootings
\textsuperscript{vi} https://wwwn.cdc.gov/nndss/data-collection.html
\textsuperscript{vii} https://www.cdc.gov/mmwr/preview/mmwrhtml/00001666.htm
Whereas, There is a significant risk of dosing error with pediatric medications; and
Whereas, Dosing cups, which are commonly supplied with pediatric medications, can increase
the risk of dosing errors; and
Whereas, Listing dosing instructions on labels in both milliliter and teaspoon volumes may
increase the risk of dosing error; and
Whereas, The American Academy of Pediatrics in a 2015 policy statement supported
expressing dosing only in metric measurements; therefore be it
RESOLVED, That our American Medical Association seek rules from the US Food and Drug
Administration requiring that all orally administered liquid over-the-counter medications list
dosing only in metric measurements and that appropriate dosing syringes be provided with all
orally administered liquid medications. (Directive to Take Action)
Fiscal Note: Modest – between $1,000 - $5,000
Received: 05/11/17

RELEVANT AMA POLICY

Promotion of Milliliter-Only for Liquid Medication Dosing D-120.939
1. Our AMA will advocate to relevant federal and state entities for the exclusive use of metric-based
dosing with milliliters (mL) and milligrams (mg) for orally administered liquid medications.
2. Our AMA will advocate that dispensing pharmacies be required to provide a device calibrated
in milliliters for medication administration.
Res. 518, A-16
Whereas, Clotrimazole/betamethasone dipropionate cream is a combination of an anti-fungal cream and a high-potency steroid that has been shown to be less effective, less safe and more expensive than single anti-fungal creams, as well as being commonly misused by physicians; and

Whereas, Clotrimazole/betamethasone dipropionate is less effective than single agent antifungal creams; and

Whereas, Clotrimazole/betamethasone dipropionate cream carries a risk of causing persistent and recurrent fungal infections in children; and

Whereas, Clotrimazole/betamethasone dipropionate is indicated for patients 12 years and over, but is often prescribed in younger patients with over half the prescriptions written for patients under 4 years old; and

Whereas, Dermatologists, who are experts in skin disease, prescribed single anti-fungal creams, as opposed to the combination cream, 96 percent of the time since they are more effective, safer and less expensive; and

Whereas, Prescribers are often not aware that the combination cream contains a high-potency steroid, increasing the risk of side effects including stretch marks, growth retardation, excess hair growth and treatment failure; and

Whereas, The combination cream is more expensive than single anti-fungal topicalcs, but is less effective and the treatment failures cause further treatment and additional expense; and

Whereas, The American Academy of Dermatology treatment guidelines for superficial fungal infections recommend single agent anti-fungals as the first line therapy and caution regarding the use of the combination cream; therefore be it

5 Ibid
RESOLVED, That our American Medical Association work with the US Food and Drug Administration to review the safety and indications of the combination clotrimazole/betamethasone dipropionate cream and lotion. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17
Whereas, Pharmacy generated retail prescription bottle labels contain patient specific information and when discarded, can unintentionally expose private identity and health information; and

Whereas, A discarded prescription bottle with an intact label for a scheduled medication could attract unwelcomed interest from someone with criminal intent; and

Whereas, Prescription labels are glued to prescription bottles so securely that they are not easily removed or destroyed when the prescription medicine is finished, and those on multiple prescriptions are especially affected; therefore be it

RESOLVED, That our American Medical Association petition the American Pharmacist Association, the US Food and Drug Administration and other relevant agencies, to recommend that labels used for retail prescription bottles be affixed in a manner that allows easy removal or destruction to protect patient privacy. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 606
(A-17)

Introduced by: Tennessee

Subject: Add Patients to the AMA Mission Statement

Referred to: Reference Committee F
(Gary R. Katz, MD, Chair)

Whereas, A significant portion of the Institute of Medicine (IOM) six aims and the Institute for Healthcare Improvement (IHI) triple aim focuses on patient issues; and

Whereas, The word “patient” does not appear in the mission statement of the American Medical Association (The AMA promotes the art and science of medicine and the betterment of public health); and

Whereas, The United States health care system is changing to become more patient-centric; therefore be it

RESOLVED, That our American Medical Association modify its mission statement to read “The American Medical Association promotes the art and science of medicine, the betterment of public health, and the improvement and accessibility of health care to our patients.” (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 05/11/17
Whereas, “Pay for performance,” is a term defined by payers and physicians first, to optimize self-care by patients and second, to support screening, education, oversight, and continuity of care for patients by physicians such that both physicians and patients “perform” to promote the best clinical outcomes as determined by clinical guidelines; and

