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

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

Date: May 17, 2018

Subject: Handbook Addendum - Supplemental Business and Information (A-18)

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

• Report of the HOD Committee on Compensation of the Officers (Reference Committee F)

Resolutions
• 016 Utilization of "LGBTQ" in Relevant Past and Future AMA Policies
• 017 Revised Mission Statement of the AMA
• 115 Expanding On-Site Physician Home Health Care to Low-Income Families and the Chronically Ill
• 116 Ban on Medicare Advantage "No Cause" Network Terminations
• 244 Increasing the Legal Age of Purchasing Ammunition and Firearms from 18 to 21
• 245 Opposing NCOIL Attempts to Stop Physician Dispensing
• 246 Support for Patients and Physicians in Direct Primary Care
• 247 Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program
• 248 Opposition to Firearm Concealed Carry Reciprocity
• 249 Support Any Willing Provider Legislation
• 317 Emerging Technologies (Robotics and AI) in Medical School Education
• 318 AMA Convene Stakeholders to Transition USMLE to Pass / Fail Scoring
• 426 Decrease Adolescent Mortality Through More Comprehensive Graduated Driver Licensing Programs
• 427 Support Gun Buyback Programs in Order to Reduce the Number of Circulating Unwanted Firearms
• 428 LGBTQIA+ Inclusive Sex Education Alongside Heterosexual Sex Education
• 429 E-Cigarette Ingredients
• 430 Vector-Borne Diseases
• 431 Low Nicotine Cigarette Product Standard
• 432 Legal Action to Compel FDA to Regulate E-Cigarettes
• 433 Firearm Safety
• 518 Portable Listening Devices and Noise Induced Hearing Loss
• 519 Warning Labels for Children's Digital and Video Games
• 520 Handling of Hazardous Drugs
• 521 EPA Glider Truck Standard
• 522 Silence Science: EPA Proposed Data Policy
• 605 Practicing Physician Declining Membership Analysis
• 606 Training Physicians in the Art of Public Forum
• 607 Discounted / Waived CPT Fees as an AMA Member Benefit and for Membership Promotion
• 712 Alternative Payment Models and Vulnerable Populations
• 713 Private Equity Firms
• 714 Laboratory Benefit Managers

Please note: Resolution 222, Evidence Based Treatment in Substance Abuse Treatment Facilities, has been revised and is included in this handbook addendum.

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

The charts listing actions taken in follow-up to resolutions and report recommendations from the 2017 Annual and Interim Meetings will be posted on the Annual Meeting website (ama-assn.org/annual-meeting).
This report by the Committee at the 2018 Annual Meeting presents one recommendation.

BACKGROUND

At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on Trustee Compensation, currently named the Committee on Compensation of the Officers, (the “Committee”). The Officers are defined in the American Medical Association’s (AMA) Constitution and Bylaws. (Note: under changes to the Constitution previously approved by the HOD, Article V refers simply to “Officer,” which includes all 21 members of the Board among whom are President, President-Elect, Immediate Past President, Secretary, Speaker of the HOD and Vice Speaker of the HOD, collectively referred to in this report as Officers). The composition, appointment, tenure, vacancy process and reporting requirements for the Committee are covered under the AMA Bylaws. Bylaws 2.13.4.5 provides:

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

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

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

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

At A-11, the HOD approved the alignment of Medical Student and Resident Officer Compensation
with that of all other Officers (excluding Presidents and Chair) because these positions perform
comparable work. At I-11, an updated compensation structure, based on research and counsel
provided by the committee’s external consultant Mr. Don Delves, founder of the Delves group, was
recommended to and approved by the HOD.

At I-13 the committee recommended and the HOD approved providing a travel allowance for each
President to be used for upgrades because of the significant volume of travel in representing our
AMA.

At I-16, based on results of a comprehensive compensation review conducted by Ms. Becky Glantz
Huddleston an expert in Board Compensation with Willis Towers Watson, the Committee
recommended and the HOD approved modest increases to the Governance Honorarium and Per
Diems for Officer Compensation, excluding the Presidents and Chair, effective July 1, 2017. A-
17’s report, approved by the HOD, modified the Governance Honorarium and Per Diem definition
so that Internal Representation, in excess of eleven days, receives a per diem.

METHODOLOGY

Early in 2018, the Committee asked its outside consultant to review and update the 2016 research
on compensation of the Officers, focusing on the compensation of the leadership positions:
President, President-elect, Immediate Past President, Chair and Chair-elect. The purpose of the
review was to ensure the leadership roles are compensated appropriately for the work performed on
behalf of the AMA.

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

• Compensation should be based on the value expected by the AMA from its Officers.
• Compensation should take into account that the AMA is a complex organization when
  comparing compensation provided to Board members by for-profit organizations and by
  complex not-for-profit organizations of similar size and activities.
• Compensation should be aligned with the long-term interests of AMA members and the
  fulfillment of the fiduciary responsibilities of the Officers.
• Officers should be adequately compensated for their value, time, and effort.
• Compensation should reinforce choices and behaviors that enhance effectiveness.
• Compensation should be approached on a comprehensive basis, rather than as an array of
  separate elements.

The process the Committee followed along with the aforementioned principles is consistent with
the guidelines recommended by the IRS for determining reasonable and competitive levels of
Officer compensation.
The Committee, with assistance from Ms. Huddleston developed their recommendations based on:

- The current compensation structure.
- Review and analysis of leadership compensation data for the past ten terms – the last increase in leadership compensation was in 2008.
- Pay practices for leadership positions at for-profit and not-for-profit organizations similar to the AMA who pay their Board members.
- A collaborative, deliberative and objective review process.

FINDINGS

The Committee notes that Board leadership roles; President, President-elect, Immediate Past President, Chair and Chair-elect continue to make significant time commitments in supporting our AMA in governance and representation functions and that representation work is unique to AMA leadership and officer roles.

AMA’s leadership roles have a significant level of responsibility, resulting in a time commitment well above that required by other not-for-profit boards. As a result, to assess the AMA compensation levels versus the not-for-profits compensation levels, a four-year average hourly rate was determined for each AMA leadership position aligned with the hourly rate for the Chair position at other not-for-profit organizations and associations. The three Presidents and the Chair-elect positions are unique to the AMA and as such, these roles were also aligned to the external data of the Chair position.

The report concluded that while the leadership compensation structure is generally aligned with the external market, modest increases are appropriate to better align AMA leadership compensation to the market median hourly rate. In considering an increase, the report also cited the fact that annual honoraria have not been changed since 2008. Additionally the external market data from other not-for-profit organizations and associations reflected a 1% annual increase in compensation for the Chair position for the past two years.

While one might apply the 1% annual market median increase to each of the past 10 years leadership did not receive an increase, the AMA’s Compensation Philosophy for Officers requires consideration of a volunteerism component in their compensation while fairly compensating leadership for the level of fiduciary responsibilities and the time commitment required of the roles. As such the Committee is recommending a modest increase of 4% to the leadership honoraria recognizing that this will be the first increase in ten years.

RECOMMENDATIONS

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

1. That the President, President-elect, Immediate Past-President, Chair, and Chair-elect Honoraria be increased by 4% effective July 1, 2018. The 4% increase results in the following Honoraria:
## POSITION GOVERNANCE HONORARIUM

<table>
<thead>
<tr>
<th>POSITION</th>
<th>GOVERNANCE HONORARIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>President</td>
<td>$290,160</td>
</tr>
<tr>
<td>Immediate Past President</td>
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<tr>
<td>President-Elect</td>
<td>$284,960</td>
</tr>
<tr>
<td>Chair</td>
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<tr>
<td>Chair-Elect</td>
<td>$207,480</td>
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(Modify Current HOD Policy)

Fiscal Note: $51,840

### APPENDIX

<table>
<thead>
<tr>
<th>POSITION</th>
<th>GOVERNANCE HONORARIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Officers</td>
<td>$65,000</td>
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</table>

Definition of Governance Honorarium Effective July 1, 2017:

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

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

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

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

Officers, excluding the Board Chair and the Presidents, who are assigned as the AMA representative to outside groups as one of their specific Board assignments or assigned Internal Representation day above eleven (11), receive a per diem rate for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for these meetings would require approval of the Chair of the Board. The amount of the Telephonic Per Diem will be $650.
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 016
(A-18)

Introduced by: GLMA: Health Professionals Advancing LGBT Equality

Subject: Utilization of “LGBTQ” in Relevant Past and Future AMA Policies

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Peter H. Rheinstein, MD, JD, MS, Chair)

Whereas, The term “queer” is defined by the Human Rights Campaign (HRC) as “an umbrella term that encompasses many people as it intersects with sexual orientation and gender identity;” and “LGBTQ” has formally been adopted by the organization as a broader representation of individuals for whom its work focuses; and

Whereas, The word “queer” includes anyone who does not associate with typical classifications of gender, gender identity, and sexual orientation; rather, they have non-binary or gender expansive identities; and

Whereas, In the HRC’s 2012 survey of 50,000 self-identified LGBTQ youth age 13-18, eight (8) percent of respondents identified as a gender other than male or female; and

Whereas, According to the HRC, when asked to label their gender and sexual orientation, hundreds of respondents used “queer,” “genderqueer,” or other responses; and many others wrote in their own descriptions of more fluid identities; and

Whereas, In 2016, the AMA Board of Trustees recognized the importance of a more expansive definition of sexual and gender minorities and officially renamed the AMA Advisory Committee on LGBTQ Issues; and

Whereas, Recent AMA policies passed by the AMA House of Delegates have utilized the abbreviation “LGBTQ” and the expanded language “lesbian, gay, bisexual, transgender, and queer” (H-160.991, H-60.927); and

Whereas, The use of “LGBTQ” has come to replace “LGBT” in many aspects of culture, medicine, academics, and advocacy; and

Whereas, It is important for the AMA to recognize those within the LGBTQ population who identify as queer so that they will be fully embraced and empowered within our AMA and the healthcare community; therefore be it

RESOLVED, That our American Medical Association utilize the terminology “lesbian, gay, bisexual, transgender, and queer” and the abbreviation “LGBTQ” in all future policies and publications when broadly addressing this population, (New HOD Policy); and be it further

RESOLVED, That our AMA revise all relevant and active policies to utilize the abbreviation “LGBTQ” in place of the abbreviations “LGBT” and “GLBT” where such text appears (Modify Current HOD Policy); and be it further
RESOLVED, That our AMA revise all relevant and active policies to utilize the terms “lesbian, gay, bisexual, transgender, and queer” to replace “lesbian, gay, bisexual, and transgender” where such text appears. (Modify Current HOD Policy)

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

Received: 05/10/18

References:
Human Rights Campaign Post-election Survey of Youth www.hrc.org/youth

RELEVANT AMA POLICY

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927
Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.
Citation: (Res. 402, A-12)

Health Disparities Among Gay, Lesbian, Bisexual and Transgender Families D-65.995
Our AMA supports reducing the health disparities suffered because of unequal treatment of minor children and same sex parents in same sex households by supporting equality in laws affecting health care of members in same sex partner households and their dependent children.
Citation: (Res. 445, A-05; Modified: CSAPH Rep. 1, A-15)

Health Care Needs of Lesbian, Gay, Bisexual and Transgender Populations H-160.991
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
Citation: CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17

Whereas, The Mission Statement of our AMA for many years has been to “Promote the art and science of medicine and the betterment of public health”; and

Whereas, Our AMA has been spending an increasing amount of time discussing physician suicide, burn out and general malaise with practicing medicine; and

Whereas, Darwin has taught that survival depends on adaptation; and

Whereas, It is vital for its survival that our AMA adapt to changing times by updating its Mission Statement; therefore be it

