AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-18)

Report of Reference Committee B

R. Dale Blasier, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 14 – Integration of Drug Price Information into Electronic Medical Records/Barriers to Price Transparency/Bidirectional Communication for EHR Software and Pharmacies/Health Plan, Pharmacy, Electronic Health Records Integration (Resolution 219-A-17; Resolution 213-I-17; Resolution 203-I-17; Resolution 205-I-17)

2. Board of Trustees Report 15 – Advanced Practice Registered Nurse Compact

3. Board of Trustees Report 16 – Protection of Clinician-Patient Privilege
   (Resolution 237-A-17)

4. Board of Trustees Report 18 – Medical Liability Coverage Through the Federal Tort Claims Act (Resolution 214-A-17)

5. Board of Trustees Report 19 – Health Information Technology Principles
   (Resolution 218-I-17)


7. Board of Trustees Report 45 – Licensing of Electronic Health Records
   (Resolution 218-A-17)

8. Resolution 203 – Updating Federal Food Policy to Improve Nutrition and Health

9. Resolution 204 – Opposition to Mandated Proficiency in EHR for Licensure

10. Resolution 216 – FDA Conflict of Interest

11. Resolution 221 – Maintaining Validity and Comprehensiveness of U.S. Census Data

12. Resolution 232 – Recording Law Reform

13. Resolution 233 – Support for Reauthorization of the Supplemental Nutrition Assistance Program

RECOMMENDED FOR ADOPTION WITH CHANGE IN TITLE

14. Resolution 253 – Separation of Children from their Parents at Border
    Resolution 257 – Separation of Children from their Parents at Border

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED


16. Board of Trustees Report 12 – Advocacy for Seamless Interface between Physician Electronic Health Records (EHRs), Pharmacies and Prescription Drug Monitoring Programs (PDMPs) (Resolution 212-A-17)

17. Resolution 237 – Safe and Efficient E-Prescribing
17. Board of Trustees Report 17 – Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care
18. Board of Trustees Report 41 – Augmented Intelligence (AI) in Health Care
19. Resolution 201 – Barriers to Obesity Treatment
21. Resolution 208 – Prior Authorization Requirements for Post-Operative Opioids
22. Resolution 209 – Substance Use Disorders During Pregnancy
23. Resolution 211 – Clarification from US Department of Justice Regarding Federal Enforcement of Medical Marijuana Laws
24. Resolution 215 – Regulation of Hospital Advertising
25. Resolution 218 – Considering Feminine Hygiene Products as Medical Necessities
26. Resolution 222 – Evidence Based Treatment in Substance Abuse Treatment Facilities
27. Resolution 240 – Treating Opioid Use Disorder in Treatment Facilities
28. Resolution 223 – Treating Opioid Use Disorder in Hospitals
29. Resolution 239 – Treating Opioid Use Disorder in Hospitals
30. Resolution 224 – Legalization of Interpharmacy Transfer of Electronic Controlled Substance Prescriptions
31. Resolution 225 – Pharmacy Benefit Managers Impact on Patients
32. Resolution 229 – Green Card Backlog for Immigrant Doctors on H-1B Visa
33. Resolution 230 – Opposition to Funding Cuts for Programs that Impact the Health of Populations
34. Resolution 231 – Online Controlled Drugs
35. Resolution 236 – Reducing MIPS Reporting Burden
36. Resolution 241 – Accuracy and Accountability of Physician Compensation Reporting by Drug and Device Companies
37. Resolution 242 – Pharmacy Benefit Managers and Compounded Medications
38. Resolution 243 – Report Health Care Provider Sex Crimes to Law Enforcement
39. Resolution 244 – Increasing the Legal Age of Purchasing Ammunition and Firearms From 18 to 21
40. Resolution 248 – Opposition to Firearm Concealed Carry Reciprocity
41. Resolution 245 – Opposing NCOIL Attempts to Stop Physician Dispensing
42. Resolution 246 – Support for Patients and Physicians in Direct Primary Care
43. Resolution 247 – Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program
44. Resolution 250 – Clarification of Guidelines for Online
45. Resolution 251 – Scope of Practice Expansion Advocacy and Impacts on Physicians and Medical Students
46. Resolution 254 – Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services
47. Resolution 255 – 340B Drug Discount Program
48. Resolution 256 – Federal Aviation Administration BasicMed Exams to be Done by Physicians with Prescriptive Authority
49. Resolution 217 – Reforming the Orphan Drug Act
50. Resolution 227 – An Optional National Prescription Drug Formulary
47. Resolution 226 – Model State Legislation for Routine Preventative Prostate Cancer Screening for Men Ages 55-69
48. Resolution 235 – Hospital Consolidation
49. Resolution 252 – Repeal of Group Purchasing Organizations and Pharmacy Benefit Managers

