**DISCLAIMER**

**The following is a preliminary report of actions taken by the House of Delegates at its 2017 Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.**

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-17)

Report of Reference Committee B

Alethia E. Morgan, MD, Chair

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Your Reference Committee recommends the following consent calendar for acceptance:

**RECOMMENDED FOR ADOPTION**

1. Board of Trustees Report 13 - Closing Gaps in Prescription Drug Monitoring Programs (Resolution 209-A-16)
2. Board of Trustees Report 14 - Medicare Part B Double Dipping
3. Resolution 203 - AMA to Support Pharmaceutical Pricing Negotiation in US
4. Resolution 210 - Violation of HIPAA Electronic Transaction Standards by Insurer
5. Resolution 220 - Accountability of 911 Emergency Services Funding
6. Resolution 226 - Direct American Medical Association to Ask CMS and HHS to Remove Practice Expense and Malpractice Expense from Publicly Reported Payments
7. Resolution 233 - Regulation of Physician Assistants
8. Resolution 236 - Retail Price of Drugs Displayed in Direct-to-Consumer Pharmaceutical Advertising

**RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED**

9. Board of Trustees Report 11 - Physician-Patient Text Messaging and Non-HIPAA Compliant Electronic Messaging
   Resolution 239 - AMA Support for Texting as Approved HIPAA Communication
10. Board of Trustees Report 22 - Council on Legislation Sunset Review of 2007 House Policies
11. Resolution 201 - Improving Drug Affordability
12. Resolution 206 - MACRA and the Independent Practice of Medicine
    Resolution 209 - Reduce Physician Practice Administrative Burden
    Resolution 222 - Response to Burdensome Governmental Mandate
13. Resolution 208 - Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States
14. Resolution 211 - Sale of Health Insurance Across State Lines
    Resolution 240 - Minimum Federal Standards for Interstate Sale of Health Insurance
15. Resolution 224 - Medicare Prepayment and RAC Audit Reform
16. Resolution 227 - Improving Clinical Utility of Medical Documentation
17. Resolution 228 - Free Speech Applies to Scientific Knowledge

18. Resolution 229 - Medicare's Appropriate Use Criteria Program
19. Resolution 231 - Naloxone Price Increase
20. Resolution 238 - Limitation on Reports to the National Practitioner Data Bank Unrelated to Patient Care

**RECOMMENDED FOR REFERRAL**

21. Resolution 212 - Advocacy for Seamless Interface between Physician Electronic Health Records, Pharmacies and Prescription Drug Monitoring Programs to be Created and Financed by the Commercial EHR and Dispensing Program Providers
22. Resolution 218 - Licensing of Electronic Health Records
23. Resolution 219 - Integration of Drug Price Information into Electronic Medical Records
24. Resolution 230 - CMS Reimbursement Guidelines for Teaching Physician Supervision
25. Resolution 237 - Protection of Clinician-Patient Privilege

**RECOMMENDED FOR NOT ADOPTION**

26. Resolution 213 - Copying and/or Scanning Costs
27. Resolution 214 - Medical Liability Coverage Through the Federal Tort Claims Act

**RECOMMENDED FOR REAFFIRMATION IN LIEU OF**

28. Resolution 205 - Limiting Medicare Part D Enrollee Costs
29. Resolution 207 - Sky Rocketing Drug Prices
30. Resolution 215 - Revisiting Exemptions for Reporting Peer-Reviewed Journal Articles and Medical Textbooks per the Sunshine Act
31. Resolution 216 - Electronically Prescribe Controlled Substances Without Added Processes
32. Resolution 217 - Inappropriate Requests for DEA Numbers
33. Resolution 223 - Tax Deductions for Direct-to-Consumer Advertising
34. Resolution 225 - Truth In Advertising
35. Resolution 235 - Towards Eliminating ERISA State Preemption of Health Plan Liability
36. Resolution 241 - Timeliness in Obtaining Medical Records from Other Providers
37. Resolution 242 - Legislation to Require Timely Action on Prior Authorization Requirements
38. Resolution 243 - Seamless Digital Interface for Best Care

The following resolutions were included on the Reaffirmation Consent Calendar and were not addressed by the Reference Committee:

Resolution 202 - Protect Individualized Compounding in Physicians' Offices
Resolution 221 - AMA Policy on American Health Care Act
Resolution 232 - Create MACRA Opt-Out Option
Resolution 234 - Protections for Patients with Genetic Conditions

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

RECOMMENDATION:

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

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

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

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

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

RECOMMENDATION:

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

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

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

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

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

RECOMMENDATION:

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

**HOD ACTION: Resolution 203 adopted.**

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

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

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

RECOMMENDATION:

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

**HOD ACTION: Resolution 210 adopted.**

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

Your Reference Committee heard limited but supportive testimony on Resolution 210. Notably, your Reference Committee heard testimony that our AMA worked for multiple years to delay and then ease the transition to the ICD-10 code set and specifically, that

our AMA secured an ICD-10 Ombudsman to receive and triage physician problems as the code set was implemented. Your Reference Committee also heard that our AMA is continuing to investigate and working to resolve problems that may have occurred during the transition to ICD-10. Accordingly, your Reference Committee recommends adoption of Resolution 210.