RESOLVED, That our American Medical Association consider its current mission statement to read: The AMA promotes professionalism, the art and science of medicine, physician wellness and the betterment of public health. (Directive to Take Action)

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

Received: 05/10/18
Whereas, In 2011, 2 million Medicare patients age 65 or older were homebound, many with severe chronic conditions and functional impairments making it difficult to visit a doctor\(^1\); and

Whereas, Lack of transportation is the third-greatest barrier to care for disabled adults, with 12.2% percent of patients stating that they could not get a ride to their doctor’s office as shown in a 2014 survey of Medicaid users\(^2\); and

Whereas, Home health technology advancements have improved physicians’ delivery of care outside the office, particularly for patients with multiple conditions and limited mobility\(^3\)\(^-\)\(^5\); and

Whereas, House call programs that target high-risk patients have significantly reduced healthcare costs and improved medical outcomes\(^6\); and

Whereas, The Patient Protection and Affordable Care Act established the Maternal and Infant Early Childhood Home Visiting program (MIECHV) in 2010, targeting high risk families and leading to reduced child health care costs and need for remedial education\(^7\); and

Whereas, Policymakers have increased support of home visits since 2012 when introducing the Independence at Home (IAH) Demonstration aimed at delivering comprehensive primary care for Medicare beneficiaries with multiple chronic conditions; and

Whereas, Based on findings from Centers for Medicare & Medicaid Services’ (CMS) IAH demonstration, introducing medically necessary home visits saved $25 million in the program’s inaugural year\(^8\); and


\(^7\) Sarah Avellar et al., Home Visiting Evidence of Effectiveness Review: Executive Summary, Washington, D.C. U.S. Department of Health and Human Services, Office of Policy, Research and Evaluation, September 2013
Whereas, The Medicaid program allows states to develop 1915(c) home and community-based services (HCBS) waivers targeting specific high-risk populations who prefer to receive long-term care in their homes or communities rather than at medical institutions. Annual HCBS waiver expenditure of $25 billion in 2006 resulted in estimated savings of over $57 billion, or $57,338 per participant. While health outcomes of HCBS programs are difficult to evaluate, as they are highly variable, it has been found that states that invest more in HCBS as a percentage of total long-term care spending produce lower rates of adverse health outcomes;

Whereas, Veterans Health Administration (VHA) created the Home-based Primary Care (HBPC) program in 1970 to provide comprehensive primary care in homes of veterans with conditions precluding them from clinic-based care. Targeting patients among the 5% highest cost, the model has been associated with 24% reduction in total cost of VHA care, 9% fewer hospitalizations, 10% fewer emergency department visits, and 23% fewer specialist visits; and

Whereas, Although these house call programs have shown great promise in cutting healthcare costs while improving medical outcomes, their utility is limited by the small number of high-risk or low income patients they serve; and

Whereas, The MIECHV program represents the largest federal investment in home visits, the program reached only 145,500 parents and children in 2015, leaving many high-risk, low-income families without home visit resources; and

Whereas, Patients must live near one of only 14 participating health care providers nationwide in order to be eligible for the IAH demonstration. Expanding project to all eligible beneficiaries could save Medicare up to $4.8 billion a year; and

Whereas, Despite being the nation’s largest house call program, HCBS provides home-and community-based services to only 4% of total Medicaid population, representing 2.2 million beneficiaries; and

Whereas, As of 2010, HBPC only provided home-based care to merely 25,000 of the 8.1 million veterans VHA served annually, significantly restricting the program’s cost-savings and impact; and

Whereas, Ensuring that at-risk families have access to home visiting services even if they are not covered by Medicaid is critical; therefore be it

RESOLVED, That our American Medical Association amend Policy H-210.981, “On-site Physician Home Health Care,” by addition and deletion to read as follows:

The AMA: (1) recognizes that timely access to physician care for the frail, chronically ill, disabled or low-income patient is a goal that can only be met by an increase in physician house calls to this vulnerable, underserved population.
(2) strongly supports the role of interdisciplinary teams in providing direct care in the patient’s own home, but recognizes that physician oversight of that care from a distance must sometimes be supplemented by on-site physician care through house calls.
(3) advocates that the physician who collaborates in a patient’s plan of care for home health services should see that patient on a periodic basis.
(4) recognizes the value of the house call in establishing and enhancing the physician-patient and physician-family relationship and rapport, in assessing the effects of the social, functional and physical environment on the patient’s illness, and in incorporating the knowledge gained into subsequent health care decisions.
(5) believes that physician on-site care through house calls is important when there is a change in condition that cannot be diagnosed over the telephone with the assistance of allied health personnel in the home and assisted transportation to the physician’s office is costly, difficult to arrange, or excessively tiring and painful for detrimental to the patient’s health.
(6) recognizes the importance of improving communication systems to integrate the activities of the disparate health professionals delivering home care to the same patient. Frequent and comprehensive communication between all team members is crucial to quality care, must be part of every care plan, and can occur via telephone, FAX, e-mail, video telemedicine and in person.
(7) recognizes the importance of removing economic, institutional and regulatory barriers to physician house calls, including the development of programs for low-income families and older adults.
(8) supports the requirement for a medical director for all home health agencies, comparable to the statutory requirements for medical directors for nursing homes and hospice.
(9) recommends that all specialty societies address the effect of dehospitalization on the patients that they care for and examine how their specialty is preparing its residents in-training to provide quality care in the home.
(10) encourages appropriate specialty societies to continue to develop educational programs for practicing physicians interested in expanding their involvement in home care.
(11) urges CMS to clarify and make more accessible to physicians information on standards for utilization of home health services, such as functional status, and severity of illness, and socioeconomic status.
(12) urges CMS, in its efforts to redefine homebound, to consider the adoption of criteria and methods that will strengthen the physician’s role in authorizing home health services, as well as how such criteria and methods can be implemented to reduce the paperwork burden on physicians. (Modify Current HOD Policy)

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

Received: 05/08/18
RELEVANT AMA POLICY

On-Site Physician Home Health Care H-210.981
The AMA: (1) recognizes that timely access to physician care for the frail, chronically ill or disabled patient is a goal that can only be met by an increase in physician house calls to this vulnerable, underserved population.
(2) strongly supports the role of interdisciplinary teams in providing direct care in the patient's own home, but recognizes that physician oversight of that care from a distance must sometimes be supplemented by on-site physician care through house calls.
(3) advocates that the physician who collaborates in a patient's plan of care for home health services should see that patient on a periodic basis.
(4) recognizes the value of the house call in establishing and enhancing the physician-patient and physician-family relationship and rapport, in assessing the effects of the social, functional and physical environment on the patient's illness, and in incorporating the knowledge gained into subsequent health care decisions.
(5) believes that physician on-site care through house calls is important when there is a change in condition that cannot be diagnosed over the telephone with the assistance of allied health personnel in the home and assisted transportation to the physician's office is costly, difficult to arrange, or excessively tiring and painful for the patient.
(6) recognizes the importance of improving communication systems to integrate the activities of the disparate health professionals delivering home care to the same patient. Frequent and comprehensive communication between all team members is crucial to quality care, must be part of every care plan, and can occur via telephone, FAX, e-mail, videotelemedicine and in person.
(7) recognizes the importance of removing economic, institutional and regulatory barriers to physician house calls.
(8) supports the requirement for a medical director for all home health agencies, comparable to the statutory requirements for medical directors for nursing homes and hospice.
(9) recommends that all specialty societies address the effect of dehospitalization on the patients that they care for and examine how their specialty is preparing its residents in-training to provide quality care in the home.
(10) encourages appropriate specialty societies to continue to develop educational programs for practicing physicians interested in expanding their involvement in home care.
(11) urges CMS to clarify and make more accessible to physicians information on standards for utilization of home health services, such as functional status and severity of illness.
(12) urges CMS, in its efforts to redefine homebound, to consider the adoption of criteria and methods that will strengthen the physician's role in authorizing home health services, as well as how such criteria and methods can be implemented to reduce the paperwork burden on physicians.
Citation: (CSA Rep. 9, I-96; Reaffirmed and Appended:CMS Rep. 4, I-97; Reaffirmation I-98; Reaffirmed: CMS Rep. 4, A-08)

Providing Cost Estimate with Home Health Care Order Authorization H-210.996
The AMA urges physicians to request home health care providers to provide a cost estimate with the physician authorization form, when the form is sent to the physician for his/her signature.
Citation: Res. 63, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed by Res. 122, A-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: CMS Rep. 01, A-17

Medicaid Patient-Centered Medical Home Models H-160.913
Our AMA: (1) recognizes that the physician-led medical home model, as described by Policy H-160.919, has demonstrated the potential to enhance the value of health care by improving access, quality and outcomes while reducing costs; and (2) will work with state medical associations to explore, and where feasible, implement physician-led Medicaid patient-centered medical home models based on the unique needs of the physicians and patients in their states.
Citation: (CMS Rep. 3, A-12)
Whereas, In recent years Medicare Advantage plans have been issuing “no cause” terminations to physicians in their network; and

Whereas, UnitedHealthcare Medicare Advantage in 2013 and Anthem Blue Cross Medicare Advantage in 2018 are but two examples of major insurers that have issued such “no cause” network terminations; and

Whereas, Physicians have been given limited time to appeal such “no cause” network terminations; and

Whereas, Appealing a “no cause” network termination presents an extreme challenge for physicians as there is no reason given for the termination; and

Whereas, Such “no cause” network termination notices often come in a non-descript generic mailing and are often missed as junk mail by physician office staff; and

Whereas, As a result, many physicians miss the limited appeal window given; and

Whereas, Patients are often misinformed and not informed in a timely matter of such physician termination; therefore be it

RESOLVED, That our American Medical Association advocate for legislation that would ban Medicare Advantage plans from issuing “no cause” network terminations, require a Medicare Advantage plan that terminates a physician from a network to provide substantive reasons for such termination, require such termination to be sent by certified mail, require that the Medicare Advantage plan provide at least sixty (60) days for physicians to appeal such termination; and require that the Medicare Advantage plan provide the physician with a listing of the impacted patient names and a copy of the correspondence sent to impacted patients. (Directive to Take Action)

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

Received: 05/08/18
Whereas, The opioid epidemic has become a critical threat to public health in the U.S.\textsuperscript{1}; and 

Whereas, Only 10 percent of individuals in the U.S. with an opioid use disorder obtain treatment\textsuperscript{1}; and 

Whereas, Facilities that provide inpatient treatment for opioid use disorder usually do not use an evidence-based approach\textsuperscript{2,3} in that less than half of these facilities offer an FDA-approved medication for opioid use disorder; and 

Whereas, The risk of a fatal overdose increases 25-fold in the month immediately after inpatient treatment of opioid use disorder without medication\textsuperscript{4}, in part due to loss of opioid tolerance\textsuperscript{5}; and 

Whereas, Opioid overdose death is reduced by 50 percent by treatment with opioid agonist or partial agonist therapy (methadone or buprenorphine)\textsuperscript{6}, which prevent loss of opioid tolerance; and 

Whereas, Clinical guidelines indicate that the choice of treatment options should be a shared decision between the clinician and the patient\textsuperscript{7}; and 

Whereas, Our AMA has many policies regarding treatment of opioid use disorder, yet no policy addresses the central role that chemical dependency treatment programs play in treating opioid use disorder; therefore be it 

RESOLVED, That our American Medical Association advocate for legislation that eliminates barriers to, increases funding for, and requires access to opioid agonist or partial agonist therapy at all certified drug treatment facilities. (New HOD Policy) 

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

Received: 05/02/18

References
\textsuperscript{3} “Where multiple modes of medication-assisted treatment are available,” Health Affairs Blog, January 9, 2018. DOI: 10.1377/hblog20180104.835958. 
Whereas, Existing AMA policy states “gun violence represents a public health crisis which requires a comprehensive public health response and solution” (D-145.995); and