Whereas, The practice of primary care medicine is an adult-to-adult relationship or an adult-to-parent relationship, and reviewers and payers must recognize that patients and/or their parents have the freedom to choose from a number of goal-oriented health choices meant to custom design a personalized health care program; and

Whereas, Patients and/or their parents sometimes fail to make the best health care choices, including the possibility that their choice may even lead to self-harm of the patient; and

Whereas, The widespread use of electronic health records allows clearer documentation of both the advice given to patients and the clinical outcomes rather than relying on claims data; and

Whereas, While physicians pledge to do their best for their patients by recommending the best preventative actions and disease treatments, patients may fail to comply or to pursue their physician’s advice even when it is delivered repeatedly in the most thoughtful manner and in a supportive environment; and

Whereas, The “Pay-for-Performance” approach has led to physicians being held responsible for the patient’s and/or parent’s action(s) while obviating the patient’s need for personal responsibility and, thus, has compromised the integrity of the physician-patient relationship; and

Whereas, Performance incentives should be linked to the performance of the physician in providing and documenting appropriate advice on preventative care and self-care to patients and/or their parents; and

Whereas, Such performance incentives earned through delivery and documentation of appropriate advice should be considered equal to performance incentives based on clinical outcomes, (e.g., a physician’s recommendation to obtain a screening colonoscopy would earn a performance incentive whether or not the patient completed the colonoscopy); therefore be it
RESOLVED, That our American Medical Association advocate with payers and other physician performance review organizations a new standard whereby performance incentives would be linked to the performance of the physician in providing and documenting appropriate advice on preventative care and self-care to patients and/or their parents and applicable incentives would be earned through delivery and documentation of appropriate advice that are considered equal to the performance incentive based on a clinical outcome (New HOD Policy); and be it further

RESOLVED, That our AMA work with any organization measuring physicians through incentive or performance programs to adopt standards that do not penalize physicians for the actions of patients who cannot or who will not comply with excellence in clinical recommendations. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 05/11/17

RELEVANT AMA POLICY

Physician Pay-for-Performance Programs H-140.872
Physician pay-for-performance (PFP) compensation arrangements should be designed to improve health care quality and patient safety by linking remuneration to measures of individual, group, or organizational performance. To uphold their ethical obligations, physicians who are involved with PFP programs must take appropriate measures to promote patients' well-being.

(1) Physicians who are involved in the design or implementation of PFP programs should advocate for:
(a) incentives that are intended to promote health care quality and patient safety, and are not primarily intended to contain costs;
(b) program flexibility that allows physicians to accommodate the varying needs of individual patients;
(c) adjustment of performance measures by risk and case-mix in order to avoid discouraging the treatment of high-risk individuals and populations;
(d) processes to make practice guidelines and explanations of their intended purposes and the clinical findings upon which they are based available to participating physicians.

(2) Practicing physicians who participate in PFP programs while providing medical services to patients should:
(a) maintain primary responsibility to their patients and provide competent medical care, regardless of financial incentives;
(b) support access to care for all people and avoid selectively treating healthier patients for the purpose of bolstering their individual or group performance outcomes;
(c) be aware of evidence-based practice guidelines and the findings upon which they are based;
(d) always provide care that considers patients' individual needs and preferences, even if that care conflicts with applicable practice guidelines;
(e) not participate in PFP programs that incorporate incentives that conflict with physicians' professional values or otherwise compromise physicians' abilities to advocate for the interests of individual patients.


See also:
Pay-for-Performance Principles and Guidelines H-450.947
Whereas, Accountable Care Organizations (ACO) have been touted as a remedy for saving health care costs while preserving or improving quality of care and access to care; and

Whereas, There is a need to ensure that studies evaluating ACO metrics, outcomes, and impact on patient experience of care, quality, cost, and clinician experience are conducted in an objective manner and by independent sources; and

Whereas, There is no current consensus on whether ACOs have proven to be successful in meeting quality and cost goals, as well as patient and clinician experience expectations; therefore be it

RESOLVED, That our American Medical Association seek objective, independent data on Accountable Care Organizations and release a whitepaper regarding their effect on cost savings and quality of care. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17