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

RECOMMENDATION:

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

**HOD ACTION: Resolution 220 adopted.**

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

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

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

RECOMMENDATION:

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

**HOD ACTION: Resolution 226 adopted.**

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

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

(7) RESOLUTION 233 – REGULATION OF PHYSICIAN ASSISTANTS

RECOMMENDATION:

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

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

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

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

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

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

RECOMMENDATION:

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

**HOD ACTION: Resolution 236 adopted.**

Resolution 236 asks that our American Medical Association advocate to the applicable Federal agencies (including the Food and Drug Administration, the Federal Trade Commission, and the Federal Communications Commission) which regulate or influence

direct-to-consumer advertising of prescription drugs that such advertising should be required to state the manufacturer's suggested retail price of those drugs. (Directive to Take Action)

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

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

RECOMMENDATION A:

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

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

RECOMMENDATION B:

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

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

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

New communication technologies must never replace the crucial interpersonal contacts that are the very basis of the patient-physician relationship. Rather, electronic mail and other forms of Internet communication should be used to enhance such contacts. Furthermore, before using electronic mail or other electronic communication tools, physicians should consider Health Information Portability and Accountability Act (HIPAA) and other privacy

requirements, as well as related AMA policy on privacy and confidentiality, including Policies H-315.978 and H-315.989. Patient-physician electronic mail is defined as computer-based communication between physicians and patients within a professional relationship, in which the physician has taken on an explicit measure of responsibility for the patient's care. These guidelines do not address communication between physicians and consumers in which no ongoing professional relationship exists, as in an online discussion group or a public support forum.

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

Communication Guidelines:

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

and the importance of alternative forms of communication for emergencies.
(o) Explain to patients that their messages should be concise.
(p) When e-mail messages become too lengthy or the correspondence is prolonged, notify patients to come in to discuss or call them.
(q) Remind patients when they do not adhere to the guidelines.
(r) For patients who repeatedly do not adhere to the guidelines, it is acceptable to terminate the e-mail relationship.

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

(2) The policies and procedures for e-mail be communicated to all patients who desire to communicate electronically.

(3) The policies and procedures for e-mail be applied to facsimile communications, where appropriate.

(4) The policies and procedures for e-mail be applied to text and electronic messaging using a secure communication platform, where appropriate.

RECOMMENDATION C:

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

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

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

Communication Guidelines:

(a) Establish turnaround time for messages. Exercise caution when using e-mail for urgent matters.
(b) Inform patient about privacy issues.
(c) Patients should know who besides addressee processes messages during addressee's usual business hours and during addressee's vacation or illness.
(d) Whenever possible and appropriate, physicians should retain electronic and/or paper copies of e-mail communications with patients.
(e) Establish types of transactions (prescription refill, appointment scheduling, etc.) and sensitivity of subject matter (HIV, mental health, etc.) permitted over e-mail.
(f) Instruct patients to put the category of transaction in the subject line of the message for filtering: prescription, appointment, medical advice, billing question.
(g) Request that patients put their name and patient identification number in the body of the message.

(h) Configure automatic reply to acknowledge receipt of messages.
(i) Send a new message to inform patient of completion of request.
(j) Request that patients use autoreply feature to acknowledge reading clinicians message.
(k) Develop archival and retrieval mechanisms.
(l) Maintain a mailing list of patients, but do not send group mailings where recipients are visible to each other. Use blind copy feature in software.
(m) Avoid anger, sarcasm, harsh criticism, and libelous references to third parties in messages.
(n) Append a standard block of text to the end of e-mail messages to patients, which contains the physician's full name, contact information, and reminders about security and the importance of alternative forms of communication for emergencies.
(o) Explain to patients that their messages should be concise.
(p) When e-mail messages become too lengthy or the correspondence is prolonged, notify patients to come in to discuss or call them.
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(a) Develop a patient-clinician agreement for the informed consent for the use of e-mail. This should be discussed with and signed by the patient and documented in the medical record. Provide patients with a copy of the agreement. Agreement should contain the following:
(b)Terms in communication guidelines (stated above).
(c) Provide instructions for when and how to convert to phone calls and office visits.
(d) Describe security mechanisms in place.
(e) Hold harmless the health care institution for information loss due to technical failures.
(f) Waive encryption requirement, if any, at patient's insistence.
(g) Describe security mechanisms in place including:
(h) Using a password-protected screen saver for all desktop workstations in the office, hospital, and at home.
(i) Never forwarding patient-identifiable information to a third party without the patient's express permission.
(j) Never using patient's e-mail address in a marketing scheme.
(k) Not sharing professional e-mail accounts with family members.
(l) Not using unencrypted wireless communications with patient-identifiable information.
(m) Double-checking all "To" fields prior to sending messages.
(n) Perform at least weekly backups of e-mail onto long-term storage. Define long-term as the term applicable to paper records.
(o) Commit policy decisions to writing and electronic form.

(2) The policies and procedures for e-mail be communicated to all patients who desire to communicate electronically.

(3) The policies and procedures for e-mail be applied to facsimile communications, where appropriate.