Whereas, Current federal law limits the purchase of handguns to age 21 and purchase of long guns to age 18 from a licensed firearms dealer, but unlicensed persons may sell a long gun to a person of any age and handguns to individuals 18 and older;¹ and

Whereas, Federal law and laws in 38 states allow 18- to 20-year-olds to legally possess handguns from unlicensed sellers, such as online retailers and sellers at gun shows;² and

Whereas, Adolescents are predisposed to risk-taking and impulsive behaviors as a result of both social pressure and physiological changes, making youths between 18 and 20 years old more likely to commit homicide than any other age-specific cohort³,⁴,⁵ with homicide offending rates rising sharply at age 18 and peaking at age 20⁶; and

Whereas, All 50 states have established 21 as the minimum legal age for consumption of alcoholic beverages due to evidence of heightened risk-taking in adolescence and to protect youth and the public from alcohol abuse⁷,⁸; and

Whereas, Homicide and suicide are the second and third leading causes of death behind motor vehicle accidents in people ages 15-24 with the main cause for within each category being discharge of a firearm⁹; and

³Ibid
Whereas, Examination of gun offenders incarcerated in the 13 states with the weakest standards for legal firearm ownership found that the largest group of offenders were between 18 and 20 years of age and that they would have been prohibited in states with stricter laws for firearm ownership; and

Whereas, Firearms regulations that reduce overall gun availability, including permit and licensing restrictions, decrease both homicide and suicide rates; and

Whereas, Twelve states and the District of Columbia currently have laws that impose a minimum age of 21 for all handgun sales, from licensed or unlicensed sellers; and

Whereas, Florida passed legislation on February 23rd, 2018 to increase the age to purchase a gun from 18 to 21; and

Whereas, In an unadjusted t-test analysis of gun related deaths in each state in 2016, there were statistically significantly fewer gun related deaths in states which had a law requiring an individual purchasing a gun to be 21 or older compared to states with a lower purchase age. (p=5.15e-06).

Whereas, In 2015, among “Crime Against Person” offenders who used a firearm, offenders ages 18-20 (our target cohort) constituted the second largest cohort (11.5%). Offenders ages 19-24 and 25-29 were the largest cohort (13.0%, tied), while offenders ages 30-34 constituted the third largest cohort (8.2%); and

Whereas, In 2015 Illinois, a state that imposes strict gun laws, reported a fourth of offenders from our target cohort (252) compared to Wisconsin’s reported offenders (1008); and

Whereas, From 2001 to 2015, Massachusetts, a state that imposes strict gun laws, reported a ninth of offenders from our target cohort (2629) compared to Tennessee’s reported offenders (23672); and

Whereas, From 2001 to 2015, in Massachusetts, 48.6% and 17.0% of firearm use among our target cohort was reported as a handgun and long gun, respectively; and

Whereas, From 2001 to 2015, in Tennessee, 77.0% and 11.3% of firearm use among our target cohort was reported as a handgun and long gun, respectively; and

Whereas, Companies such as Dick’s Sporting Goods, LL Bean, and Walmart changed their age of firearm purchase to 21 in 2018; and

15 https://wonder.cdc.gov
17 Easy Access to NIBRS Victims (EZANIBRS) https://www.ojjdp.gov/ojstatbb/ezanibrsdv/
18 Massachusetts NIBRS https://masscrime.chs.state.ma.us/public/Browse/browsetables.aspx
Whereas, Over 80% of the public supports increasing the age of being able to purchase an assault-weapon or gun to 21 years old\textsuperscript{21}; and

Whereas, The Age 21 Act, introduced to the Senate on February 28th, 2018, prohibits the purchase of certain firearms by individuals under the age of 21\textsuperscript{22}; and

Whereas, Existing AMA policy supports “bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 18” (H-60.972); and

RESOLVED, That our American Medical Association amend policy H-145.985, “Ban on Handguns and Automatic Repeating Weapons,” by addition and deletion to read as follows:

It is the policy of the AMA to:

(1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:

(a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;

(b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 18 and bans of purchases of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21.

(c) the imposition of significant licensing fees for firearms dealers;

(d) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and

(e) mandatory destruction of any weapons obtained in local buy-back programs.

(2) Support legislation outlawing the Black Talon and other similarly constructed bullets.

(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls. (Modify Current HOD Policy)

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

Received: 05/08/18


RELEVANT AMA POLICY

Prevention of Unintentional Shooting Deaths Among Children H-145.979
Our AMA supports legislation at the federal and state levels making gun owners legally responsible for injury or death caused by a child gaining unsupervised access to a gun, unless it can be shown that reasonable measures to prevent child access to the gun were taken by the gun owner, and that the specifics, including the nature of "reasonable measures," be determined by the individual constituencies affected by the law.
Citation: (Res. 204, I-98; Reaffirmed: BOT Rep. 23, A-09)

See also:
Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
Gun Safety H-145.978
Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
Gun Violence as a Public Health Crisis D-145.995
Physicians and the Public Health Issues of Gun Safety D-145.997
Safety of Nonpowder (Gas-Loaded/Spring-Loaded) Guns H-145.989
Guns in School Settings H-60.947
Guns in Hospitals H-215.977
Gun Regulation H-145.999
AMA Campaign to Reduce Firearm Deaths H-145.988
Waiting Period Before Gun Purchase H-145.992
Firearm Availability H-145.996
Waiting Periods for Firearm Purchases H-145.991

Correlation Between State Handgun Purchase Age and Rate of Deaths from Firearms
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 245
(A-18)

Introduced by: Maryland

Subject: Opposing NCOIL Attempts to Stop Physician Dispensing

Referred to: Reference Committee B
(R. Dale Blasier, MD, Chair)

Whereas, The National Conference of Insurance Legislators (NCOIL) is an organization that convenes legislators from around the United States who are involved with insurance legislation; and

Whereas, NCOIL is dominated by legislators who are connected to the insurance industry; and

Whereas, NCOIL is considering endorsing legislation entitled “Workers’ Compensation Pharmaceutical Reimbursement Rates Model Act” (“Model Act”); and

Whereas, This “Model Act” would disallow physician dispensing after seven days from the injury to a worker except in very limited circumstances; and

Whereas, This “Model Act” would not allow a physician dispenser to charge his or her normal reimbursement and would limit that reimbursement to that charged by a chain pharmacy; and

Whereas, If enacted, this “Model Act” would effectively end the ability of pain management practices and orthopedic practices from dispensing medicines to their patients as well as any other physician practices which are currently dispensing medicines to their patients; and

Whereas, This “Model Act” was developed without any physician input in that only representatives from the Workers’ Compensation Research Institute (WCRI) and a representative of Pharmacy Benefit Managers (PBMs) presented testimony; and

Whereas, The work product of WCRI is well known to MedChi because of legislative debates on physician dispensing from 2010 to 2015; and

Whereas, The work product of WCRI was totally discredited by the Maryland Workers’ Compensation Commission with the result that the Legislature refused to consider any limitation on physician dispensing in the 2015 and 2016 Sessions of the General Assembly; and

Whereas, Physician dispensing has not been the subject matter of any legislation introduced in the 2017 or the 2018 General Assembly; and

Whereas, The full details of the Maryland Workers’ Compensation Commission’s repudiation of WCRI data may be found at www.physiciansresearchinstitute.org by clicking on “Insurance Funded Studies;” and

Whereas, WCRI is the primary data source for proponents who seek to limit or end physician dispensing and was the primary data source for the NCOIL “Model Act;” and
Whereas, Any "Model Act," even from a group such as NCOIL, is not in the interest of the physician community; therefore be it

RESOLVED, That our American Medical Association oppose the National Conference of Insurance Legislators “Workers’ Compensation Pharmaceutical Reimbursement Rates Model Act.” (New HOD Policy)

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

Received: 05/08/18
Whereas, Under Direct Primary Care (DPC), the physician does not contract with any insurer; the patient pays a monthly membership fee directly to the physician, and the physician provides the patient with a basket of services, including office visits, access by telephone and email, etc., for no additional charge; and

Whereas, The DPC model allows physicians to provide care to their patients unencumbered by coding requirements, by MACRA, or by the need to satisfy any insurer’s incentive structure; and

Whereas, Most patients in DPC practices maintain health insurance to cover for services not provided by their PCP, such as hospital care and care by other specialists; and

Whereas, A DPC practice typically provides enhanced access to its patients, and coordinates care that cannot be provided within the practice; and

Whereas, Two significant obstacles were discussed. First, under current federal law, DPC membership fees cannot be paid with health savings account pre-tax dollars. Second, many insurers will not reimburse the patient for specialist care, even when the specialist contracts with the insurer, unless the patient is referred by a contracting PCP; therefore be it

RESOLVED That our American Medical Association advocate for changes in federal law to establish that Direct Primary Care membership fees may be paid with pre-tax funds (New HOD Policy); and be it further

RESOLVED, That our AMA develop model legislation to establish the right of patients to seek care from specialists who are contracted with their insurance plan and to have that service covered when referred by a primary care physician who is not contracted with their insurance plan. (Directive to Take Action)

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

Received: 05/08/18
Whereas, Medicare Access and CHIP Re-Authorization Act (MACRA) of 2015 replaced Sustainable Growth Rate SGR and two payment tracks under the Quality Payment Program (QPP). Participants in an Advanced Alternative Payment Model (APM) will assume significant risk and will therefore also be eligible for significant bonuses. Currently less than 20% of all clinicians participate in an advanced APM, leaving the bulk of clinicians in the fee for service (FFS) or non-risk bearing entities which will constitute the Merit-Based Incentive Payment System (MIPS); and

Whereas, MedPAC and several government agencies have recommended elimination of MIPS and replacement with the Voluntary Value Program (VVP); and

Whereas, The VVP would evaluate physicians and other clinician’s quality based on population measures in a geographic region to determine the quality of an individual practitioner and whether or not he/she should receive financial bonuses or penalties; and

Whereas, Population measures that have been considered include Patient Experience surveys, ED visits, Readmission rates, Mortality and Home and Community Days; and

Whereas, These population measures are associated with significant risks based on socioeconomic factors in a given region, which cannot be accurately attributed to an individual physician’s performance; and

Whereas, The physician’s performance might therefore be rewarded or penalized without any correlation to the actual quality of care that physician provides; and

Whereas, Under the VVP, physicians who are not already involved in an advanced APM would have choices:

1. Virtual Group: Physicians could join/form an Advanced APM Virtual Group with providers from different specialties and/or different regions
2. Join an already existing Advanced APM (Acquisition, Consolidation, Co-Management, Purchase)
3. Remain in FFS (after all the MIPS would no longer exist) and receive a 2 % reduction in Medicare (not including the sequester); therefore be it
RESOLVED, That our American Medical Association oppose the replacement of the Merit-Based Incentive Payment System (MIPS) with the Voluntary Value Program (VVP) as currently defined (New HOD Policy); and be it further

RESOLVED, That our AMA study the criticisms of the Merit-Based Incentive Payment System (MIPS) program as offered by proponents of the VVP to determine where improvement in the MIPS program need to be made (Directive to Take Action); and be it further

RESOLVED, That our AMA continue its advocacy efforts to improve the MIPS program, specifically requesting:

1. True EHR data transparency, as the free flow of information is vital to the development of meaningful outcome measures,
2. Safe harbor protections for entities providing clinical data for use in the MIPS program,
3. Continued infrastructure support for smaller practices that find participation particularly burdensome,
4. Support for risk adjustment of geographic populations for outcome measures, and
5. Limiting public reporting of physician performance to those measures used for scoring in the MIPS program (New HOD Policy); and be it further