RECOMMENDED FOR REFERRAL FOR DECISION

50. Resolution 219 – Improving Medicare Patients’ Access to Kidney Transplantation

RECOMMENDED FOR NOT ADOPTION

51. Resolution 212 – Value-Based Payment System
52. Resolution 249 – Support Any Willing Provider Legislation

RECOMMENDED FOR FILING

53. Board of Trustees Report 21 – Ownership of Patient Data

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

Resolution 206 – Appropriate Use of Telehealth Services
Resolution 207 – Quality Improvement Requirements
Resolution 210 – Banning the Sale of Bump Stocks
Resolution 213 – Utilization Review
Resolution 214 – Strengthening the Background Check System for Firearm Sales
Resolution 220 – Ban on Semi-Automatic Assault Weapons and High Capacity Ammunition Magazines
Resolution 228 – Medicare Quality Incentives
Resolution 234 – Support for the Primary Care Enhancement Act
(1) BOARD OF TRUSTEES REPORT 14 – INTEGRATION
OF DRUG PRICE INFORMATION INTO ELECTRONIC
MEDICAL RECORDS/BARRIERS TO PRICE
TRANSPARENCY/BIDIRECTIONAL COMMUNICATION
FOR EHR SOFTWARE AND PHARMACIES/HEALTH
PLAN, PHARMACY, ELECTRONIC HEALTH RECORDS
INTEGRATION (RESOLUTION 219-A-17; RESOLUTION
213-I-17; RESOLUTION 203-1-17; RESOLUTION 205-1-
17)

RECOMMENDATION:

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

The BOT recommends that: the following be adopted in lieu of Resolutions 219-A-17,
203-I-17, 205-I-17, and 213-I-17, and that the remainder of the report be filed, 1. That
our American Medical Association reaffirm Policies H-110.988, “Controlling the
110.991, “Price of Medicine;” (Reaffirm HOD Policy)

2. That our AMA collaborate with other interested stakeholders to explore (a) current
availability and accessibility of EHR, pharmacy and payer functionalities that enable
integration of price, insurance coverage, formulary tier and drug utilization management
policies, and patient cost information at the point of care, (b) at what levels barriers exist
to this functionality or access, and (c) what is currently being done to address these
barriers; (Directive to Take Action), 3. That our AMA collaborate with other interested
stakeholders to develop and implement a strategic plan for improving the availability and
accessibility of real-time prescription cost information at the point of care. (Directive to
Take Action)

Your Reference Committee heard supportive testimony on Board of Trustees Report 14.
Your Reference Committee heard testimony that integrating drug price and cost
information into electronic health records will help improve drug price transparency and
ultimately facilitate better-informed, shared treatment decisions that could help reduce
prescription drug spending. Your Reference Committee also heard testimony that our
AMA should work with stakeholders to address the barriers and complexities
surrounding this issue and to also develop a strategic plan to improve the availability and
accessibility of real-time prescription cost information. Accordingly, your Reference
Committee recommends adoption.

(2) BOARD OF TRUSTEES REPORT 15 – ADVANCED
PRACTICE REGISTERED NURSE COMPACT

RECOMMENDATION:
Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 15 be adopted and the remainder of the report be filed.

The BOT recommends that: AMA Policy H-35.988(2), “Independent Practice of Medicine by Advanced Practice Registered Nurses,” be rescinded and that the remainder of this report be filed. (Rescind HOD Policy)

Your Reference Committee heard testimony in support of Board of Trustees Report 15. Your Reference Committee also heard that the Scope of Practice Summit resulting from AMA Policy H-35.988 was timely and strategic, and presented a welcome opportunity to discuss scope of practice trends and priorities. Your Reference Committee understands that conversations about potential advocacy strategies and resources will be ongoing and will continue to take place through AMA meetings dedicated to advocacy and scope of practice, as well as through the Scope of Practice Partnership (SOPP). Your Reference Committee heard great appreciation for the ample scope of practice resources our AMA provide through its Advocacy Resource Center and the combined efforts of the SOPP. Your Reference Committee commends our AMA on a successful Scope of Practice Summit, and recommends that Board of Trustees Report 15 be adopted.

(3) BOARD OF TRUSTEES REPORT 16 – PROTECTION OF CLINICIAN-PATIENT PRIVILEGE (RESOLUTION 237-A-17)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 16 be adopted and the remainder of the report be filed.

The BOT recommends that: AMA Policy H-315.983 be amended in lieu of Resolution 237-A-17 and the remainder of the report be filed: Policy H-315.983, “Patient Privacy and Confidentiality,” 1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; and (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure.; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received. (Modify Current HOD Policy)
Your Reference Committee heard limited but supportive testimony on Board of Trustees Report 16. Your Reference Committee heard testimony that regardless of the clinical care setting that HIPAA’s privacy protections should be the minimal level of privacy afforded to a patient. Accordingly, your Reference Committee recommends adoption of Board Report 16.

(4) BOARD OF TRUSTEES REPORT 18 – MEDICAL LIABILITY COVERAGE THROUGH THE FEDERAL TORT CLAIMS ACT (RESOLUTION 214-A-17).

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 18 be adopted and the remainder of the report be filed.

The BOT recommends that: Resolution 214-A-17 not be adopted and the remainder of the report be filed.

Your Reference Committee heard generally supportive testimony on Board of Trustees Report 18. Your Reference Committee heard testimony that application of the Federal Tort Claims Act to all federal health programs would result in physicians having no control over the direction of a medical liability case, be a broad overreach and significant departure from Congressional intent, and conflict with strong AMA policy where our AMA cannot support federal preemptive legislation that would undermine effective state tort reform efforts. For all the reasons articulated in a thorough and extensive Board of Trustees Report, your Reference Committee recommends that Board of Trustees Report 18 be adopted.