RELEVANT AMA POLICY

Studying Physician Access to ACO Participation D-160.930
Our AMA will study: (a) the criteria and processes by which various types of accountable care organizations (ACOs) determine which physicians will be selected to join vs. excluded from the ACO; (b) the criteria and processes by which physicians can be de-selected once they are members of an ACO; (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 will be reported back to the HOD and to our AMA membership at large by the 2015 Annual Meeting.
Res. 736, A-14

Health Care Reform Physician Payment Models D-385.963
1. Our AMA will: (a) work with the Centers for Medicare and Medicaid Services and other payers to participate in discussions and identify viable options for bundled payment plans, gain-sharing plans, accountable care organizations, and any other evolving health care delivery programs; (b) develop guidelines for health care delivery payment systems that protect the patient-physician relationship; (c) make available to members access to legal, financial, and ethical information, tools and other resources to enable physicians to play a meaningful role in the governance and clinical decision-making of evolving health care delivery systems; and (d) work
with Congress and the appropriate governmental agencies to change existing laws and regulations (e.g., antitrust and anti-kickback) to facilitate the participation of physicians in new delivery models via a range of affiliations with other physicians and health care providers (not limited to employment) without penalty or hardship to those physicians.

2. Our AMA will: (a) work with third party payers to assure that payment of physicians/healthcare systems includes enough money to assure that patients and their families have access to the care coordination support that they need to assure optimal outcomes; and (b) will work with federal authorities to assure that funding is available to allow the CMMI grant-funded projects that have proven successful in meeting the Triple Aim to continue to provide the information we need to guide decisions that third party payers make in their funding of care coordination services.

3. Our AMA advises physicians to make informed decisions before starting, joining, or affiliating with an ACO. Our AMA will provide information to members regarding AMA vetted legal and financial advisors and will seek discount fees for such services.

4. Our AMA will develop a toolkit that provides physicians best practices for starting and operating an ACO, such as governance structures, organizational relationships, and quality reporting and payment distribution mechanisms. The toolkit will include legal governance models and financial business models to assist physicians in making decisions about potential physician-hospital alignment strategies. The toolkit will also include model contract language for indemnifying physicians from legal and financial liabilities.

5. Our AMA will continue to work with the Federation to identify, publicize and promote physician-led payment and delivery reform programs that can serve as models for others working to improve patient care and lower costs.

6. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.

7. Our AMA will work with states to: (a) ensure that current state medical liability reform laws apply to ACOs and physicians participating in ACOs; and (b) address any new liability exposure for physicians participating in ACOs or other delivery reform models.

8. Our AMA recommends that state and local medical societies encourage the new Accountable Care Organizations (ACOs) to work with the state health officer and local health officials as they develop the electronic medical records and medical data reporting systems to assure that data needed by Public Health to protect the community against disease are available.

9. Our AMA recommends that ACO leadership, in concert with the state and local directors of public health, work to assure that health risk reduction remains a primary goal of both clinical practice and the efforts of public health.

10. Our AMA encourages state and local medical societies to invite ACO and health department leadership to report annually on the population health status improvement, community health problems, recent successes and continuing problems relating to health risk reduction, and measures of health care quality in the state.

See also:
Accountable Care Organization Principles H-160.915
Whereas, Patients often struggle with pain for years prior to being referred by their primary care physician to a pain management specialist; and

Whereas, Pain can become its own disease state rather than a symptom of an underlying disorder; and

Whereas, “Conservative” treatment is often required by third-party payers prior to evaluation by a pain management specialist; and

Whereas, “Conservative” treatment often includes expensive and time-consuming modalities such as physical therapy and advanced imaging; and

Whereas, Pain management specialists are the only physicians trained to utilize the full array of pain management modalities and interventions in order to address the full biological, psychological and social impact pain has on a patient; and

Whereas, Pain management specialty care has an opioid-sparing effect that reduces the risk of opioid morbidity and mortality for the patient; and

Whereas, Pain management specialty care may reduce the societal burden of opioids, including risk of harm to those in the community who may gain access to non-prescribed opioids causing further harm beyond the scope of the patient; therefore be it

RESOLVED, That our American Medical Association urge the Centers for Medicare and Medicaid Services and the Medicare Contractor Advisory Committee to endorse and adopt evidence-based clinical practice guidelines on the management and treatment of pain including but not limited to timely and appropriate referral to pain management specialists. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17
RELEVANT AMA POLICY