RESOLVED, That our AMA determine if population measures are appropriate and fair for measuring physician performance (Directive to Take Action); and be it further

RESOLVED, That our AMA, if possible, develop criteria under which appropriate and fair population measures might be considered for measurement of physician performance. (Directive to Take Action)

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

Received: 05/08/18
Whereas, Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths (D-145.995, H-145.997); and

Whereas, Nationally, among children and youth under 19 in 2015, more than 70 percent of all homicide deaths and over 40 percent of suicide deaths were the result of a firearm, and most firearm-related injuries and deaths of children and adolescents involve a handgun;¹ and

Whereas, The rate of gun deaths and injuries in states with strict licensing regulations and background check requirements is lower than that of states with lax rules. For example, in 2016 Massachusetts had the lowest rate of gun-related deaths in the country at 3.4 deaths per 100,000 population compared with a rate of 21.5 per 100,000 in Alabama, according to the CDC;² and

Whereas, AMA policy (H-145.985) supports the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourages state and local medical societies to evaluate and support local efforts to enact useful controls; and

Whereas, Federal legislation to permit “concealed carry reciprocity” across state lines would lower standards across the country to the lowest common denominator by requiring all states to recognize concealed carry permits granted by other states and by allowing citizens with concealed carry permits in one state to carry guns into states that have stricter laws;³ and

Whereas, Attorneys General from 16 states and the District of Columbia, the National Law Enforcement Partnership to Prevent Gun Violence made up of 9 national law enforcement organizations, and the International Association of Chiefs of Police representing 18,000 police departments across the U.S. have opposed “concealed carry reciprocity” because of the danger it poses to law enforcement agents, to victims of domestic violence, and to the public;⁴,⁵,⁶ and

Whereas, Currently twelve states have no requirements for background checks, firearms training, or a proven need to carry a weapon;⁷,⁸ therefore be it

RESOLVED, That our American Medical Association, in the interest of safety for all citizens, vigorously oppose “concealed carry reciprocity” federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws. (New HOD Policy)
References:


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

Received: 05/08/18

RELEVANT AMA POLICY

Gun Violence as a Public Health Crisis D-145.995
Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress to lift the gun violence research ban.

Citation: Res. 1011, A-16;

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms; (2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths; (3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns; (4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible; (6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms; (7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and (8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

Citation: (CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13)
Whereas, Health insurers are increasingly limiting the size of primary care and specialty networks available to plan members as a cost containment measure, without much consideration to the effect on quality and access to care*; and

Whereas, Such narrowed networks may prevent patients from obtaining or maintaining the physician of their choice; and

Whereas, Such narrowed networks may prevent a physician from referring their patients to the specialist or sub specialist of their choice; and

Whereas, Current AMA Policy strongly opposes the use of tiered and narrow physician networks that deny patient access to, or attempt to steer patients towards certain physicians primarily based on cost of care (H-450.941(2)); and

Whereas, Current AMA Policy seeks legislation to require health plans inform physicians of new panel networks to give physicians sufficient time to satisfy the criteria (D-285.972 (3)); and

Whereas, Our AMA supports fair and equitable compensation to out-of-network providers in the event a network is deemed inadequate (H-285.908 (6)); and

Whereas, Our AMA supports health insurers paying out-of-network physicians fairly and equitable for emergency and out-of-network bills in a hospital ((H-285.908 (7)); and

Whereas, Our AMA supports health system reforms that are consistent with freedom of choice and freedom of practice (H-165.838 (4)); and

Whereas, Current AMA Policy is that Health Insurance Exchange Plans should not restrict enrollees’ access to out-of-network physicians (H-165.838 (5)); and

Whereas, Twenty-seven states currently have “Any Willing Provider” statutes, including AL, AK, CT, DE, GA, ID, IL, IN, KY, LA, MA, ME, MN, MO, MS, NH, NJ, NC, ND, SD, TN, TX, UT, VA, WV, WI, and WY **; and

Whereas, There is no current AMA policy supporting the right of all patients, regardless of plan type and acuity of illness, to select the physician of their choice, and for those physicians to receive compensation for the care they deliver, therefore be it
RESOLVED, That our American Medical Association draft and promote model state legislation which:
1. Allows any patient covered by a specific managed care organization to choose to receive medical care from a physician (MD and DO) licensed in that state willing to agree to the terms of that managed care organization’s contract, and
2. Allows a physician (MD or DO) licensed in that state willing to agree to the terms of a specific managed care organization’s contract to participate in delivering medical services to the patients covered by that managed care organization without being mandated to accept any specific type of insurance or managed care organizations contract. (Directive to Take Action)

*http://www.academyhealth.org/files/ppublications/files/fioedownloads/RIBrief031
** Http://www.ncsl.org/research/health/any-willing-or-authorized-providers.aspx

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

Received: 05/10/18
Whereas, A host of novel technologies are revolutionizing the nature of healthcare delivery, notably including, but not limited to, machine learning\(^1\), surgical robotics\(^2\), high-throughput sequencing\(^3\), and virtual reality\(^4\); and

Whereas, There have been significant advancements to image recognition technology using deep neural networks, a machine learning method that has been applied to a variety of consumer applications and social networks\(^5\); and

Whereas, These image recognition technologies have been demonstrated to be effective for medical applications\(^1\); and

Whereas, The advent of high-throughput sequencing technologies in the past decade has facilitated an explosion of genetic data, including DNA and RNA sequencing technologies\(^3\), and related techniques to conduct genome-wide assays of regulatory protein activity and chromatin accessibility to develop novel gene therapies\(^6\); and

Whereas, Robot-assisted surgery presents an opportunity to enable wider access to surgical procedures across the world through a reduction in cost and training\(^2\), and doctors training to be surgeons should be prepared to learn the techniques that complement the machines, and thus deliver the best care to patients; and

Whereas, It is highly likely that the nature of the careers of most medical students beginning today will be entangled with machine learning technologies such as deep learning technologies used today to identify cancerous cells\(^7\), and thus understanding their high-level uses and limitations is critical to being able to deploy treatments involving machine learning in a manner that optimizes the care given to patients; and

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\(^{3}\) Goodwin S, McPherson JD, McCombie WR. Coming of age: ten years of next-generation sequencing technologies. *Nature Reviews Genetics*. 2016;17(6),333-351.


Whereas, These technologies require specialized training to understand their value and limitations with respect to healthcare delivery; and

Whereas, Partnerships with technology companies already exist in medical school environments\(^8\), thus providing a basis for expanded training programs in future technologies; and

Whereas, AMA policy (H-295.995) states that students should be educated in an increased breadth of clinical knowledge and the AMA MSS (295.044MSS) recognizes the future of medicine as an important educational goal for medical students; and

Whereas, Preparation of medical students and physicians for these transformations in healthcare delivery will reduce associated risks\(^9\) by preventing AI and machine learning from outpacing human understanding; and

Whereas, The automation and increased efficiency of documentation will empower physicians and healthcare professionals to focus on empathy, compassion, and actual time spent with patients; therefore be it

RESOLVED, That our American Medical Association encourage medical schools to evaluate and update as appropriate their curriculum to increase students’ exposure to emerging technologies, in particular those related to robotics and artificial intelligence (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage medical schools to provide student access to computational resources like cloud computing services (Directive to Take Action); and be it further

RESOLVED, That our AMA reaffirm H-480.988 which urges physicians to continue to ensure that, for every patient, technologies will be utilized in the safest and most effective manner by health care professionals (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA reaffirm Section 1.2.11 of the AMA Code of Ethics and H-480.996 that states the guidelines for the ethical development of medical technology and innovation in healthcare. (Reaffirm HOD Policy)

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

Received: 05/01/18

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

**RELEVANT AMA POLICY**

*Recommendations for Future Directions for Medical Education H-295.995*
*Update on the Uses of Simulation in Medical Education D-295.330*
*Physician Reentry D-300.984*
*Nanotechnology, Safety and Regulation H-480.949*
*The Precision Medicine Initiative D-460.968*

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 318
(A-18)

Introduced by: Nebraska

Subject: AMA Convene Stakeholders to Transition USMLE to Pass/Fail Scoring

Referred to: Reference Committee C
(Sherri Baker, MD, Chair)

Whereas, The intended purpose of USMLE examinations (Step 1, Step 2 CK, Step 2 CS, Step 3) is for initial medical licensure, yet the score of the examination is commonly used for purposes beyond licensure including the screening of residency applicants, despite the fact that USMLE scores were not intended to serve this purpose (1, 2); and

Whereas, In the 2016 AAMC Residency PD Survey, 75% of responding PD’s (n=1453) “use filters or minimum thresholds when selecting applicants to interview” (3); and

Whereas, In the 2015 NRMP Applicant Survey, US graduating seniors submitted a median of 30 applications to residency program for matched applicants and 54 residency programs for unmatched applicants (independent applicants applied to 75 and 68 residency programs respectively) (4); and

Whereas, PD’s commonly state that application materials other than USMLE scores (e.g., medical student performance evaluation, letters of recommendation) provide useful information about an applicant but cannot be efficiently utilized to identify students for interviews; and

Whereas, AMA Policy H-275.953 states that USMLE examination scoring should be reported to students in a “pass/fail” format instead of the current three-digit score used by USMLE; and

Whereas, Removing three-digit scores for USMLE examinations, in lieu of other available applicant materials, may create overwhelming administrative burden for PD’s; and

Whereas, Current residency program accreditation standards remain dependent upon a rolling pass rate of ABMS Board Certification by graduates of that program, thereby influencing PD decisions about interviews and rankings of medical students; and

Whereas, While numerical USMLE scores are an objective way to screen applicants for interviews, reliance on such scores may be having negative consequences on curricular innovation, student well-being, and resident diversity (5), a concern that was recently validated by curricular leaders of the AMA Change Med Ed Consortium; and

Whereas, AMA Policy H-275.953 also states, “That our AMA work with the appropriate stakeholders to study alternate means of scoring USMLE exams in order to avoid the inappropriate use of USMLE scores for screening residency applicants”; and

Whereas, The complex topic of USMLE score reporting was a key item of discussion at the March 2018 AMA Change Med Ed Consortium meeting where many potential solutions were identified; and
Whereas, The momentum generated by this meeting and the years of experience related to the Consortium makes the AMA an appropriate convening body for further innovative work in this important area; therefore be it

RESOLVED, That our American Medical Association amend Policy H-275.953, “The Grading Policy for Medical Licensure Examinations,” by addition and deletion to read as follows:

1. Our AMA’s representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection.

2. Our AMA adopts the following policy on NBME or USMLE examination scoring: (a) Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students.

3. Our AMA will work with the appropriate stakeholders to study alternate means of possible mechanisms for transitioning scoring of the USMLE exams to a Pass/Fail system in order to avoid the inappropriate use of USMLE scores for screening residency applicants while still affording program directors adequate information to meaningfully and efficiently assess medical student applications, and that the recommendations of this study be made available by the 2019 Interim Meeting of the AMA House of Delegates. (Modify Current HOD Policy)

References:

Fiscal Note: Modest - between $1,000 - $5,000.
Received: 05/10/18

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

RELEVANT AMA POLICY
The Grading Policy for Medical Licensure Examinations H-275.953
1. Our AMA’s representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection.
2. Our AMA adopts the following policy on NBME or USMLE examination scoring: (a) Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students.
3. Our AMA will work with the appropriate stakeholders to study alternate means of scoring USMLE exams in order to avoid the inappropriate use of USMLE scores for screening residency applicants.