(5) BOARD OF TRUSTEES REPORT 19 – HEALTH INFORMATION TECHNOLOGY PRINCIPLES (RESOLUTION 218-I-17)

RECOMMENDATION:

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

liquidity; 7. Facilitate digital and mobile patient engagement; and 8. Expedite user input into product design and post-implementation feedback. (New HOD 24 Policy) 3. That our AMA utilize HiT principles to: 1. Work with vendors to foster the development of usable EHRs; 2. Advocate to federal and state policymakers to develop effective HIT policy; 3. Collaborate with institutions and health care systems to develop effective institutional HIT policies; 4. Partner with researchers to advance our understanding of HIT usability; and 5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care. (New HOD Policy)

Your Reference Committee heard mixed testimony on Board of Trustees Report 19. Your Reference Committee agrees with testimony that health information technology has numerous usability and security issues that have negatively impacted the physician-user experience. Your Reference Committee also heard testimony that our AMA released EHR usability priorities in 2014. These priorities have successfully guided our AMA’s advocacy efforts including requiring real-world testing of EHRs, disclosing of EHR vendors fees, and prohibiting restrictions on user communications about EHR usability. Your Reference Committee believes that our Board had the opportunity to fully discern this issue of reconciling original Resolution 218-1-17 with our AMA policy and in conjunction with the usability priorities with the including principle eight from the original Resolution, which essentially asks our AMA to take a position that payers are responsible for reimbursing physicians for the costs associated with implementing EHR systems. Additionally, our AMA previously elected to not adopt a similar resolution (831-1-16), instead resolving to focus on encouraging vendors and payers to actively work toward better, more user-friendly and cost-effective solutions that do not overburden physicians and practices. Your Reference Committee further heard testimony that our AMA should adopt these successful priorities into AMA policy. Accordingly, your Reference Committee recommends adoption of Board of Trustees Report 19.

(6) BOARD OF TRUSTEES REPORT 44 – CMS
REIMBURSEMENT GUIDELINES FOR TEACHING PHYSICIAN SUPERVISION (RESOLUTION 230-A-17)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 44 be adopted and the remainder of the report filed.

The Board of Trustees recommends that Resolution 230-A-17 be adopted and the remainder of this report be filed.

Your Reference Committee heard supportive testimony on Board of Trustees Report 44. Your Reference Committee heard that it is not logical to treat major and minor procedures differently based solely on the length of the procedure. Your Reference Committee also heard testimony that procedures should be treated the same regardless of the length of time the procedure takes. Your Reference Committee agrees and accordingly recommends adoption of Board of Trustees Report 44.
(7) BOARD OF TRUSTEES REPORT 45 – LICENSING OF ELECTRONIC HEALTH RECORDS (RESOLUTION 218-A-17)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 45 be adopted and the remainder of the report be filed.

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 218-A-17 and the remainder of the report be filed: 1. That our American Medical Association (AMA) continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care. (Directive to Take Action) 2. That our AMA reaffirm Policies D-460.968, D-478.972, D-478.973, D-478.994, D-478.995, and D-478.996, which broadly direct AMA to continue its leadership in efforts to define and promote standards that facilitate the interoperability of Electronic Health Records (EHRs); to advocate for improvements to EHRs that will enable interoperability and access while not creating additional burdens and usability challenges for physicians; and to advocate for physician flexibility for the adoption and use of certified EHRs and to not financially penalize physicians for using certified EHRs technology that does not meet current standards. (Reaffirm HOD Policy)

Your Reference Committee heard limited testimony on Board of Trustees Report 45. Your Reference Committee heard testimony that our AMA should continue leading efforts to advance policies to improve the usability and interoperability of EHRs in lieu of developing model legislation to license EHRs. Accordingly, your Reference Committee recommends that Board of Trustees Report 45 be adopted and the rest of the report be filed.

(8) RESOLUTION 203 – UPDATING FEDERAL FOOD POLICY TO IMPROVE NUTRITION AND HEALTH

RECOMMENDATION:

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

Resolution 203 asks that our American Medical Association amend existing AMA Policy D-440.978, 26 “Culturally Responsive Dietary and Nutritional Guidelines,” by addition to read as follows: D-440.978 Culturally Responsive Dietary and Nutritional Guidelines. Our AMA and its Minority Affairs Section will: (1) encourage the United States Department of Agriculture (USDA) to include culturally effective guidelines that include listing an array of ethnic staples and use of multicultural symbols to depict serving size in their Dietary Guidelines for Americans and Food Guide; (2) seek ways to assist physicians with applying the USDA Dietary Guidelines for Americans and MyPlate food guide in their practices as appropriate; (3) recognize that lactose intolerance is a common and normal condition among many Americans, especially African Americans, Asian Americans, and Native Americans, with a lower prevalence in whites, often manifesting in childhood; and (4) monitor existing research and identify opportunities where organized medicine can...
impact issues related to obesity, nutritional and dietary guidelines, racial and ethnic health disparities as well as assist physicians with delivering culturally effective care. (Modify Current HOD Policy); and be it further that our AMA propose legislation that modifies the National School Lunch Act, 42 U.S.C. § 1758, so as to eliminate requirements that children produce documentation of a disability or a special medical or dietary need in order to receive an alternative to cow’s milk (Directive to Take Action); and be it further that our AMA recommend that the U.S. Department of Agriculture and U.S. Department of Health and Human Services clearly indicate in the Dietary Guidelines for Americans and other federal nutrition guidelines that meat and dairy products are optional, rather than recommended or required. (New HOD Policy)

Your Reference Committee heard overwhelming supportive testimony on Resolution 203. Testimony was presented that lactose intolerance is a common condition among African Americans, Asian Americans, and Native Americans. Your Reference Committee also heard testimony that African Americans are at particularly high risk for prostate cancer, colorectal cancer, and cardiovascular mortality, and that prostate and colorectal cancer are strongly linked to dairy and meat consumption, respectively, which are promoted in federal nutrition policies. Accordingly, your Reference Committee recommends that Resolution 203 be adopted.