<u>(4) The policies and procedures for e-mail be applied to text and electronic messaging using a secure communication platform, where appropriate.</u>

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

Your Reference Committee heard supportive testimony on Board of Trustees Report 11. Those testifying noted the potential benefits of using text messaging to communicate with colleagues and patients but expressed confusion about when it is appropriate to use this technology to convey health information. Your Reference Committee recognizes this lack of clarity and appreciates the guidance provided in Board of Trustees Report 11. Specifically, the Report includes examples of when physicians can utilize texting and also outlines considerations that should be addressed before sending electronic messages. Your Reference Committee believes that the recommendations to the Board of Trustees Report 11 should reference text messaging in the title of the policy that is being amended to further support the intent behind the Report. Furthermore, the Board of Trustees Report 11 recommendations should recognize the higher level of confidentiality for substance abuse disorders. Your Reference Committee therefore recommends that the phrase “and other privacy requirements” be added to the amended language.

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

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

RECOMMENDATION A:

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

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

RECOMMENDATION B:

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

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

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

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

(11) RESOLUTION 201 – IMPROVING DRUG AFFORDABILITY

RECOMMENDATION A:

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

RESOLVED, That our American Medical Association support drug price transparency legislation ~~that requires pharmaceutical manufacturers to disclose, in a timely fashion, the basis for the prices of all prescription drugs, including but not limited to: (1) research and development costs paid by both the manufacturer and any other entity; (2) manufacturing costs; (3) advertising and marketing costs; (4) total revenues and direct and indirect sales; (5) unit price; (6) financial assistance provided for each drug including any discounts, rebates and/or prescription drug assistance; (7) any offshoring of either jobs or profits; (8) any reverse payment settlements; (9) payments to third parties--such as wholesalers, group purchasing organizations (GPOs), managed care organizations (MCOs), and pharmacy benefit management companies (PBMs) (New HOD Policy); and be it RESOLVED, That our AMA support legislation~~ that requires pharmaceutical manufacturers to provide public notice before increasing the ~~wholesale~~ price of any ~~brand or specialty~~ drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase (New HOD Policy); and be it further

RECOMMENDATION B:

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

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

RECOMMENDATION C:

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

**HOD ACTION: Resolution 201 adopted as amended.**

Resolution 201 asks that our American Medical Association support drug price transparency legislation that requires pharmaceutical manufacturers to disclose, in a timely fashion, the basis for the prices of all prescription drugs, including but not limited to: (1) research and development costs paid by both the manufacturer and any other entity; (2) manufacturing costs; (3) advertising and marketing costs; (4) total revenues and direct and indirect sales; (5) unit price; (6) financial assistance provided for each drug including any discounts, rebates and/or prescription drug assistance; (7) any offshoring of either jobs or profits; (8) any reverse payment settlements; (9) payments to third parties--such as wholesalers, group purchasing organizations (GPOs), managed care organizations (MCOs), and pharmacy benefit management companies (PBMs) (New HOD Policy); and be it further that our AMA support legislation that requires pharmaceutical manufacturers to provide public notice before increasing the wholesale price of any brand or specialty drug by10% or more each year or per course of treatment (New HOD Policy); and be it further that our AMA support legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients (New HOD Policy); and be it further that our AMA support the expedited review of generic drug applications and prioritize review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment. (New HOD Policy)

Your Reference Committee heard overwhelmingly supportive testimony on Resolution 201, but that urged modification to simplify and combine the first and second Resolves and adopt Resolves 3 and 4. Your Reference Committee strongly believes there is a need to address price gouging and anti-competitive behaviors by pharmaceutical companies. Your Reference Committee supports added transparency as well as new authorities to expedite competition through the regulatory process as well as to expand authorities for federal agencies to address monopoly behaviors. Your Reference Committee also heard testimony that transparency is essential but should be targeted and meaningful. Your Reference Committee also heard testimony that Resolve 1 may be

too prescriptive and inhibits innovation, and that a more flexible approach will be more effective by focusing generally on the issues related to price gouging. Therefore, your Reference Committee recommends adoption of Resolution 201 with amendments combining Resolves 1 and 2, striking original Resolve 2, and adopting Resolves 3 and 4.

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

RECOMMENDATION:

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

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

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

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

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

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

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

the administrative burdens and penalties associated with compliance with the MIPS and APM programs. (New HOD Policy)

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

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

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

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

RECOMMENDATION A:

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

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

H-160.903, Eradicating Homelessness

Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable

housing coupled with social services; (2) will work with state medical societies to advocate for legislation implementing stable, affordable housing and appropriate voluntary social services as a ~~first~~ priority in the treatment of chronically-homeless individuals, without mandated therapy or services compliance; and (3) supports the appropriate organizations in developing an effective national plan to eradicate homelessness. (Modify Current HOD Policy)

RECOMMENDATION B:

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

**HOD ACTION: Resolution 208 referred.**

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

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

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

RECOMMENDATION:

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

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

SALE OF HEALTH INSURANCE ACROSS STATE LINES

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

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

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

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

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

RECOMMENDATION A:

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

Medicare Prepayment and Postpayment Audits H-330.921.
1. AMA policy is that with respect to prepayment and postpayment audits by the Medicare program, the following principles guide AMA advocacy efforts:
(a) The confidential medical record should be preserved as an instrument of clinical care, with strong confidentiality protections and, we oppose its use as an accounting document;
(b) CMS should discontinue random prepayment audits of E&M services;
(c) In lieu of prepayment audits, CMS should use focused medical review of outliers based on reviews of patterns of services, using an independent medical peer review process, where physicians practicing in the same specialty, review their peers;
(d) No financial or legal penalties should be assessed based on one level of disagreement in E&M code assignment; and
(e) CMS must stop the practice of requiring physicians to repay alleged Medicare overpayments before an actual appeal is rejected or a final administrative decision or a court order is rendered. Legislative relief will be sought if advocacy with CMS is not successful in this regard.