Whereas, Motor vehicle crashes are the leading causes of death for teenagers in the United States (16-19);¹ and

Whereas, Teen drivers ages 16-19 are three times more likely to be involved in a fatal accident than drivers over the age of 20;² and

Whereas, Teenagers (age 16-19) involved in fatal motor vehicle crashes are twice as likely to bear significant responsibility for their crash compared to similar fatal crashes of older counterparts;³,⁴ and

Whereas, Newly licensed teenage drivers are twice as likely to crash in their first month of driving than they are after a year of experience, and most incidents tend to involve errors in judgement or lack of experience;⁵ and

Whereas, Teenage drivers are more likely than their older counterparts to not recognize hazardous conditions or make critical decision errors while driving;⁶,⁷ and

Whereas, The risk of fatal crashes amongst teenage drivers increases with the number of teen passengers, and said crashes are more likely to be in single vehicle-crashes;⁸,⁹,¹⁰ and

Whereas, Graduated Driver Licensing (GDL) programs have been associated with a substantial reduction in fatal crash rates among teenage drivers,¹¹-¹² and

⁷ McDonald CC, Curny AE, Kandadai V, et. al. Comparison of teen and adult driver crash scenarios in a nationally representative sample of serious crashes. Accident Analysis & Prevention 2014;72:302-308.
Whereas, All 50 states and DC have adopted some form of GDL program, but they vary quite drastically with respect to their specific requirements;\textsuperscript{13} and

Whereas, The NIH and United States Department of Transportation have found that the most effective legislation includes at least 5 of the following 7 elements, “A minimum age of 16 for a learner’s permit, a mandatory waiting period of at least six months before a driver can apply for an intermediate license, a requirement for 50 to 100 hours of supervised driving before testing for an intermediate license, a minimum age of 17 for an intermediate license, restrictions on nighttime driving, a limit on the number of teenaged passengers allowed in the car, and a minimum age of 18 for a full license;”\textsuperscript{14} and

Whereas, As of March 2018 no states have adopted all of the best practices for state GDL laws proposed by the Insurance Institute for Highway Safety who estimate such measures could save over 500 lives a year;\textsuperscript{15} and

Whereas, Research has shown that the most influential components of varying Graduated Driving Licensing programs in lowering the risk of fatal teen crashes are a delayed permit and licensing age, more required practice hours, nighttime restrictions, and teenage passenger restrictions;\textsuperscript{16-17} therefore be it

RESOLVED, That our American Medical Association support the standardization and implementation of more comprehensive Graduated Driver Licensing programs including but not limited to increasing permit and licensing age requirements, mandatory minimum training hours, and nighttime and teenage passenger restrictions. (New HOD Policy)

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

Received: 05/08/18

RELEVANT AMA POLICY
Licensing People to Drive H-15.972
Older Driver Safety H-15.954
Medical Advisory Boards in Driver Licensing H-15.995
Automobile-Related Injuries H-15.990
Fatigue, Sleep Disorders, and Motor Vehicle Crashes H-15.958
Options for Improving Motorcycle Safety D-15.999
Automatic (i.e., Passive) Restraints to Prevent Injuries and Deaths from Motor Vehicle Accidents H-15.986
Motor Vehicle Accidents H-15.992


AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 427
(A-18)

Introduced by: Maryland

Subject: Support Gun Buyback Programs in Order to Reduce the Number of Circulating Unwanted Firearms

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, Existing AMA-policy states “gun violence represents a public health crisis which requires a comprehensive public health response and solution” (D-145.995); and

Whereas, A survey of 186 people in Massachusetts who turned in 339 weapons (and received between $25-75 for doing so) for which 109 (59%) responded found that 54% turned in guns for safety reasons, 47% for no longer needing or wanting their guns, and 13% for concern that the gun(s) were accessible to children1; and

Whereas, 87% of respondents in the survey felt that the buyback program helped encourage neighborhood awareness of firearm safety1; and

Whereas, Gun buyback programs have also been utilized in Maryland, with motivating factors including recent school shootings and a desire for guns to be removed from circulation so they do not end up in the wrong hands and cause harm to others;2,3,4 and

Whereas, Following the massacre of 35 people in Australia in 1996 by a lone gunman using a semi-automatic weapon, Australia instituted several measures among which were compulsory buybacks of the banned guns5; and

Whereas, Australia’s national firearm stockpile decreased by ¼ following the passing of this legislation, rates of total gun deaths have declined, public mass shootings stopped, and it was estimated that at least 200 deaths and $500 million was being saved annually2; and

Whereas, The UK has used a few approaches to stemming gun violence, among which is a gun buyback program6; and

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Whereas, It was estimated in 2010 that there were 3.78 guns per 100 people in the UK while the
US had 101 guns per 100 people, and that there have been 50-60 gun-related deaths per year
in the UK while the US, with about 6 times more people, has more than 160 times as many gun-
related homicides; therefore be it

RESOLVED, That our American Medical Association support the institution of gun buyback
programs. (New HOD Policy)

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

Received: 05/08/18

References:
http://lawcenter.giffords.org/gun-laws/policy-areas/who-can-have-a-gun/minimum-age/#federal

RELEVANT AMA POLICY

Prevention of Unintentional Shooting Deaths Among Children H-145.979
Our AMA supports legislation at the federal and state levels making gun owners legally responsible for
injury or death caused by a child gaining unsupervised access to a gun, unless it can be shown that
reasonable measures to prevent child access to the gun were taken by the gun owner, and that the
specifics, including the nature of "reasonable measures," be determined by the individual constituencies
affected by the law.
Citation: (Res. 204, I-98; Reaffirmed: BOT Rep. 23, A-09)

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious
threat to the public's health inasmuch as the weapons are one of the main causes of intentional and
unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development
and presentation of safety education programs that will engender more responsible use and storage of
firearms;
(2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-
related injuries and in the development of ways and means of reducing such injuries and deaths;
(3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate
traffic of all handguns;
(4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of
nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the
improvement or modification of firearms so as to make them as safe as humanly possible;
(6) encourages nongovernmental organizations to develop and test new, less hazardous designs for
firearms;
(7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers
through legal proceedings be used for gun safety education and gun-violence prevention; and
(8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun
violence on a national level.
Citation: (CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appendied: Res. 403, I-99; Reaffirmation A-
07; Reaffirmation A-13; Appendied: Res. 921, I-13)

See also:
Gun Safety H-145.978
Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
Gun Violence as a Public Health Crisis D-145.995
Physicians and the Public Health Issues of Gun Safety D-145.997
Safety of Nonpowder (Gas-Loaded/Spring-Loaded) Guns H-145.989
Guns in School Settings H-60.947
Guns in Hospitals H-215.977
Gun Regulation H-145.999
AMA Campaign to Reduce Firearm Deaths H-145.988
Firearm Availability H-145.996
Waiting Periods for Firearm Purchases H-145.991
WHEREAS, Many LGBTQIA students do not receive formal sex or sexuality education in schools and must seek information elsewhere;¹ and

WHEREAS, Only about 5 percent of students reported being taught positive information about L.G.B.T. people or issues in their health classes;² and

WHEREAS, L.G.B.T. youth are five times more likely than their non-L.G.B.T. peers to search for sexuality information online;² and

WHEREAS, Inclusive sex education should give all students the opportunity to increase awareness, dispel myths and break down stereotypes;³ and

WHEREAS, Truly L.G.B.T.-inclusive sex ed weaves the issues of L.G.B.T. people throughout the curriculum without judgment or stigma and creates space for honest discussions of sexual orientation and gender identity;³ therefore be it

RESOLVED, That our American Medical Association update the policy on Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools to mandate inclusive sexuality education in all schools. (Modify Current HOD Policy)

² 2015 National School Climate Survey: LGBTQ students experience discrimination but school systems can make a difference. GLSEN. 2015.

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

Received: 05/08/18
Whereas, Cigarettes remain a major health threat to Americans; and

Whereas, Research into the dangers of cigarette smoking was hampered due to the proprietary nature of the ingredients used in cigarettes; and

Whereas, Electronic cigarettes are increasingly marketed toward youth; and

Whereas, Youth who smoke e-cigarettes may be more likely to start smoking standard cigarettes; and

Whereas, Some believe that e-cigarettes may play a role as a smoking-cessation aid; and

Whereas, E-cigarette cartridge makers have refused to reveal the ingredients of their products; and

Whereas, Current e-cigarette labels may not accurately reflect the amount of nicotine inhaled during vaping; and

Whereas, There is evidence that, in addition to nicotine, e-cigarettes release formaldehyde (a probable carcinogen), ethylene glycol, diacetyl and acetyl propionyl (associated with respiratory disease), and other substances not commonly considered to be part of the electronic cigarette liquid; and

Whereas, It is in the interest of public health to avoid repeating the policies of the past in which research into smoking products was hampered to the detriment of our society, both in terms of the health of our society and the considerable economic costs incurred; and

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Whereas, That research, which depends upon understanding the ingredients in e-cigarette cartridges, is necessary to determine the risks and benefits of the use of e-cigarettes by the public, particularly comparing those risks and benefits in current tobacco smokers as opposed to current non-smokers; and

Whereas, Jurisdiction over electronic cigarettes is at the federal, rather than state level; and

Whereas, The Food and Drug Administration has previously indicated its plans to regulate nicotine delivery devices such as e-cigarettes; therefore be it

RESOLVED, That our American Medical Association urge federal officials, including but not limited to the U.S. Food and Drug Administration (FDA), to prohibit the sale of any e-cigarette cartridge that does not include a complete list of ingredients on its packaging, in the order of prevalence (similar to food labeling) (New HOD Policy); and be it further

RESOLVED, That our AMA urge federal officials, including but not limited to the FDA, to require that an accurate nicotine content of e-cigarettes be prominently displayed on the product alongside a warning of the addictive quality of nicotine. (New HOD Policy)

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

Received: 05/08/18

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Whereas, Current AMA policy supports US and global efforts to fight epidemics and pandemics (H-440.835) and

Whereas, The Centers for Disease Control and Prevention (CDC) reported in May 2018 that during the 13-year period from 2004 to 2016, illnesses from mosquito, tick and flea bites have tripled in the United States, and nine new vector-borne human diseases were discovered or introduced; and

Whereas, According to the CDC, “To effectively reduce transmission and respond to outbreaks (of vector-borne diseases) will require major national improvement of surveillance, diagnostics, reporting and vector control, as well as new tools, including vaccines”; and

Whereas, According to the CDC, “The data show that we’re seeing a steady increase and spread of tick-borne diseases, and an accelerating trend of mosquito-borne diseases introduced from other parts of the world. We need to support state and local health agencies responsible for detecting and responding to these diseases and controlling mosquitoes, ticks, and fleas that spread them”; and

Whereas, According to the CDC, “Zika, West Nile, Lyme, and chikungunya—a growing list of diseases caused by the bite of an infected mosquito, tick, or flea—have confronted the US in recent years, making a lot of people sick. And we don’t know what will threaten Americans next. Our Nation’s first lines of defense are state and local health departments and vector control organizations, and we must continue to enhance our investment in their ability to fight against these diseases”; and

Whereas, According to the CDC, “Preventing and responding to vector-borne disease outbreaks are high priorities for CDC and will require additional capacity at state and local levels for tracking, diagnosing, and reporting cases; controlling vectors; and preventing transmission;” and

Whereas, In the United States, the number of tick-borne diseases, including Lyme disease, spotted fever rickettsioses, babesiosis, and anaplasmosis/ehrlichiosis, more than doubled from 2004-2016; and
Whereas, In the United States, the number of mosquito-borne diseases, including West Nile, dengue, Zika and Plague, increased nearly ten-fold from 2004-2016; and

Whereas, Our AMA currently has no policy regarding the emerging healthcare concern of vector-borne diseases; therefore be it

RESOLVED, That our American Medical Association study the emerging epidemic of vector-borne diseases including an analysis of currently available testing and treatment standards and their effectiveness (Directive to Take Action); and be it further

RESOLVED, That our AMA issue a white paper on vector-borne diseases for the purpose of increasing awareness of the epidemic of vector-borne diseases (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for local, state and national research, education, reporting and tracking on vector-borne diseases. (Directive to Take Action)

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

Received: 05/10/18

RELEVANT AMA POLICY

AMA Role in Addressing Epidemics and Pandemics H-440.835
1. Our AMA strongly supports U.S. and global efforts to fight epidemics and pandemics, including Ebola, and the need for improved public health infrastructure and surveillance in affected countries.
2. Our AMA strongly supports those responding to the Ebola epidemic and other epidemics and pandemics in affected countries, including all health care workers and volunteers, U.S. Public Health Service and U.S. military members.
3. Our AMA reaffirms Ethics Policy E-2.25, The Use of Quarantine and Isolation as Public Health Interventions, which states that the medical profession should collaborate with public health colleagues to take an active role in ensuring that quarantine and isolation interventions are based on science.
4. Our AMA will collaborate in the development of recommendations and guidelines for medical professionals on appropriate treatment of patients infected with or potentially infected with Ebola, and widely disseminate such guidelines through its communication channels.
5. Our AMA will continue to be a trusted source of information and education for physicians, health professionals and the public on urgent epidemics or pandemics affecting the U.S. population, such as Ebola.
6. Our AMA encourages relevant specialty societies to educate their members on specialty-specific issues relevant to new and emerging epidemics and pandemics.