(9) RESOLUTION 204 – OPPOSITION TO MANDATED PROFICIENCY IN ELECTRONIC HEALTH RECORDS FOR LICENSURE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 204 be adopted.

Resolution 204 asks that our American Medical Association adopt a policy that provides that no physician should be denied a medical license on the grounds of failure to use an electronic health record or failure to demonstrate proficiency in use of an electronic health record. (New HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 204. Your Reference Committee heard testimony that Resolution 204 is in line with existing AMA policy that licensing laws should relate only to requirements for the practice of medicine. Accordingly, your Reference Committee recommends that Resolution 204 be adopted.

(10) RESOLUTION 216 – FDA CONFLICT OF INTEREST

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 216 be adopted.

Resolution 216 asks that our American Medical Association advocate that the Food and Drug Administration place a greater emphasis on a candidate’s conflict of interest when selecting members for advisory committees (New HOD Policy); and be it further, that
our AMA advocate for a reduction in conflict of interest waivers granted to Advisory Committee candidates. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 216. Your Reference Committee heard testimony that industry funding of FDA activities and the regular interactions that occur between industry and the FDA that frequently do not include the participation or representation of the physician community. Your Reference Committee believes that disclosure and transparency into conflicts is important and that challenges may exist to find qualified individuals without conflicts with industry. However, your Reference Committee also heard testimony that the FDA advisory committees should utilize generally accepted conflicts of interest policies and should limit waivers of such policies. Accordingly, your Reference Committee recommends adoption of Resolution 216.

(11) RESOLUTION 221 – MAINTAINING VALIDITY AND COMPREHENSIVENESS OF U.S. CENSUS DATA

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 221 be adopted.

Resolution 221 asks that our American Medical Association support adequate funding for the U.S. Census to assure accurate and relevant data is collected and disseminated. (New HOD Policy)

Your Reference Committee heard mostly supportive testimony on Resolution 221. Your Reference Committee heard about the importance of the U.S. Census in determining the allocation of more than $675 billion in federal funding to states and communities annually. Additional testimony noted that these funds are used for community development, public health, education, transportation, and other community resource investments that are critical to decreasing the health, social, and economic disparities experienced by vulnerable populations. Your Reference Committee also heard that an inaccurate count during the 2020 Census would have significant consequences as the demographic data from the count are the basis for surveys that are benchmarks for major businesses, governments, and researchers, and would affect the distribution of funding to states and communities across the nation for community development, public health, education, transportation, and other community resource investments. Your Reference Committee notes that while our AMA has no policy related to the U.S. Census, our AMA has numerous policies related to addressing health disparities experienced by vulnerable populations, including Hispanics, African-Americans, American Indians, and women. Your Reference Committee believes that adoption of this resolution would be consistent with the goals of these policies. Your Reference Committee recognizes that the author of Resolution 221 offered a second resolved regarding a citizenship question on the 2020 Census. Your Reference Committee heard testimony both for and against this amendment; however, your Reference Committee does not believe that it has sufficient information or the expertise to make an informed recommendation. Therefore, your Reference Committee recommends adoption of Resolution 221.
(12) RESOLUTION 232 – RECORDING LAW REFORM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 232 be adopted.

Resolution 232 asks that our American Medical Association draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation. (Directive to Take Action)

Your Reference Committee heard overwhelming supportive testimony on Resolution 232. Your Reference Committee heard testimony that the physician-patient relationship is sacred and based on trust. Your Reference Committee also heard testimony that Resolution 232 further supports the physician-patient relationship and helps foster greater trust between a physician and a patient. Your Reference Committee agrees with the testimony and recommends adoption.

(13) RESOLUTION 233 – SUPPORT FOR REAUTHORIZATION OF THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM

RECOMMENDATION:

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

Resolution 233 asks that our American Medical Association actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives (Directive to Take Action); and be it further, that AMA Policy D-150.975, which calls for action to remove sugar-sweetened beverages from the Supplemental Nutrition Assistance Program, be reaffirmed (Reaffirm HOD Policy); and be it further, that AMA Policy H-150.937, which in part aims to replace calorie-rich, nutrient-poor food with nutrient-dense food within the Supplemental Nutrition Assistance Program, be reaffirmed. (Reaffirm HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 233. Your Reference Committee heard testimony that the Supplemental Nutrition Assistance Program (SNAP, formerly known as food stamps) is the country’s most effective anti-hunger program with most SNAP participants being children, seniors, or people with disabilities. Your Reference Committee also heard testimony that SNAP is reauthorized through the Farm Bill, which is being reauthorized this year. The proposed changes to SNAP are projected to result in more than 1 million low-income households with more than 2 million people losing their benefits altogether or have them reduced. Your Reference Committee understands that our AMA has policy related to SNAP and improvements to the program, but our AMA does not currently have policy directing our AMA to actively lobby Congress to preserve and protect SNAP through the reauthorization of the 2018 Farm Bill. Accordingly, your Reference Committee recommends adoption of Resolution 233.
Resolution 253 asks that our AMA oppose the practice of separating migrating children from their caregivers in the absence of immediate physical or emotional threats to the child’s well-being; and be it further (New HOD Policy), that our AMA urge the federal government to withdraw its policy of requiring separation of migrating children from their caregivers, and instead, give priority to supporting families and protecting the health and well-being of the children within those families (Directive to Take Action). Resolution 257 asks that our American Medical Association urge the Department of Homeland Security, Attorney General Sessions, and President Trump to withdraw its new policy to require separation of children from their parents, and instead, give priority to supporting families and protecting the health and well-being of the children within those families. (Directive to Take Action).