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

3. Our AMA supports the enactment of federal legislation or regulation that requires fairness in the practice of conducting physicians' post-payment audits as contained in paragraph 1 above, and which would include the following:
(a) The requirement for such audits to be reviewed by a physician board certified within the same specialty prior to

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

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

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

RECOMMENDATION B:

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

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

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

documentation requests, prohibiting recoupment of physician payment until the appeals process is final, imposing penalties on auditors for inaccurate findings, and incentivizing the auditors to perform more physician education. (Directive to Take Action)

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

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

RECOMMENDATION A:

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

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

RECOMMENDATION B:

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

**HOD ACTION: Resolution 227 adopted as amended by deletion.**

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

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

ongoing advocacy efforts and tailor the request to addressing documentation requirements.

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

RECOMMENDATION A:

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

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

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

RECOMMENDATION B:

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

**HOD ACTION: Resolution 228 adopted as amended.**

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

Your Reference Committee heard conflicting testimony on Resolution 228. Testimony was presented that supports the underlying issues raised by Resolution 228, including the importance of protecting scientific integrity and the dissemination of scientific knowledge. Testimony was also presented that these are important issues but that the resolves are too broad, such as calling on our AMA to support legal proceedings in opposition to violations of scientific integrity policies. Your Reference Committee agrees that the underlying issues raised by Resolution 228, such as protecting scientific integrity

and the dissemination of scientific knowledge, are important and that protecting them is consistent with existing AMA policy; however, your Reference Committee agrees with testimony that the language of the second resolve is too broad. Your Reference Committee also heard testimony that the reference to a specific administration within Resolution 228 should be eliminated. Accordingly, your Reference Committee recommends that Resolution 228 be amended by addition and deletion.

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

RECOMMENDATION A:

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

RESOLVED, That our AMA continue to advocate to delay the effective date of the Medicare AUC Program until the Centers for Medicare & Medicaid (CMS) can adequately address~~es~~ technical and workflow challenges with its implementation and any interaction between ~~can adequately assess how~~ the Quality Payment Program and ~~affects~~ the use of advanced diagnostic imaging appropriate use criteria.

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

RECOMMENDATION B:

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

**HOD ACTION: Resolution 229 adopted as amended.**

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

Your Reference Committee heard an abundance of testimony on Resolution 229. Generally, the testimony supported the concept of appropriate use criteria but urged for further delay of the program. Your Reference Committee agrees with the general tenor of the testimony and believes that our AMA will continue to advocate for a delay of the Appropriate Use Criteria program to resolve technical and workflow challenges.

Specifically, the program needs to address integration of criteria into Electronic Health Records and increase interoperability between ordering and referring providers. Furthermore, your Reference Committee heard testimony that all physicians will have difficulty incorporating AUC at the same time they are grappling with the Quality Payment Program. Your Reference Committee does, however, agree with testimony that seeking a congressional approach is not appropriate at this time and instead that continued advocacy with CMS would be more effective. Accordingly, your Reference Committee agrees with an amendment offered by the Council on Legislation that would delete the second Resolve and amend the first Resolve to reflect specific challenges with current implementation. Therefore, your Reference Committee recommends that Resolution 229 be adopted with amendments.

(19) RESOLUTION 231 – NALOXONE PRICE INCREASE

RECOMMENDATION A:

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

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

RECOMMENDATION B:

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

**HOD ACTION: Policy H-95.932 adopted as amended in lieu of Resolution 231.**

Resolution 231 asks that our American Medical Association amend existing AMA Policy, H-95.932, "Increasing Availability of Naloxone," by addition and deletion as follows: 1. Our AMA supports legislative, and regulatory, and national advocacy efforts that to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery. (Modify Current HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 231. Your Reference Committee heard testimony that some manufacturers of naloxone have

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

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

RECOMMENDATION A:

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

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

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

RECOMMENDATION B:

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

**HOD ACTION: Resolution 238 adopted as amended.**

Resolution 238 asks that our American Medical Association formally request that the Health Resources and Services Administration (HRSA) clarify that reports of medical staff appointment denial by physicians are contingent upon competency issues related to physicians' provision of or failure to provide healthcare services that result in patient harm (Directive to Take Action); and be it further, that our AMA formally petition the Secretary of HHS to direct the HRSA to remove the name of any physician from the

National Practitioner Data Bank reported for reasons not related to patient care that resulted in patient harm. (Directive to Take Action)

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

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

RECOMMENDATION:

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

**HOD ACTION: Resolution 212 referred.**

Resolution 218 asks that our American Medical Association join the American College of Legal Medicine to advocate federally-mandated interfaces between provider/dispenser electronic health record systems in the clinical, hospital and pharmacy environments and state prescription drug databases and/or prescription drug management plans (Directive to Take Action); and be it further, that our AMA advocate that the cost of generating these interfaces be borne by the commercial EHR and dispensing program providers (Directive to Take Action); and be it further, that our AMA advocate that the interface should include automatic query of any opioid prescription, from a provider against the state prescription drug database/prescription drug management plan (PDMP) to determine whether such a patient has received such a medication, or another Schedule II drug from any provider in the preceding ninety (90) days (Directive to Take Action); and be it further, that our AMA advocate that the prescriber and the patient's EHR-listed dispensing pharmacy should then be notified of the existence of the referenced patient in the relevant PDMP database, the substance of the previous prescription(s) (including the medication name, number dispensed and prescriber's directions for use) in real time and prior to the patient receiving such medication (Directive to Take Action); and be it further, that our AMA advocate that the electronic record management program at the pharmacy filling the relevant prescription, contemporaneously as it enters the filling of the prescription by the pharmacist, likewise be required to automatically query the state PDMP as a secondary mechanism to prevent inappropriate prescribing, forgery, duplication and/or too great a frequency of use of the involved controlled medication (Directive to Take Action); and be it further, that our AMA work with ACLM and other concerned societies to urge Congress to timely enact and implement such a statutory scheme supported by a workable and concise regulatory framework, chiefly concentrating on the interfacing of all applicable electronic health record and pharmaceutical dispensing systems with every individual state's PDMP, thereafter

designating a timeframe wherein all treating providers and dispensing pharmacists would be required to perform such queries, in concert with the routine ordering of and filling of a controlled substance to be used in the treatment of patients (Directive to Take Action); and be it further, that our AMA advocate that oversight of the appropriate prescribing of and filling of prescriptions for controlled substances remain with the involved individual federal and state criminal law enforcement agencies, the involved state departments of health, or similar entities and the involved relevant state provider and/or pharmacy licensure authorities (Directive to Take Action); and be it further, that our AMA advocate that statistics be maintained and reviewed on a periodic basis by state PDMP personnel and relayed to state departments of health or agencies similarly situated so as to identify and possibly treat those patients identified through this screening mechanism as potential drug abusers and/or at risk of addiction. (Directive to Take Action).

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

(22) RESOLUTION 218 – LICENSING OF ELECTRONIC HEALTH RECORDS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 218 be <u>referred</u>.

**HOD ACTION: Resolution 218 <u>referred</u>.**

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

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

requirements, state licensing could result in EHR vendors passing additional costs on to physicians. Your Reference Committee that this is a complex issue that warrants further study, and therefore recommends referral.

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

RECOMMENDATION:

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

**HOD ACTION: Resolution 219 referred.**

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

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

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

RECOMMENDATION:

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

**HOD ACTION: Resolution 230 referred.**

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

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

(25) RESOLUTION 237 – PROTECTION OF CLINICIAN-PATIENT PRIVILEDGE

RECOMMENDATION:

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

**HOD ACTION: Resolution 237 referred.**

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

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

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

RECOMMENDATION:

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

**HOD ACTION: Resolution 213 not adopted.**

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

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

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

RECOMMENDATION:

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

**HOD ACTION: Resolution 214 referred.**

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

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

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

RECOMMENDATION:

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

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

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

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

> Cost Sharing Arrangements for Prescription Drugs H-110.990
> Our AMA:
> 1. believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients;
> 2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes; and
> 3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and out-of-pocket costs of individual prescription drugs prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition.

(29) RESOLUTION 207 – SKY ROCKETING DRUG PRICES

RECOMMENDATION:

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

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

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

Your Reference Committee heard supportive testimony on Resolution 207. Testimony was heard of our AMA efforts to combat price spikes in previously affordable generic

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

H-110.986 Incorporating Value into Pharmaceutical Pricing
(1) Our AMA supports value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by the following principles: (a) value-based prices of pharmaceuticals should be determined by objective, independent entities; (b) value-based prices of pharmaceuticals should be evidence-based and be the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes; (c) processes to determine value-based prices of pharmaceuticals must be transparent, easily accessible to physicians and patients, and provide practicing physicians and researchers a central and significant role; (d) processes to determine value-based prices of pharmaceuticals should limit administrative burdens on physicians and patients; (e) processes to determine value-based prices of pharmaceuticals should incorporate affordability criteria to help assure patient affordability as well as limit system-wide budgetary impact; and (f) value-based pricing of pharmaceuticals should allow for patient variation and physician discretion. (2) Our AMA supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research. (3) Our AMA supports direct purchasing of pharmaceuticals used to treat or cure diseases that pose unique public health threats, including hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size. CMS Rep. 05, I-16

H-110.987 Pharmaceutical Cost

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

H-110.988 Controlling the Skyrocketing Costs of Generic Prescription Drugs
(1) Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs. (2) Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients. (3) Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs. (4) Our AMA supports measures that increase price transparency for generic prescription drugs. Sub. Res. 106, A-15 Reaffirmed: CMS 2, I-15 Reaffirmed in lieu of: Res. 817, I-16