Promotion of Better Pain Care D-160.981
1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; (b) encourages relevant specialties to collaborate in studying the following: (i) the scope of practice and body of knowledge encompassed by the field of pain medicine; (ii) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care; (iii) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (iv) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic; and (c) will participate in the International Association for the Study of Pain (IASP) International Pain Summit to be held in Montreal, Canada, on September 3, 2010; and encourages the participation of affiliate pain specialty societies, the American Board of Medical Specialties, the Accreditation Council for Graduate Medical Education, the Association of American Medical Colleges, and other relevant organizations in the IASP Pain Summit.
2. Our AMA encourages relevant stakeholders to research the overall effects of opioid production cuts.
3. Our AMA encourages the US Drug Enforcement Administration to be more transparent when developing medication production guidelines.
4. Our AMA and the physician community reaffirm their commitment to delivering compassionate and ethical pain management, promoting safe opioid prescribing, reducing opioid-related harm and the diversion of controlled substances, improving access to treatment for substance use disorders, and fostering a public health based-approach to addressing opioid-related morbidity and mortality.

Pain Control in Long-Term Care H-280.958
Our AMA will work: (1) to promulgate clinical practice guidelines for pain control in long term care settings and support educational efforts and research in pain management in long term care; and (2) to reduce regulatory barriers to adequate pain control at the federal and state levels for long term care patients.

Coverage for Chronic Pain Management H-185.931
1. Our American Medical Association will advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician led, and recognize the interdependency of treatment methods in addressing chronic pain.
2. Our AMA supports health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits.
3. Our AMA supports efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, which have the ability to address the physical, psychological, and medical aspects of the patient's condition and presentation and involve patients and their caregivers in the decision-making process.


Whereas, Many hospital or nursing home patients may be stabilized on new medications prescribed during their admission; and

Whereas, Certain medications may or may not be covered under the insurance company formulary; and

Whereas, Many patients may be discharged on a weekend or holiday; and

Whereas, Most insurance companies do not have staff available on weekends and holidays to confirm or deny coverage of a medication; and

Whereas, There is no way for a prescribing physician or facility to know if a medication is covered or not without access to the insurance company staff; and

Whereas, Patients discharged on vital new medications may be denied access to these medications and suffer harm because of it; therefore be it

RESOLVED, That our American Medical Association work with pharmacy benefit managers (PBMs), health insurers, and pharmacists at a national level to address the problem of patients, discharged by a health care facility on a weekend or holiday, being denied access to vital medications because the patient’s health insurance carrier or applicable PBM does not have staff available on weekends or holidays to resolve coverage and/or formulary issues. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17
RELEVANT AMA POLICY

Expanded Use of the AMA's Principles of a Sound Drug Formulary H-125.985
Our AMA urges managed care organizations, pharmacy benefit managers, and others who design benefit packages and/or make pharmacy benefit decisions, to utilize the Principles of a Sound Drug Formulary System (as described in BOT Rep. 28, I-00) as they develop their pharmaceutical benefit plan(s) and that the Principles of a Sound Drug Formulary System be readily available on the AMA web site.

Health Plan Coverage of Prescription Drugs D-125.995
In consultation with pharmacy benefit managers (PBMs), public and private sector payers, as well as other appropriate entities, our AMA will continue to pursue the development of model procedures for prescribing non-formulary prescription drugs and promote these procedures to PBMs, public and private sector payers, as well as other appropriate entities.
CMS Rep. 6, A-03 Reaffirmation I-04 Reaffirmation A-08
Whereas, The health care industry, among other sectors of the economy (e.g., compared to banking, media and journalism, engineering, and legal services) has been one of the later adopters of the transformation from paper documentation to electronic data entry, storage, and retrieval; and

Whereas, Electronic health records provide major advances over paper records with respect to legibility, portability, and the ability to audit and mine data for quality analysis; and

Whereas, The electronic health record (EHR) industry has itself become a huge sector of the economy and expenditures on EHRs are among the most massive consumers of capital investment in the health care industry; and

Whereas, The transformation to the use of EHRs has proven stressful for physicians and other health professionals, has been documented to be a major contributor to physician practice dissatisfaction and physician burnout\(^1,2,3,4,5\), and has changed how physicians spend their time each and every practice day; and

Whereas, Physicians are intensely trained and highly educated and skilled members of the health care team, and their years of undergraduate and graduate medical education can be put to optimum use on behalf of patients when physicians spend time with patients, collect data from the history and physical and from diagnostic tests, and engage in medical decision-making in the service of well-designed and well-implemented treatment plans on behalf of patients; and