Your Reference Committee heard supportive testimony on Resolution 253 and Resolution 257. Your Reference Committee heard testimony that separating children from their parents entering the United States will cause harm to children, parents, and their families. Testimony also stated that childhood trauma and adverse childhood experiences create negative health impacts that could last an individual’s entire lifespan. Your Reference Committee further heard testimony that our AMA has policy that opposes the separation of parents from their children who are detained while seeking safe haven. Your Reference Committee heard testimony that Resolution 253 should be amended to use the term caregivers in the title to be consistent with the content of the resolution. Accordingly, your Reference Committee recommends adoption of Resolution 253 with amendment and in lieu of Resolution 257.
RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Recommendation of Board of Trustees Report 9 be amended by addition to read as follows:

The Board of Trustees recommends that the House of Delegates policies listed in Appendix 1 to this report be acted upon in the manner indicated, except for Policy H-270.965, which should be rescinded, and Policy H-315.977, which should be retained, and the remainder of this report be filed.

RECOMMENDATION B:

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

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

Your Reference Committee heard and agreed with testimony urging that Policy H-270.965 be rescinded, and that Policy H-315.977 be retained. Therefore, your Reference Committee recommends that the recommendation of Board of Trustees Report 9 be adopted as amended and that the remainder of the report be filed.

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 of Board of Trustees Report 12 be amended by addition and deletion to read as follows:

1. That our American Medical Association (AMA) advocate for a federal study to evaluate the use of PDMPs to improve pain care as well as treatment for substance use
disorders as part of medication assisted treatment with counseling. This would include identifying whether new PDMPs can distinguish team-based care from uncoordinated care, misuse, or “doctor shopping,” as well as whether PDMPs help coordinate care for a patient with a substance use disorder or other condition requiring specialty care. (Directive to Take Action); 

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations of the Board of Trustees Report 12 be adopted as amended in lieu of Resolution 237 and the remainder of the report be filed.

The Board of Trustees recommends that: the following recommendations be adopted in lieu of Resolution 212-A-17: 1. That our American Medical Association (AMA) advocate for a federal study to evaluate the use of PDMPs to improve pain care as well as treatment for substance use disorders. This would include identifying how PDMPs can distinguish team-based care from uncoordinated care, misuse, or “doctor shopping,” as well as help coordinate care for a patient with a substance use disorder or other condition requiring specialty care. (Directive to Take Action), 2. That our AMA urge EHR vendors to increase transparency of custom connections between their products and PDMP software. (Directive to Take Action), 3. That our AMA support state-based pilot studies of best practices to integrate EHRs, EPCS and PDMPs as well as efforts to identify burdensome state and federal regulations that prevent such integration from occurring. (New HOD Policy) Resolution 237 asks that our American Medical Association study current e-prescribing processes and make recommendations to improve these processes to make them as safe as possible for patients and as efficient as possible for prescribers. (Directive to Take Action).

Your Reference Committee heard support for using prescription drug monitoring programs (PDMPs), electronic health records (EHRs), and electronic prescribing of controlled substances (EPCS). Your Reference Committee agrees with testimony that treatment for evidence-based treatment substance use disorders includes medication assisted treatment with counseling. Your Reference Committee appreciates the fact that physicians are increasingly using PDMPs, EHRs and EPCS, but as noted by the Board in its report, there often are significant barriers to using these tools effectively in practice. The Board’s recommendations would help identify those barriers in a comprehensive manner as an important step in reversing the nation’s opioid epidemic. Moreover, your Reference Committee appreciates comments that the first question is whether these tools are, in fact, working as intended. At a time when policy development is accelerating at a rapid pace, it is important to know whether those policies impede clinical practice.
(17) BOARD OF TRUSTEES REPORT 17 – EVALUATING
ACTIONS BY PHARMACY BENEFIT MANAGERS AND
PAYER POLICIES ON PATIENT CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends
that recommendation one of Board of Trustees Report 17
be amended by addition and deletion to read as follows:

That our American Medical Association (AMA) urge the
National Association of Boards of Pharmacy, Federation of State Medical Boards (FSMB), and National
Association of Insurance Commissioners (NAIC) to support
having national pharmacy chains, health insurance
companies, and Pharmacy Benefits Managers (PBMs)
testify at state-level public hearings by state medical/pharmacy boards, respectively, and state
departments of insurance, on whether the pharmacy
chains, health insurance companies, and PBMs' policies to
restrict the prescribing/dispensing of opioid analgesics are
in conflict with state insurance laws or state laws governing
the practice of medicine and pharmacy, respectively.