H-110.990 Cost Sharing Arrangements for Prescription Drugs
Our AMA: (1) believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients; (2) believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being

treated; personal income; and other factors known to affect patient compliance and health outcomes; and (3) supports the development and use of tools and technology that enable physicians and patients to determine the actual price and out-of-pocket costs of individual prescription drugs prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition. CMS Rep. 1, I-07 Reaffirmation A-08 Reaffirmed: CMS Rep. 1, I-12 Reaffirmed in lieu of Res. 105, A-13

H-110.991 Price of Medicine
Our AMA (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications, and (2) will pursue legislation requiring pharmacies to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication. CMS Rep. 6, A-03 Appended: Res. 107, A-07

H-110.997 Cost of Prescription Drugs
Our AMA (1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs; (2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices; (3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products; (4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies; (5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies; (6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and (7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients. BOT Rep. O, A-90 Sub. Res. 126 and Sub. Res. 503, A-95 Reaffirmed: Res. 502, A-98 Reaffirmed: Res. 520, A-99 Reaffirmed: CMS Rep. 9, I-99 Reaffirmed: CMS Rep.3, I-00 Reaffirmed: Res. 707, I-02 Reaffirmation A-04 Reaffirmed: CMS Rep. 3, I-04 Reaffirmation A-06 Reaffirmed in lieu of Res. 814, I-09 Reaffirmed in lieu of Res. 201, I-11

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

RECOMMENDATION:

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

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

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

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

D-140.958 Medical Textbooks and Peer-Reviewed Journal Reprints per the Sunshine Act
Our AMA will work, first, with the Centers for Medicare & Medicaid Services (CMS) to administratively expand the Sunshine Act exception that covers "...educational materials that directly benefit patients or are intended for patient use" to include medical textbooks and peer-reviewed journal articles provided to physicians; {given that such resources are, in fact, "continuing educational materials" that assist physicians to become better informed about their clinical decision-making and thus "...directly benefit patients..."}; and if no redress is obtained from CMS, our AMA will work with the Congress to legislatively expand the exception in ACA section 1128G(e)(10)(B)(iii) to include medical textbooks and peer-reviewed journal articles provided to physicians.

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

RECOMMENDATION:

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

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

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

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

D-120.956 Electronic Prescribing and Conflicting Federal Guidelines
Our American Medical Association will address with the Centers for Medicare & Medicaid Services and the Drug Enforcement Administration the contradictory guidance, issued respectively by those two federal agencies, relating to electronic transmission of physicians? prescriptions to pharmacies--commonly referred to as "e-prescribing"--for Schedules III, IV and V drugs, as those current guidelines add rather than reduce administrative paperwork and defeat the purpose of electronic handling of prescriptions.

D-120.958 Federal Roadblocks to E-Prescribing
(1) Our AMA will initiate discussions with the Centers for Medicare and Medicaid Services and state Medicaid directors to remove barriers to electronic prescribing including removal of the Medicaid requirement that physicians write, in their own hand, "brand medically necessary" on a paper prescription form. (2) Our AMA will

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

H-478.991 Federal EMR and Electronic Prescribing Incentive Program
Our AMA: (1) will communicate to the federal government that the Electronic Medical Record (EMR) incentive program should be made compliant with AMA principles by removing penalties for non-compliance and by providing inflation-adjusted funds to cover all costs of implementation and maintenance of EMR systems; (2) supports the concept of electronic prescribing, as well as the offering of financial and other incentives for its adoption, but strongly discourages a funding structure that financially penalizes physicians that have not adopted such technology; and (3) will work with the Centers for Medicaid & Medicare Services and the Department of Defense to oppose programs that unfairly penalize or create disincentives, including e-prescribing limitations for physicians who provide care to military patients, and replace them with meaningful percentage requirements of e-prescriptions or exemptions of military patients in the percentages, where paper prescriptions are required.

H-120.957 Prescription of Schedule II Medications by Fax and Electronic Data Transmission
Our AMA: (1) encourages the Drug Enforcement Administration to rewrite Section 1306 of Title 21 of the Code of Federal Regulations to accommodate encrypted electronic prescriptions for Schedule II controlled substances, as long as sufficient security measures are in place to ensure the confidentiality and integrity of the information. (2) Our AMA supports the concept that public key infrastructure (PKI) systems or other signature technologies designed to accommodate electronic prescriptions should be readily adaptable to current computer systems, and should satisfy the criteria of privacy and confidentiality, authentication, incorruptibility, and nonrepudiation. (3) Because sufficient concerns exist about privacy and confidentiality, authenticity, and other security measures, the AMA does not support the use of "hard copy" facsimile transmissions as the original written prescription for Schedule II controlled

substances, except as currently allowed in Section 1306 of Title 21 of the Code of Federal Regulations.

(32) RESOLUTION 217 – INAPPROPRIATE REQUESTS FOR DEA NUMBERS

RECOMMENDATION:

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

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

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

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

H-100.972 Misuse of the DEA License Number
Our AMA: (1) affirms its opposition to use of the Drug Enforcement Administration (DEA) license number for any purpose other than for verification to the dispenser that the prescriber is authorized by federal law to prescribe the substance; and will explore measures to discourage or eliminate the use of physicians' DEA license numbers as numerical identifiers in insurance processing and other data bases, either through legislation, regulation or accommodation with organizations which currently insist on collection of this sensitive data; (2) seeks to have its proposed legislation introduced, which would limit the use of DEA numbers to those federal and state entities that use the

number to oversee and enforce the law regarding the manufacture, distribution, and dispensing of controlled substances; and (3) continues to advocate for the adoption of the AMA's Medical Education number as the unique identifier for physicians.