Citation: Sub. Res. 925, I-14; Reaffirmed: Res. 418, A-17
Whereas, Regardless of the route of administration, nicotine is a highly addictive substance that has adverse health effects on neurological development and the cardiovascular system; and

Whereas, The 2009 Family Smoking Prevention and Tobacco Control Act gave the Food and Drug Administration authority to regulate all tobacco products, including developing a nicotine product standard for cigarettes; and

Whereas, FDA Commission Scott Gottlieb, MD, has expressed support for developing a cigarette nicotine product standard that would reduce the addictive potential of cigarettes; and

Whereas, Effective regulation will require the development of a nicotine product standard in all tobacco products; and

Whereas, The Food and Drug Administration has issued an advanced notice of proposed rule-making seeking public input on the creation of a nicotine product standard for cigarettes; and

Whereas, A nicotine product standard on cigarettes, without parallel action on other nicotine products – like cigars and e-cigarettes – will not truly address the significant adverse health effects of nicotine addiction; therefore be it

RESOLVED, That our American Medical Association develop a report on the individual health and public health implications of a low nicotine standard for cigarettes. Such a report should consider and make recommendations on scientific criteria for selection of a nicotine standard that is non-addictive, regulatory strategies to ensure compliance with an established standard, and how a low-nicotine standard should work with other nicotine products in a well-regulated nicotine market. (Directive to Take Action)

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

Received: 05/10/18
RELEVANT AMA POLICY

Light and Low-Tar Cigarettes H-495.981

Our AMA concurs with the key scientific findings of National Cancer Institute Monograph 13, Risks Associated with Smoking Cigarettes with Low Machine-Measured Yields of Tar and Nicotine:
(a) Epidemiological and other scientific evidence, including patterns of mortality from smoking-caused diseases, does not indicate a benefit to public health from changes in cigarette design and manufacturing over the last 50 years.
(b) For spontaneous brand switchers, there appears to be complete compensation for nicotine delivery, reflecting more intensive smoking of lower-yield cigarettes. (c) Cigarettes with low machine-measured yields by Federal Trade Commission (FTC) methods are designed to allow compensatory smoking behaviors that enable a smoker to derive a wide range of tar and nicotine yields from the same brand.
(d) Widespread adoption of lower yield cigarettes in the United States has not prevented the sustained increase in lung cancer among older smokers.
(e) Many smokers switch to lower yield cigarettes out of concern for their health, believing these cigarettes to be less risky or to be a step toward quitting; many smokers switch to these products as an alternative to quitting.
(f) Advertising and promotion of low tar cigarettes were intended to reassure smokers who were worried about the health risks of smoking, were meant to prevent smokers from quitting based on those same concerns; such advertising was successful in getting smokers to use low-yield brands.
(g) Existing disease risk data do not support making a recommendation that smokers switch cigarette brands. The recommendation that individuals who cannot stop smoking should switch to low yield cigarettes can cause harm if it misleads smokers to postpone serious attempts at cessation.
(h) Measurements of tar and nicotine yields using the FTC method do not offer smokers meaningful information on the amount of tar and nicotine they will receive from a cigarette.

Our AMA seeks legislation or regulation to prohibit cigarette manufacturers from using deceptive terms such as "light," "ultra-light," "mild," and "low-tar" to describe their products.

Whereas, The Family Smoking Prevention and Tobacco Control Act of 2009 passed by Congress and signed by the president gave the Food and Drug Administration (FDA) authority to regulate all tobacco products; and

Whereas, The Family Smoking Prevention and Tobacco Control Act established that all products that were introduced in the U.S. market after February 15, 2007 would be considered new products and would need to be reviewed by the FDA under its premarket approval process; and

Whereas, In 2016 the FDA issued a final rule that expressed authority to regulate all tobacco products including e-cigarettes and cigars; and

Whereas, The 2016 FDA deeming rule established a series of time lines for manufacturers to submit product information on cigars and e-cigarettes to begin the FDA pre-market review of these products; and

Whereas, Since its introduction in the U.S., e-cigarettes market has grown into a multi-billion dollar industry; and

Whereas, E-cigarettes are produced in a variety of flavors, including “cotton candy”, “gummy bear”, “peanut butter cup”, “cookies ‘n cream”, “pop rocks” and “unicorn vomit” intended to appeal to youth; and

Whereas, E-cigarettes are now the most commonly used nicotine product by middle school and high school children; and

Whereas, Since the banning of flavored cigarettes, tobacco companies have introduced a new generation of candy flavored cigars, including flavors like “chocolate”, “wild berry”, “watermelon”, “lemonade” and “cherry dynamite”, that are targeted to appeal to youth; and

Whereas, Cigar use has now surpassed cigarette use in middle school and high school children; and

Whereas, The FDA recently issued a multi-year delay in the timeline for tobacco manufacturers to submit product information on cigars and e-cigarettes under the premarket review authority; and
Whereas, The FDA recently issued an advanced notice of proposed rule-making on regulation of cigars and a separate advance notice of proposed rule-making on flavoring agents in tobacco products; and

Whereas, The two advance notice of proposed rule makings appear to ignore the public comments and final determination made by FDA on cigars and tobacco flavoring agents under the 2016 FDA deeming rule; and

Whereas, The American Academy of Pediatrics, the American Lung Association and other public health groups has filed suit in federal court to compel the FDA to take swift action to regulate cigars and e-cigarettes; and

Whereas, The American Thoracic Society will file an amicus brief in support of the petitioner’s case to seek court action to compel FDA to take swift action to regulate cigars and e-cigarettes products; therefore be it

RESOLVED, That our American Medical Association consider joining other medical organizations in an amicus brief supporting the American Academy of Pediatrics legal action to compel the U.S. Food and Drug Administration to take timely action to establish effective regulation of e-cigarettes, cigars and other nicotine tobacco products. (Directive to Take Action)

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

Received: 05/10/18

RELEVANT AMA POLICY

FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products H-495.973

Our AMA: (1) supports the U.S. Food and Drug Administration’s (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act, as amended by the Family Smoking Prevention and Tobacco Control Act; and (2) supports legislation and/or regulation of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that: (a) establishes a minimum legal purchasing age of 18; (b) prohibits use in all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health care is delivered; (c) applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople; (d) prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA; (e) requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on containers of replacement fluids (e-liquids) used in e-cigarettes; (f) establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use; (g) requires transparency and disclosure concerning product design, contents, and emissions; and (h) prohibits the use of characterizing flavors that may enhance the appeal of such products to youth.


See also: Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes H-495.986
Whereas, The United States has about 25 times the incidence of gun homicides than other high income countries and on an average day 96 Americans are killed with guns including 7 children and teens;¹ and

Whereas, United States citizens are 51 times more likely to be killed by firearms than people in Great Britain;² and

Whereas, In Australia there were four mass shootings between 1987 and 1996, and Australia then passed restrictive gun laws including banning assault rifles and there have been no mass shootings in Australia since;³ and

Whereas, In the United States we have been plagued by mass shootings with assault weapons with high capacity magazines and high velocity bullets including 17 killed in Parkland, FL in February 2018; 26 killed in Sutherland Springs, TX in November 2017; 58 killed in Las Vegas, NV in October 2017 with bump stock addition to assault weapons; 49 killed in Orlando, FL in June 2016; 14 killed in San Bernardino, CA in December 2015; 27 killed in Newtown, CT in December 2012; and 12 killed in Aurora, CO in July 2012; and

Whereas, States with shall-issue laws permitting concealed carry (in contrast to may-issue laws) have 10.6% higher handgun homicide rates;⁴ and

Whereas, In an average month 50 women in the United States are shot to death by intimate partners;⁵ and

Whereas, There are often warning signs that individuals are harboring violent intentions to harm themselves or others, and five states (CA, CO, IN, WA and OR) have enacted “red flag” laws that empower relatives and close friends as well as law enforcement officers to ask judges to issue “gun violence restraining orders;”⁶ therefore be it
RESOLVED, That our American Medical Association adopt the following firearm safety policies:

1. Amend Policy H-145.993, “Restriction of Assault Weapons,” by addition to read as follows:

   Our AMA supports appropriate legislation that would restrict the sale and private ownership of inexpensive handguns commonly referred to as "Saturday night specials," and large clip, high-rate-of-fire automatic and semi-automatic firearms, or any weapon that is modified or redesigned to operate as a large clip, high-rate-of-fire automatic or semi-automatic weapon and ban the sale and ownership to the American public of all assault-type weapons, bump stocks and related devices, high capacity magazines of more than 10 bullets, and high-velocity and armor piercing bullets.

2. Require the licensing of owners of firearms including completion of a required safety course and registration of all firearms.

3. Support local law enforcement in the permitting process in such that local police chiefs are empowered to make permitting decisions regarding “concealed carry”, by supporting “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and by supporting "red-flag" laws for individuals who have demonstrated significant signs of potential violence. In supporting local law enforcement, we support as well as the importance of “due process” so that decisions could be reversible by individuals petitioning in court for their rights to be restored. (New HOD Policy)

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

Received: 05/08/18

RELEVANT AMA POLICY

Restriction of Assault Weapons H-145.993

Our AMA supports appropriate legislation that would restrict the sale and private ownership of inexpensive handguns commonly referred to as "Saturday night specials," and large clip, high-rate-of-fire automatic and semi-automatic firearms, or any weapon that is modified or redesigned to operate as a large clip, high-rate-of-fire automatic or semi-automatic weapon.