RECOMMENDATION B:

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

The BOT recommends that: the remainder of the report be filed. 1. That our American
Medical Association (AMA) urge the National Association of Boards of Pharmacy and
Federation of State Medical Boards to support having national pharmacy chains, health
insurance companies and PBMs testify at state-level public hearings by state/pharmacy
boards, respectively, on whether their policies to restrict the prescribing/dispensing of
opioid analgesics are in conflict with state law governing the practice of medicine and
pharmacy, respectively. (Directive to Take Action), 2. That our AMA oppose specific
dose or duration limits on pharmacologic therapy that are not supported by medical
relationships with law enforcement, regulatory agencies, pharmacists and other
professional groups as necessary to identify situations where a person is attempting to
obtain a prescription for fraudulent or otherwise illegal means. (Reaffirm HOD Policy), 4.
That our AMA reaffirm Policy H-95.932, "Increasing Availability of Naloxone," which
supports legislative, regulatory, and national advocacy efforts to increase access to
affordable naloxone, including but not limited to collaborative practice agreements with
pharmacists and standing orders for pharmacies. (Reaffirm HOD Policy)
Your Reference Committee heard strong support for the recommendations in Board of Trustees Report 17. As background, your Reference Committee points out that the Centers for Disease Control and Prevention’s 2016 opioid prescribing guidelines were intended—as CDC has repeatedly said—to be voluntary guidelines largely focused on primary care, acute pain episodes of care. Since then, however, as our Board explains, many state legislatures, health insurance companies, pharmacies and pharmacy benefit management companies have taken the guidelines—or a variation of them—and transformed them into hard policy thresholds, state laws and other requirements. Your Reference Committee agrees that physicians have a responsibility to be leaders in supporting more judicious prescribing habits, and your Reference Committee are pleased that our AMA Opioid Task Force reported a 22.2 percent national decrease in opioid prescribing between 2013 and 2017. Your Reference Committee agrees that specific dose or duration limits on pharmacologic therapy must be supported by medical evidence and clinical practice. Your Reference Committee also agrees that it is time for a close look at how these policies are affecting patients, including whether they are in conflict with state licensing laws that govern the practice of medicine, pharmacy and/or insurance. Your Reference Committee hopes that this dialogue will create much-needed transparency to review the evidence for their policies. For these reasons, your Reference Committee recommends adoption of the recommendations in Board of Trustees Report 17 as amended.

(18) BOARD OF TRUSTEES REPORT 41 – AUGMENTED INTELLIGENCE IN HEALTH CARE
RESOLUTION 205 – AUGMENTED INTELLIGENCE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 41 be amended by addition to read as follows:

As a leader in American medicine, our American Medical Association (AMA) has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community. To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians’ professional satisfaction to help set priorities for health care AI.

2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.

3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
   a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
   b. is transparent;
   c. conforms to leading standards for reproducibility;
d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
e. safeguards patients’ and other individuals’ privacy interests and preserves the security and integrity of personal information.

2. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.

3. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 41 be adopted as amended in lieu of Resolution 205 and the remainder of the report be filed.

The Board recommends that: the following be adopted and the remainder of this report be filed as a leader in American medicine, our American Medical Association (AMA) has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community. To that end our AMA will seek to: 1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians’ professional satisfaction to help set priorities for health care AI, 2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI, 3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that: a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team; b. is transparent; c. conforms to leading standards for reproducibility; d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and e. safeguards individuals’ privacy interests and preserves the security and integrity of personal information, 4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI, 5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI. (New HOD Policy) Resolution 205 asks that our American Medical Association develop Augmented Intelligence (AI) policy that reflects the principle that all patients should have 24-7 access to primary care physicians who can see the medical records of the patients (New HOD Policy); and be it further, that AI should be funded as an enhancement of the primary care medical home so that patients who really need AI can benefit from the technology and such that AI does not
become a requirement that must be incorporated into the care of every patient. (New
HOD Policy)

Your Reference Committee heard overwhelmingly supportive testimony on Board Report
41 and mixed testimony on Resolution 205. Your Reference Committee heard testimony
that physicians must provide a clear set of policy positions on health care augmented
intelligence (AI) and to ensure the best interests of patients are served. Your Reference
Committee also heard testimony that while safeguarding individuals’ privacy interest is
laudable, the focus should be on safeguarding patients’ privacy interest. Your Reference
Committee believes that Resolution 205 intends to advance important goals of health
care AI such as ensuring it is part of workflow, that it is not mandated for use, and it
strengthens the medical home. Your Reference Committee believes that Board of
Trustees Report 41 captures those goals and ensures that policy addresses other
important issues like guarding against bias, applies to specialty care, and explores the
legal implications of health care AI.

Your Reference Committee heard further testimony that federal and state legislators and
policymakers are already becoming actively engaged in developing laws and regulations
on health care AI. Your Reference Committee agrees with testimony that physicians
have a critical perspective and must engage now to ensure this technology develops and
is integrated to improve patient outcomes, reduce administrative and technological
burdens, and supports physician satisfaction. Your Reference Committee heard
testimony offering an amendment to safeguard patients’ and individuals’ privacy
interests. Accordingly, your Reference Committee recommends adoption of Board
Report 41 with amendment in lieu of Resolution 205.

(19) RESOLUTION 201 – BARRIERS TO OBESITY
TREATMENT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends
that the first Resolve of Resolution 201 be adopted.