H-100.982 Confidentiality of Drug Enforcement Agency Numbers
Our AMA (1) believes that the Drug Enforcement Agency should refrain from divulging a physician's DEA number unless there is a valid reason for doing so; (2) believes that insurance companies and pharmaceutical companies should use a physician's state medical license number to identify a physician in the computer files instead of the DEA number when controlled substances are not involved; (3) will develop model legislation to restrict the use of the DEA number for monitoring the prescribing of controlled substances only; and (4) supports legislation or regulations to prevent insurance companies and other entities from using DEA registration numbers for identification of physicians.

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

RECOMMENDATION:

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

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

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

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

Committee therefore recommends that H-105.988 be reaffirmed in lieu of Resolution 223.

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

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

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

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

(b) In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug's or device's approval for marketing.

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

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

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

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

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

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

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

(j) The advertisement should be targeted for placement in print, broadcast, or other electronic media so as to avoid audiences that are not age appropriate for the messages involved.
(k) In addition to the above, the advertisement must comply with all other applicable Food and Drug Administration (FDA) regulations, policies and guidelines.
3. That the FDA review and pre-approve all DTCA for prescription drugs or implantable medical device products before pharmaceutical and medical device manufacturers (sponsors) run the ads, both to ensure compliance with federal regulations and consistency with FDA-approved labeling for the drug or implantable medical device product.
4. That the Congress provide sufficient funding to the FDA, either through direct appropriations or through prescription drug or implantable medical device user fees, to ensure effective regulation of DTCA.
5. That DTCA for newly approved prescription drug or implantable medical device products not be run until sufficient post-marketing experience has been obtained to determine product risks in the general population and until physicians have been appropriately educated about the drug or implantable medical device. The time interval for this moratorium on DTCA for newly approved drugs or implantable medical devices should be determined by the FDA, in negotiations with the drug or medical device product's sponsor, at the time of drug or implantable medical device approval. The length of the moratorium may vary from drug to drug and device to device depending on various factors, such as: the innovative nature of the drug or implantable medical device; the severity of the disease that the drug or implantable medical device is intended to treat; the availability of alternative therapies; and the intensity and timeliness of the education about the drug or implantable medical device for physicians who are most likely to prescribe it.
6. That our AMA opposes any manufacturer (drug or device sponsor) incentive programs for physician prescribing and pharmacist dispensing that are run concurrently with DTCA.
7. That our AMA encourages the FDA, other appropriate federal agencies, and the pharmaceutical and medical device industries to conduct or fund research on the effect of DTCA, focusing on its impact on the patient-physician relationship as well as overall health outcomes and cost benefit analyses; research results should be available to the public.
8. That our AMA supports the concept that when companies engage in DTCA, they assume an increased responsibility for the informational content and an increased duty to warn consumers, and they may lose an element of protection normally accorded under the learned intermediary doctrine.
9. That our AMA encourages physicians to be familiar with the above AMA guidelines for product-claim DTCA and with the Council on Ethical and Judicial Affairs Ethical Opinion E-9.6.7 and to adhere to the ethical guidance provided in that Opinion.
10. That the Congress should request the Agency for Healthcare Research and Quality or other appropriate entity to perform periodic evidence-based reviews of DTCA in the United States to determine the impact of DTCA on health outcomes and the public health. If DTCA is found to have a negative impact on health outcomes and is detrimental to the public health, the Congress should consider enacting legislation to increase DTCA regulation or, if necessary, to prohibit

DTCA in some or all media. In such legislation, every effort should be made to not violate protections on commercial speech, as provided by the First Amendment to the U.S. Constitution.
11. That our AMA supports eliminating the costs for DTCA of prescription drugs as a deductible business expense for tax purposes.
12. That our AMA continues to monitor DTCA, including new research findings, and work with the FDA and the pharmaceutical and medical device industries to make policy changes regarding DTCA, as necessary.
13. That our AMA supports "help-seeking" or "disease awareness" advertisements (i.e., advertisements that discuss a disease, disorder, or condition and advise consumers to see their physicians, but do not mention a drug or implantable medical device or other medical product and are not regulated by the FDA).

(34) RESOLUTION 225 – TRUTH IN ADVERTISING

RECOMMENDATION:

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

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

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

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

Your Reference Committee also heard that our AMA policy has long discouraged discrimination against physicians based on board certification status or the fact that a physician’s license is or has been restricted by the physician’s state medical board. Your Reference Committee heard concerns that this resolution, if adopted, could lead to such discrimination against physicians. In addition, your Reference Committee heard testimony suggesting that disclosure of medical license restrictions would be a particular burden for young physicians in those states that require one or more years of practice

before being eligible for board certification. For these reasons, your Reference Committee recommends that AMA Policy H-405.969 be reaffirmed in lieu of Resolution 225.