Citation: Sub. Res. 264, A-89; Reaffirmed: BOT Rep. 50, I-93; Amended: Res.215, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17

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Whereas, Portable listening devices have been replaced by explosive growth of cellular telephones which can produce even higher sound levels; and

Whereas, The growth in cellular has occurred across a wide population demographic. It has correlated with wider use of earbuds in adolescents and young adults in particular; and

Whereas, The popularity of cell phones has resulted in greater daily use of earbuds increasing the potential for hearing loss; and

Whereas, Some manufacturers have developed earbuds which limit the maximum sound produced reducing the risk of hearing loss; and

Whereas, Many manufacturers still produce earbuds without that technology thus raising the risk of hearing loss; therefore be it

RESOLVED, That our American Medical Association update its policy on portable listening devices to support the use of portable listening devices that limit the maximum sound amplitude to safe levels (New HOD Policy); and be it further

RESOLVED That our AMA advocate on a federal level for labeling on earbuds that do not have amplitude limiters to warn of the risk of hearing loss with extended use at high volume levels for extended periods as described in Council on Scientific Affairs Report 6-A-08. (New HOD Policy)

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

Received: 05/08/18
Whereas, MedChi in 2005 adopted a resolution asking that the AMA study the behavioral
effects of video games including the potential for being addictive and possibly including warning
labels on them if there was evidence of this; and

Whereas, The Council on Science and Public Health in response to the MedChi resolution
reviewed the literature and reported to the HOD at the 2007 Annual Meeting that there was
evidence of “over use” by a small portion of the population with was estimated at 10- 15% of
players; and

Whereas, The report recommended further study and in the APA DSM 5 (2013) Internet
Gaming Disorder was a condition recommended for further study; and

Whereas, *AMA Morning Rounds* and *APA Headline News* both reported that the World Health
Organization added “gaming disorder” to its list of mental health conditions” in ICD-11 in 2018; and

Whereas; There are some video games that can be used educationally and do not have the
same addiction potential as others, those with violence are often the ones that are most
susceptible to this and are heavily marketed by the industry; and

Whereas, Many of the video games are especially targeted to children; and

Whereas, Children’s first and often only exposure to high power rapid firing weapons of war is
often through video games; and

Whereas, The Army uses similar means to desensitize soldiers to killing enemy soldiers by
having targets in the shape of human beings; and

Whereas, The human brain is still developing well into the twenties; therefore be it

RESOLVED, That our American Medical Association advocate for putting warning labels on
digital and video games, warning parents to monitor children’s use and be aware that for some
children this can become habit forming, leading to increased time spent on gaming at the cost of
more important developmental issues, take precedence over other aspects of their life and
escalate despite the occurrence of negative consequences and withdrawal symptoms may
occur when attempts are made to reduce or stop it. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.
Received: 05/08/18
Whereas, There is a flurry of regulatory and legislative activities to mandate the guidance outlined in the current revision of General Chapter <800> Hazardous Drugs$^1$ – Handling in Healthcare Settings in the United States Pharmacopeia (USP) Compounding Compendium; and

Whereas, The official date of implementation of Chapter <800> is December 1, 2019; and

Whereas, In Chapter <800>, USP refers to the National Institute for Occupational Safety and Health (NIOSH) list$^2$ of hazardous drugs for required handling guidelines and specifically identifies several therapeutic drugs for the treatment of bladder, kidney and prostate cancers currently prepared and administered in the physician’s office as antineoplastics; and

Whereas, There is limited or no risk of exposure/harm to health care providers/workers in the manner in which these therapeutic drugs are currently prepared in the physicians’ office; and

Whereas, Because of these agent’s designation as antineoplastics, they are considered hazardous and Chapter <800> requires the use of a containment primary engineering control (C-PEC) ventilated device designed to minimize worker and environmental exposure, a containment secondary engineering control (C-SEC) room where the C-PEC is placed and Closed System Transfer Devices (CSTD), such as a hood, and personal protective equipment for handling of hazardous drugs; and

Whereas, Facilities required to adhere to Chapter <800> Hazardous Drugs must also follow guidelines outlined in General Chapter <795> Pharmaceutical Compounding$^3$ – Nonsterile Preparations and General Chapter <797> Pharmaceutical Compounding – Sterile Preparations. New revisions to Chapters <795> and <797> include reference “must comply with Hazardous Drugs – Handling in the Healthcare Settings (800)”; and

$^1$ General Chapter <800> describes practice and quality standards for the handling of hazardous drugs to promote patient safety, worker safety, and environmental protection of healthcare personnel.

$^2$ NIOSH identified hazardous drugs in three groups: Table 1 Antineoplastic drugs including antineoplastic drugs with special handling information, Table 2 Non antineoplastic drugs with special handling instructions and Table 3 Non-antineoplastic drugs that primarily have adverse reproductive effects. NIOSH has a draft document Policy and Procedures for Developing NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings that outlines how drugs are selected to be included on the NIOSH list and how they determine the drugs to be hazardous.

$^3$ These chapters are undergoing revisions this year to provide a unified approach to quality compounding. Chapter <795> was open for public comment ending in April 2018 and <797> will be available in July 2018.
Whereas, The Food & Drug Administration’s (FDA)\(^4\) does not consider compounding of a drug if it is reconstituted according to manufacturers’ recommendations. General Chapter <795> defines nonsterile preparations as “nonsterile compounding is defined as combining, admixing, diluting, pooling, reconstituting other than as provided in the manufacturer package insert, or otherwise altering a drug or bulk drug substance to create a nonsterile medication.

Reconstituting a conventionally manufactured nonsterile product in accordance with the directions contained in the approved labeling provided by the product’s manufacturer is not considered compounding as long as the product is prepared for an individual patient and not stored for future use.” This should apply to all preparations if there are no special instructions from the manufacturer; and

Whereas, These regulations will negatively impact provision of cancer treatments to patients. The costs to physician practices required to install hoods and ventilation systems in their offices is prohibitive. In many instances, the installations are not physically possible in the facilities where the practices are located. In most communities, there are not sufficient alternative facilities that can meet the C-PEC, C-SEC, and CSTD required for reconstitution or mixing prior to administration of the drugs included in the NIOSH list, leaving the majority of patients without access to the therapeutics they require; and

Whereas, Access to care is prohibitive/hinders access to the full range of treatments for prostate and bladder cancer for urologic patients if General Chapter <800> must be adhered to; therefore be it

RESOLVED, That our American Medical Association work with United States Pharmacopeia to revisit the requirements in General Chapter <800> of the USP Compounding Compendium and review Chapters <795> and <797> to ensure that the requirements included in those chapters are not onerous to physicians and prohibitive to their current ability to provide medications to their patients. (Directive to Take Action)

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

Received: 05/10/18

RELEVANT AMA POLICY

Protect Individualized Compounding in Physicians’ Offices as Practice of Medicine H-120.929

Our AMA will advocate that the US Food and Drug Administration remove physician offices and ambulatory surgery centers from its definition of a compounding facility.

USP Compounding Rules H-120.930

1. Our AMA will engage in efforts to convince United States Pharmacopeia (USP) to retain the current special rules for procedures in the medical office that could include but not be limited to allergen extract compounding in the medical office setting and, if necessary, engage with the U.S. Food and Drug Administration (FDA) and work with the U.S. Congress to ensure that small volume physician office-based compounding is preserved.

2. Our AMA will undertake to form a coalition with affected physician specialty organizations such as allergy, dermatology, immunology, otolaryngology, oncology, ophthalmology, neurology, and rheumatology to jointly engage with USP, FDA and the U.S. Congress on the issue of physician office-based compounding preparations and the proposed changes to USP Chapter 797.

3. Our AMA reaffirms that the regulation of compounding in the physician office for the physician’s patients be under the purview of state medical boards and not state pharmacy boards.

4. Our AMA supports the current 2008 USP Chapter 797 sterile compounding rules as they apply to allergen extracts, including specifically requirements related to the beyond use dates of compounded allergen extract stock.

Citation: Res. 204, A-16; Reaffirmation: A-17

See also: USP Compounding Rules H-120.930; Appropriate Use of Compounded Medications in Medical Offices H-120.934; Opposition to USP 800 D-120.941; Pharmacy Compounding H-120.945; Access to In-Office Administered Drugs H-330.884

\(^4\) Personal communication, Food and Drug Administration (Compounding) to AUA.
WHEREAS, Air pollution emissions from diesel truck engines are an important source of air pollution emissions in the U.S.; and

WHEREAS, Reducing air pollution emissions from diesel engines in the U.S. will improve air quality and reduce adverse health effects associated with air pollution; and

WHEREAS, The U.S. Environmental Protection Agency (EPA) has established emissions for new diesels truck engines that significantly reduce emissions compared to older diesel engines; and

WHEREAS, An industry has developed, known as the glider kit industry, that reconditions old diesel truck engines, installs them in new chassis and sells these trucks as “new”; and

WHEREAS, These “new” glider kits do not meet emissions standards for new diesels trucks; and

WHEREAS, The EPA’s internal research shows glider kit diesel engines emit 40-50 times more emissions than diesel trucks that meet the new diesel truck emissions standard; and

WHEREAS, In 2016, the EPA issued final rules to limit the number of glider kits that can be sold that evade new diesel engines emissions standards; and

WHEREAS, In 2017, the EPA issued a proposed rule to repeal limits on glider trucks – dramatically expanding the number of glider kit diesel engines that can be sold that do not meet new diesel engine emissions standard; and

WHEREAS, In providing a justification repealing the limits on Glider Kits, the EPA relied, in part, on a non-peer reviewed study conducted at Tennessee Tech that was paid for by the glider kit industry and that study findings (that glider kits engines have emissions comparable to new disease engines) have since come under question; and

WHEREAS, If the roll back of glider kit roll is implemented, it is estimated in year 2025 glider kits will comprise 5 percent of the U.S. diesel truck vehicle fleet but will emit 1/3 of all U.S. diesel truck emissions; therefore be it

RESOLVED, That our American Medical Association send a letter to U.S. Environmental Protection Agency (EPA) Administrator opposing the EPA’s proposal to roll back the “Glider Kit Rule” which would effectively allow the unlimited sale of re-conditioned diesel truck engines that do not meet current EPA new diesel engine emission standards. (Directive to Take Action)
Fiscal Note: Minimal - less than $1,000.

Received: 05/10/18

RELEVANT AMA POLICY

Reducing Sources of Diesel Exhaust D-135.996

Our AMA will:
(1) encourage the US Environmental Protection Agency to finalize the most stringent feasible standards to control pollutant emissions from both large and small non-road engines including construction equipment, farm equipment, boats and trains;
(2) encourage all states to continue to pursue opportunities to reduce diesel exhaust pollution, including reducing harmful emissions from existing diesel; and
(3) call for all trucks traveling within the United States, regardless of country of origin, to be in compliance with new diesel emissions standards promulgated by US EPA.