RECOMMENDATION B:

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

RESOLVED, That our AMA actively lobby work with
interested state medical societies and other interested
stakeholders to remove out-of-date restrictions at the state
and federal level prohibiting healthcare providers from
providing the current standard of care to patients affected
by obesity. (Directive to Take Action)
RECOMMENDATION C:

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

Resolution 201 asks that our American Medical Association work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment (Directive to Take Action); and be it further, that our AMA actively lobby with state medical societies and other interested stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity. (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 201. Your Reference Committee heard testimony that there are many evidence-based, effective and safe treatment options for obesity. Those testifying expressed an appreciation for existing AMA policy, which recognizes that obesity requires a range of interventions to advance obesity treatment and prevention and directs our AMA to work with specialty and state medical societies to advocate for patient access to the full continuum of evidence-based treatment modalities. Your Reference Committee heard, however, of the need to build on existing policy to ensure the elimination of barriers to obesity treatment that is consistent with the standard of care. Your Reference Committee recommends a minor amendment to reflect that AMA direct engagement in state legislative affairs occurs only with the approval of state medical associations. Your Reference Committee, therefore, recommends that Resolution 201 be adopted as amended.

(20) RESOLUTION 202 – UNIVERSAL AND STANDARDIZED PROTOCOLS FOR EHR DATA TRANSITION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 202 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols required universal and standard protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 202 be adopted as amended.
Resolution 202 asks that our American Medical Association seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish required universal and standard protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 202. Your Reference Committee heard testimony that switching EHR vendors can be costly and disruptive to patient care. Your Reference Committee also heard testimony that without standard methods or protocols to transfer data among EHR vendors, physician and health systems may be effectively required to continue to use the current EHR vendors. Testimony supporting amendment to Resolution 202 included implementing non-charged upgrades/updates to EHR systems during an EHR data transitions and also imposed specific deadlines of regulatory implementation. Your Reference Committee believes that it may be difficult for any regulation to carve out an interoperability update from a regular EHR update. Moreover, your Reference Committee believes that vendors could just shift costs somewhere else like monthly “service” fees or more exorbitant start-up costs. Your Reference Committee further believes that imposing artificial deadlines without knowing the technical standards or proper testing of those standards may further inhibit interoperability and increase physician frustration. Accordingly, your Reference Committee recommends adopting Resolution 202 as amended.

(21) RESOLUTION 208 – PRIOR AUTHORIZATION REQUIREMENTS FOR POST-OPERATIVE OPIOIDS

RECOMMENDATION A:

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

RESOLVED, That our American Medical Association strongly oppose prior authorization requirements for post-operative analgesia equivalent to five days or less so as to prevent patient suffering.

RECOMMENDATION B:

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

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 208 be changed to read as follows:

PRIOR AUTHORIZATION REQUIREMENTS FOR POST OPERATIVE ANALGESIA
Resolution 208 asks that our American Medical Association strongly oppose prior authorization requirements for postoperative analgesia equivalent to five days or less so as to prevent patient suffering. (New HOD Policy)

Your Reference Committee heard extended testimony on Resolution 208. Your Reference Committee heard clear support that prior authorization policies for a “five-day” limit on post-operative opioids are often a barrier to care for patients requiring adequate pain relief. Testimony highlighted the individual characteristics of the type of surgical intervention and unique characteristics of the patient should be the determining factor in whether an opioid—or other pharmacologic—option is most appropriate. Your Reference Committee notes that Board of Trustees Report 17 also discussed the need for any dose or duration requirement to be based on clinical evidence and medical practice. Your Reference Committee agrees with our Board that our AMA should not support arbitrary thresholds or guidelines for any medical practice. Rather, your Reference Committee agrees with testimony that the practice of medicine be governed by the best medical evidence and evolving clinical practice. And while your Reference Committee acknowledges that prior authorization for many medical, pharmacologic, and non-pharmacologic therapies are adversely affected by disruptive prior authorization policies, your Reference Committee did not expand the scope of the resolution beyond the author’s intent. Accordingly, your Reference Committee recommends that Resolution 208 be adopted with amendment by deletion and a change in title.

(22) RESOLUTION 209 – SUBSTANCE USE DISORDERS DURING PREGNANCY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 209 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support legislation legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance abuse disorders during pregnancy without mandating any specific form of therapy.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 209 be adopted as amended.

Resolution 209 asks that our American Medical Association (AMA) reaffirm Policy H-420.969 (#4) so as to oppose any legislation that seeks to specifically penalize women who are diagnosed with a substance abuse disorder during pregnancy (Reaffirm HOD Policy); and be it further, that our AMA oppose any efforts to imply that the diagnosis of substance abuse disorder during pregnancy represents child abuse (New HOD Policy); and be it further, that our AMA support legislation for the expansion and improved access to evidence-based treatment for substance abuse disorders during pregnancy without mandating any specific form of therapy. (Directive to Take Action)
Your Reference Committee heard clear testimony in support of longstanding AMA policy that pregnant women should not be penalized for having a medical disease. Rather, your Reference Committee heard testimony that our AMA should continue its efforts in support of all persons with a substance use disorder from facing criminal penalties or punitive measures as a result of having a substance use disorder. Your Reference Committee emphasizes that this does not suggest in any way that the our AMA condones criminal activity or drug use during pregnancy—simply that the focus on treatment for substance use disorders must remain squarely in the medical realm, with a clear focus on supporting treatment based on the best medical evidence. This resolution accomplishes that goal. Your Reference Committee further heard testimony that Resolution 209 should be amended to reflect current medical terminology and to provide our AMA with more flexibility and avenues to achieve Resolution 209. For these reasons, your Reference Committee recommends adopting the resolution as amended.

(23) RESOLUTION 211 – CLARIFICATION FROM US DEPARTMENT OF JUSTICE REGARDING FEDERAL ENFORCEMENT OF MEDICAL MARIJUANA LAWS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 211 be amended by addition to read as follows:

RESOLVED, That our American Medical Association when necessary and prudent seek clarification from the United States Justice Department (DOJ) about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, ask the DOJ to provide federal guidance to physicians.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 211 by adopted as amended.