H-405.969 Definition of a Physician
1. The AMA affirms that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine. 2. AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition above, must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree. 3. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign.

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

RECOMMENDATION:

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

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

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

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

H-285.915 AMA Policy on ERISA
1. Our AMA will seek, through amendment of the ERISA statute, through enactment of separate federal patient protection legislation, through enactment of similar state patient protection legislation that is uniform across states, and through targeted elimination of the ERISA preemption of self-insured health benefits plans from state regulation, to require that such self-insured plans: (a) Ensure that plan enrollees have access to all needed health care services; (b)

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

H-285.945 Establishment of Liability of Managed Care Organizations
Our AMA supports changes in federal law to prohibit the exemption from liability of managed care organizations, including ERISA plans, for damages resulting from their policies, procedures, or administrative actions taken in relation to patient care.

D-383.984 ERISA and Managed Care Oversight
Our AMA will develop, propose, and actively support (1) federal legislation clarifying that ERISA preemption does not apply to physician/insurer contracting issues; (2) federal legislation that requires all third party payers serving as administrators for ERISA plans to accept assignment of benefits by patients to physicians; and (3) federal and state legislation prohibiting "all products" clauses or linking participation in one product to participation in other products ("tied") administered or offered by third party payers or their affiliates.

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

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

RECOMMENDATION:

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

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

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

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

D-190.992 HIPAA Privacy Regulations Implementation
Our AMA shall continue to make it an urgent priority to undertake a comprehensive review including unfunded physicians costs of implementation of HIPAA transaction, privacy and security rules to identify provisions that should be clarified, improved or repealed and communicate there urgently needed changes to the Department of Health and Human Services and Congress for prompt action, including any necessary delays in implementation, as appropriate.

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

RECOMMENDATION:

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

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

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

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

> H-320.948 Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans
> It is the policy of our AMA, when a health plan or utilization review organization makes a determination to retrospectively deny payment for a medical service, or down-code such a service, the physician rendering the service, as well as the patient who received the service, shall receive written notification in a timely manner that includes: (1) the principal reason(s) for the determination; (2) the clinical rationale used in making the determination; and (3) a statement describing the process for appeal.
>
> H-320.952 External Grievance Review Procedures. Our AMA establishes an External Grievance procedure for all health plans including those under the Affordable Care Act (ACA) with the following basic components: (1) It should apply to all health carriers and Accountable Care Organizations; (2) Grievances involving adverse determinations may be submitted by the policyholder, their representative, or their attending physician; (3) Issues eligible for external grievance review should include, at a minimum, denials for (a) medical necessity determinations; and (b) determinations by carrier that such care was not covered because it was experimental or investigational; (4) Internal grievance procedures should generally be exhausted before requesting external review; (5) An

expedited review mechanism should be created for urgent medical conditions; (6) Independent reviewers practicing in the same state should be used whenever possible; (7) Patient cost sharing requirements should not preclude the ability of a policyholder to access such external review; (8) The overall results of external review should be available for public scrutiny with procedures established to safeguard the confidentiality of individual medical information; (9) External grievance reviewers shall obtain input from physicians involved in the area of practice being reviewed. If the review involves specialty or sub-specialty issues the input shall, whenever possible, be obtained from specialists or sub-specialists in that area of medicine.

H-320.958 Emerging Trends in Utilization Management
The AMA will: (1) maintain a leadership role in coordinating private sector efforts to develop and refine utilization management and quality assessment programs; (2) establish an active role in the development of any national utilization management and quality assessment programs that are proposed in the ongoing health system reform debate; and (3) advocate strongly for utilization management and quality assessment programs that are non-intrusive, have reduced administrative burdens, and allow for adequate input by the medical profession.

H-320.968 Approaches to Increase Payer Accountability
Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability. (1) Disclosure Requirements. Our AMA supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on (a) coverage provisions, benefits, and exclusions; (b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient; (d) medical expense ratios; and (e) cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97) (2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review; (c) Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity or

appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay. (3) Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above.

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

RECOMMENDATION:

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

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

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

Your Reference Committee heard generally supportive testimony on Resolution 243. Your Reference Committee strongly agrees that interoperability of electronic medical data, including the context of Prescription Drug Monitoring Programs (PDMP), can be invaluable in providing quality patient care. Your Reference Committee also agrees that interoperability should focus on usefulness, timeliness, correctness and completeness of data, as well as the ease and cost of information access. Your Reference Committee heard testimony that AMA already has strong policy regarding PDMPs and for advocating for interoperability. Thus, your Reference Committee recommends reaffirming Policies D-478.995 and D-478.972 in lieu of Resolution 243.

D-478.995 National Health Information Technology.
(1) Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the

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

D-478.972 EHR Interoperability
Our AMA: (1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System; (2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange; (3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges; (4) will continue efforts to promote interoperability of EHRs and clinical registries; (5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates; and (6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private.

Madam Speaker, this concludes the report of Reference Committee B. I would like to thank Joseph Costabile, MD, George Smith, Jr., MD, John Wernert, MD, Ray Callas, MD, Robert Couch, MD, Elie Azrak, MD, and AMA Staff Paul Westfall, Ashley McGlone, and Kristin Schleiter, and all those who testified before the Committee.

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