Res. 428, A-04 Reaffirmed in lieu of Res. 507, A-09 Reaffirmation A-11 Reaffirmation A-14
Whereas, The *Journal of the American Medical Association* has published seminal research documenting the adverse human health effects associated with exposure to environmental pollution; and

Whereas, Journal articles published in peer-reviewed science journals have provided researchers, clinicians and policy makers critical information on the health effects of environmental exposures; and

Whereas, Federal agencies, including the U.S. Environmental Protection Agency (EPA), have relied on the peer review process of scientific and medical journals to provide scientifically reliable information to help share public policy; and

Whereas, The EPA has issued a proposed rule that, if implemented, would exclude many seminal peer review journal considerations from consideration by EPA during the policy making process; and

Whereas, Removing valid scientific publications from the EPA’s policy making process will undermine the science-basis for EPA environmental policy, therefore be it

RESOLVED, That our American Medical Association submit comments during the public comment period, or join comments written by other medical organizations, to express concern with the U.S. Environmental Protection Agency’s (EPA) proposal to limit the use of research studies published in peer reviewed scientific journals that describe the adverse health effects of exposure to air pollution and other environmental exposures (Directive to Take Action); and be it further

RESOLVED, That our AMA reaffirm the value and integrity of the journal peer review process by sending a letter to the EPA stating that studies that have been published in scientific peer reviewed journals should be used by the agency in informing EPA regulatory policy making. (Directive to Take Action)

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

Received: 05/10/18
RELEVANT AMA POLICY

E-7.1.3 Study Design & Sampling
To be ethically justifiable, biomedical and health research that involves human subjects must uphold fundamental principles of respect for persons, beneficence, and justice. These principles apply not only to the conduct of research, but equally to the selection of research topics and study design. Well-designed, ethically sound research aligns with the goals of medicine, addresses questions relevant to the population among whom the study will be carried out, balances the potential for benefit against the potential for harm, employs study designs that will yield scientifically valid and significant data, and generates useful knowledge. For example, research to develop biological or chemical weapons is antithetical to the goals of the medical profession, whereas research to develop defenses against such weapons can be ethically justifiable. Physicians who engage in biomedical or health research with human participants thus have an ethical obligation to ensure that any study with which they are involved:
(a) Is consistent with the goals and fundamental values of the medical profession.
(b) Addresses research question(s) that will contribute meaningfully to medical knowledge and practice.
(c) Is scientifically well designed to yield valid data to answer the research question(s), including using appropriate population and sampling controls, clear and appropriate inclusion/exclusion criteria, a statistically sound plan for data collection and analysis, appropriate controls, and when applicable, criteria for discontinuing the study (stopping rules).
(d) Minimizes risks to participants, including risks associated with recruitment and data collection activities, without compromising scientific integrity.
(e) Provides mechanisms to safeguard confidentiality.
(f) Does not disproportionately recruit participants from historically disadvantaged populations or populations whose ability to provide fully voluntary consent is compromised. Participants who otherwise meet inclusion/exclusion criteria should be recruited without regard to race, ethnicity, gender, or economic status.
(g) Recruits participants who lack the capacity to give informed consent only when the study stands to benefit that class of participants and participants with capacity would not yield valid results. In this event, assent should be sought from the participant and consent should be obtained from the prospective participants legally authorized representative, in keeping with ethics guidance.
(h) Has been reviewed and approved by appropriate oversight bodies.
AMA Principles of Medical Ethics: I,II,III,V,VII
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016
Whereas, The AMA’s membership for physicians 40 years and older (Life Stage categories “Mature” and “Senior,” based on the AMA Physician Masterfile) declined from 118,504 in December 2010 to 109,186 in June 2017; \(^1,^2\) and

Whereas, Physician membership to the AMA decreased from 16.0% of all physicians to 15.6% of all physicians from December 2010 to July 2017; \(^1,^2\) and

Whereas, A clear discrepancy exists between declines in AMA membership for the majority of practicing physicians and the AMA’s intent to be the voice of physicians; and

Whereas, Reasons for this discrepancy need to be understood and acted upon so that membership declines in practicing physicians can be reversed for the strength and financial health of the organization as well as the larger voice of physicians in the country; and

Whereas, It is in the interest of any membership organization to represent a substantial portion of the individuals it claims to represent; therefore be it

RESOLVED, That our American Medical Association release to its membership annually in its Annual Report any and all aggregate data for that year it has pertaining to reasons physicians are either leaving or not joining the AMA (“Data”), including but not limited to, survey data, focus group data, and exit interview data, giving specific attention to those physicians in the “Young,” “Mature,” and “Senior” membership categories. (Directive to Take Action)

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

Received: 05/10/18
Whereas, Our country’s health care system belongs to the public, our patients; and
Whereas, The success of our country’s health care system depends on a well-informed public; therefore be it
RESOLVED, That our American Medical Association establish a program for training physicians in the art and science of conducting public forums in order to ensure that the public is well informed on the health care system of our country. (Directive to Take Action)

Fiscal Note: Estimated cost to implement this resolution is $25,000.

Received: 05/10/18
Whereas, The assignment of Current Procedural Terminology (CPT) codes for a patient's medical conditions is required for each doctor-patient encounter; and

Whereas, Our American Medical Association has exclusive rights to CPT coding; and

Whereas, Our AMA receives licensing revenue related to CPT coding, including CPT code usage within electronic medical billing systems; and

Whereas, These costs are often passed on to physicians; and

Whereas, Discounted or waived CPT fees would be a valuable AMA member benefit and would probably drive an increase in AMA membership; therefore be it

RESOLVED, That our American Medical Association investigate mechanisms by which AMA members may receive a discount or waiver on CPT-related fees, including fees associated with using CPT codes within electronic medical billing systems. (Directive to Take Action)

Fiscal Note: Estimated cost of $14,000 to complete the requested study.

Received: 05/10/18
Whereas, In 2015, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA). MACRA had many goals, but its key driver was to “fix” the Sustainable Growth Rate (SGR). The SGR formula was legislation established in the Balance Budget Act of 1997 and utilized by Centers for Medicare and Medicaid Services (CMS) to control Medicare spending for physician and other health care providers’ services. The SGR formula was developed to limit Medicare Physician spending based on the GDP growth; and

Whereas, MACRA places providers in one of two tracks: the advanced Alternative Payment Model (APM) or the Merit-Based Incentive Payment System (MIPS). The providers participating in the MIPS program will be evaluated based on the Quality Payment Program (QPP). The goals of the QPP are to promote quality, cost-effective and value-based care, encompassing provider accountability and patient care coordination. Providers will receive payment bonuses or penalties based on performances. On the other hand all Alternative Payment Models do not qualify to be an advanced APM. Advanced APM criteria are listed below:

<table>
<thead>
<tr>
<th>CMS requirements for Advance APM Qualification</th>
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<tbody>
<tr>
<td>1. Clinicians must use <strong>certified electronic health record</strong> technology</td>
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<tr>
<td>2. The APM pays for covered services “based on <strong>quality measures</strong> comparable to those used in the quality performance category of the MIPS”</td>
</tr>
<tr>
<td>3. “Either be a Medical Home Model expanded under CMMI Center authority; or (2) require participating APM Entities to bear more than a nominal amount of <strong>financial risk</strong> for monetary losses”</td>
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Whereas, APMs have a framework to improve quality, increase provider accountability and potentially improve coordination of high value care, the advance APM incorporates not only upside risk but also downside risk which is reflected in financial risk for monetary losses; and

Whereas, Providers are rewarded with shared savings if their patients’ average Medicare Spending per Beneficiaries (MSPB) falls below a benchmark MSPB, in contrast providers whose patients’ cost exceeds the MSPB benchmark this results in a shared loss; and
Whereas, Risk adjustment for financial cost should include the factors that lead to higher cost of comprehensive comparable care and needs to include comorbid conditions, poverty and other social economic status factors; and

Whereas, Vulnerable populations, such as those living in poverty, and people with disabilities disproportionately encounter high healthcare cost and in addition have poor outcomes; and

Whereas, Disproportionate share hospital systems have an increased proportion of impoverished, dual eligible and minority patients and they are subjected to greater penalties associated with readmission rates, hospital acquired conditions reduction Program and the Physician Value-Based Payment Modifier; and

Whereas, Under advanced APMs the vulnerable population may present the greatest opportunity for cost saving and improved coordination of care. The impact of the current risk adjustment tool (with advanced APMs) on providers who care for vulnerable population needs to be further studied; therefore be it

RESOLVED That our American Medical Association study the impact of current advanced Alternative Payment Models (APMs) and risk adjustment on providers caring for vulnerable populations (Directive to Take Action); and be it further

RESOLVED That our AMA advocate legislatively that advanced APMs examine the evaluation of quality performance (for bonus or incentive payment) of providers caring for vulnerable populations in reference to peer group (similarities in SES status, disability, percentage of dual eligible population). (Directive to Take Action)

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

Received: 05/08/18
Whereas, Private practices in several specialties -- including dermatology, anesthesiology, radiology, ophthalmology, pediatric, emergency medicine -- are consolidating due to the burden of current administrative requirements; and

Whereas, Private equity (PE) groups and venture capital firms have an increasing interest in acquiring a majority and/or controlling stake in specialty practices; and

Whereas, There are some pros and cons that physicians should be aware of when considering selling their private practice to larger practices or companies backed by PE firms or considering joining a private equity-owned business or controlled business; and

Whereas, It is necessary to ensure there is no conflict between corporate profit seeking and physician’s fiduciary responsibility to their patient; and

Whereas, Since this is an emerging trend, minimal data is available to determine the impact of PE groups and venture capital firms on physician practices; and

Whereas, A study on this topic is necessary to guide future AMA activities; therefore be it RESOLVED, That our American Medical Association study, with report back at the 2018 Interim Meeting, the effects on the healthcare marketplace of venture capital/PE firms acquiring a majority and/or controlling stake in physician private independent, small group and large group practices, including, but not limited to, such topics as:

- the degree of venture capital/PE penetration and investment in the healthcare marketplace;
- the impact on physician practice and independence;
- patient access;
- resultant trends in the use of unsupervised, independently practicing non-physician extenders;
- long term financial viability of purchased practices;
- effects of ownership turnovers and bankruptcies on patients and practice patterns;
- effectiveness of methodologies employed by unpurchased private independent, small group and large group practices to compete for insurance contracts in consolidated marketplaces;
- and the relative impact venture capital/PE purchases have on the paths and durations of junior, mid-career and senior physicians (Directive to Take Action); and be it further
RESOLVED, That, in order to address the particular concerns of physicians entering into management service organization contracts, our AMA amend the AMA Annotated Model Physician-Group Practice Employment Agreement (H-215.981) to read:

“(2) At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations.” (Modify Current HOD Policy)

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

Received: 05/10/18

RELEVANT AMA POLICY

Corporate Practice of Medicine H-215.981
(1) Our AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine. (2) At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs. (3) Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues.
Whereas, Health insurance payers’ use of laboratory benefit management has the potential to impinge upon the practice of medicine if not properly administered and structured; and

Whereas, Laboratory benefit management programs used by health insurance payers should be based upon transparent, verifiable and published medical and scientific evidence, and should not be influenced by improper financial conflicts of interests in the administration of such programs arising from the health insurance payer or administrator of the program; and

Whereas, More than nine in 10 physicians (92 percent) say that prior authorizations programs have a negative impact on patient clinical outcomes, according to a physician survey released in March 2018 by the American Medical Association; and

Whereas, AMA currently has general policy on benefit management and prior authorization, as well as specific policies on radiology benefit management (H-320.946) and pharmaceutical benefits management companies (H-125.986), however no policy specifically address laboratory benefit management; and

Whereas, The use of laboratory benefit management programs by health insurance payers should not adversely curtail physician medical judgment nor adversely impact patient diagnosis and treatment, especially for life-threatening medical conditions; and

Whereas, Ordering physician referrals to in-network laboratories, made in a manner consistent with the ethics policies of the American Medical Association, should not be dictated nor constrained by laboratory benefit management, when such referral remains in-network; and

Whereas, No adverse claims impact should accrue to any laboratory or physician who performs a pathology or laboratory service pursuant to a lawful order for such services by a health care provider; therefore be it
RESOLVED, That our American Medical Association adopt policy that supports the adoption of laws, regulations and public or private sector policies regarding laboratory benefit management arrangements to preclude:

1) Any potential financial conflict of interest in programs adopted by health insurance payors to provide laboratory benefit management, including prohibition on the use of any laboratory benefit management entity financially affiliated with a clinical laboratory;

2) Health insurance payer constraints on ordering physician discretion for referrals made to any in-network laboratory or pathology providers when such referrals are medically and ethically appropriate;

3) Any adverse claims impact on the laboratory or pathology provider who receives a lawful order from a health care provider for medically necessary services, based upon a compliance failure in the laboratory benefit management ordering process;

4) The implementation by a health insurance payer of prior authorization or prior notification imposed on ordering physicians for any pathology or laboratory test ordered on a patient specimen obtained in a hospital or ambulatory surgical center. (New HOD Policy)

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

Received: 05/10/18