Whereas, The last decade has seen a transformation in the workdays of physicians, such that they are spending less time with patients, more time with computer keyboards and monitors, less time with medical decision-making, and more time with basic data entry tasks, contributing to diminished satisfaction with their professional roles and even an acceleration of physician retirement rates, adversely impacting the physician workforce\(^2,5,6\); and

Whereas, If an industrial engineer were to arrive in the United States during this decade and examine the U.S. health care delivery system from a high-altitude perspective, what would be found is a system in which the most highly trained and skilled members of the delivery system and the most highly compensated clinicians in the delivery system – physicians – were devoting a disproportionate amount of their time performing data entry tasks, and that significant amounts of work had shifted from clerical staff such as unit clerks, medical transcriptionists, and billers, to physicians; and
Whereas, Using physicians to do data entry tasks, and compensating them at physician salary rates to do such tasks, is remarkably inefficient and leads to a massive misallocation of financial resources in the industry responsible for the health status of all workers in the economy and all citizens, an industry that contributes to 1/6 of the gross domestic product of the world’s largest economy; and

Whereas, It is not just that the daytime hours of physicians are compensated by health systems for physicians doing tasks that much lower paid members of the health care team could, and arguably should, complete, but the “after-hours” time of physicians that should be devoted to personal, family, recreational, and restorative pursuits is spent completing the voluminous non-direct-patient-care clerical-type tasks of clinical data entry and charge entry that the physician “didn’t get around to completing” in the daytime, and these hours are completed uncompensated; and

Whereas, Every stakeholder in the health care system would benefit if financial resources and physician time were not allocated to having physicians do tasks related to the EHR that would more efficiently be performed by others on the health care team; and

Whereas, Our AMA has devoted significant resources to studying and improving physician professional satisfaction and practice sustainability, and has documented the contribution of the EHR to these areas, and the American College of Physicians has recently published a Position Paper addressing imbalances within physician work each day wherein administrative tasks have taken on too large of a position; therefore be it

RESOLVED, That our American Medical Association work with leaders of the health care delivery system (clinics, hospitals and health systems) and federal governmental leaders at the highest level to use industrial engineering and quality improvement principles and practices to examine the imbalances that have evolved in the time allocation of physician work in order to propose systematic reforms that will reduce the amount of a physician’s time in data entry tasks and allow physicians to maximize the time available in their daily work to interact directly with patients and families and maximize the time available for them to design and implement treatment plans within health care teams and to be able to do what they are uniquely trained to do: make appropriate evidence-based medical decisions on behalf of patients. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/11/17

References:


Whereas, A longstanding and widespread practice exists for a physician to retain a substitute physician (locum tenens) to take over his or her professional practice when the regular physician is absent for reasons such as illness, pregnancy, family emergency, or vacation, and for the regular physician to bill and receive payment for the locum tenens’ services as though the regular physician performed them; and

Whereas, The regular physician generally pays the locum tenens a fixed amount per diem, as allowed by the Social Security Act Amendments of 1994; and

Whereas, The Centers for Medicare & Medicaid Services (CMS) allows regular physicians to bill for locum tenens services for up to 60 consecutive days during the absence of the regular physician; and

Whereas, Circumstances can occur, such as serious illness, physical impairment, or family emergency, that could require regular physicians to be out of the office for more than 60 consecutive days; and

Whereas, Those regular physicians should be able to apply for an exception to allow them to continue billing for locum tenens services beyond the 60-day limit; and

Whereas, CMS has made exceptions before as documented in Section 116 of the “Medicare, Medicaid, and SCHIP Extension Act of 2007” (MMSE), enacted on Dec. 29, 2007, which provided for an exception to the 60-day limit on substitute physician billing for physicians called to active duty in the Armed Forces for services furnished Jan. 1, 2008, through June 30, 2008, and in Section 137 of the “Medicare Improvements for Patients and Providers Act of 2008”, enacted on July 15, 2008, which made this exception permanent; therefore be it

RESOLVED, That our American Medical Association request that the Centers for Medicare & Medicaid Services (CMS) create an exception process to the 60-day locum tenens limit for those physicians with unforeseen circumstances, such as serious illness, physical impairment, or family emergency (Directive to Take Action); and be it further

RESOLVED, That our AMA ensure that the exception process contains the same requirements as are necessary to currently bill under a CMS locum tenens arrangement. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000
Received: 05/11/17