Resolution 211 asks that our American Medical Association seek clarification from the United States Justice Department about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, provide guidance to physicians. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 211. Your Reference Committee heard testimony that no physicians have been prosecuted yet and that bringing this issue to the Department of Justice may inadvertently cause an actual prosecution. Your Reference Committee also heard that our AMA should be provided flexibility to seek clarification when appropriate. Testimony was also provided to clarify who should provide any potential guidance to our AMA members. Your Reference Committee agrees that there is a possibility of federal prosecution of physicians for
prescribing medical marijuana that complies with a state program. Accordingly, your Reference Committee recommends adoption as amended.

(24) RESOLUTION 215 – REGULATION OF HOSPITAL ADVERTISING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy H-225.994 be amended by addition to read as follows.

Hospital Advertising in Printed and Broadcast Media H-225.994

RESOLVED, In order to prevent medical misinformation, the AMA encourages (1) medical staff participation in hospital administration decisions regarding marketing and advertising and (2) hospital and medical advertising be consistent with federal regulatory standards and with the Code of Medical Ethics.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-225.994 be adopted as amended in lieu of Resolution 215.

Resolution 215 that our American Medical Association advocate for regulations which promote responsible hospital and medical advertising. (New HOD Policy)

Your Reference Committee heard supportive testimony for Resolution 215. Your Reference Committee heard that our AMA supports truth in advertising and keeping patients informed as they are being treated by a health care provider. Your Reference Committee also heard that the Code of Medical Ethics Opinion 9.6.1 clearly lays out the principles of medical ethics surrounding physician advertising, although it does not specifically speak to hospital advertising. In addition, your Reference Committee heard that, under existing AMA Policy H-225.994, our AMA encourages medical staff participation in hospital administration decisions regarding marketing and advertising to prevent medical misinformation. Testimony supported amending this policy to include language ensuring that hospital and medical advertising be consistent with federal regulatory standards and with the Code of Medical Ethics. Your Reference Committee agrees and recommends that AMA Policy H-225.994 be adopted as amended in lieu of Resolution 215.
Madam Speaker, your Reference Committee recommends that Resolution 218 be amended by addition of a second resolve to read as follows:

RESOLVED, That our American Medical Association work with state and specialty medical societies to advocate for the removal of barriers to feminine hygiene products in state and local prisons and correctional institutions to ensure incarcerated women have affordable access to the appropriate type and quantity of feminine hygiene products including tampons for their needs.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 218 be adopted as amended.

Resolution 218 asks that our American Medical Association encourage the Internal Revenue Service to classify feminine hygiene products as medical necessities. (New HOD Policy).

Your Reference Committee heard supportive testimony on Resolution 218. Your Reference Committee heard that, under current Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from a Flexible Spending Account (FSA) or other tax-favored health plan when a licensed health care provider certifies that they are medically necessary. Your Reference Committee heard that the IRS deems feminine hygiene products as items which are not required for treatment, prevention, or diagnosis of a medical condition and are therefore not eligible for reimbursement with an FSA or similar program, nor are these products allowable under the tax-deductions for allowable medical expenses. Testimony also noted that Resolution 218 is consistent with existing AMA policy H-270.953, Tax Exemptions for Feminine Hygiene Products, which supports legislation to remove all sales tax on feminine hygiene products. An amendment was offered that would add a second resolve that would call on our AMA to ensure that incarcerated women have affordable access to feminine hygiene products. Your Reference Committee agrees and accordingly recommends that Resolution 218 be adopted as amended.
(26) RESOLUTION 222 – EVIDENCE BASED TREATMENT IN
SUBSTANCE ABUSE TREATMENT FACILITIES
RESOLUTION 240 – TREATING OPIOID USE
DISORDER IN TREATMENT FACILITIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends
the adoption of the following resolution in lieu of
Resolutions 222 and 240.

SUPPORT THE ELIMINATION OF BARRIERS TO
MEDICATION-ASSISTED TREATMENT FOR
SUBSTANCE USE DISORDER

RESOLVED, That our American Medical Association
advocate for legislation that eliminates barriers to,
increases funding for, and requires access to all
appropriate FDA-approved medications or therapies used
by licensed drug treatment clinics or facilities (New HOD
Policy); and be it further

RESOLVED, That our AMA develop a public awareness
campaign to increase awareness that medical treatment of
substance use disorder with medication-assisted treatment
is a first-line treatment for this chronic medical disease.
(Directive to Take Action)

Resolution 222 asks 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)
Resolution 240 asks that our American Medical Association adopt a policy that
recognizes the use of buprenorphine or methadone as effective treatment for opioid use
disorder, and encourages the appropriate use of medication and non-medication-based
treatment (New HOD Policy); and be it further, that our AMA advocate for legislation to
eliminate barriers and require access to all three FDA-approved medications
(buprenorphine, methadone and naltrexone) at all legally certified drug treatment
facilities, and advocate for standards, policies and funding to support access to these
medications at treatment facilities (New HOD Policy); and be it further, that our AMA
conduct a campaign to increase awareness on the part of providers, treatment
programs, and the public that AMA recognizes the use of buprenorphine or methadone
as effective treatment for opioid use disorder. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolutions 222 and 240.
There is no question that patients are experiencing delays and denials of care when
trying to begin treatment for a substance use disorder. This includes clinics and facilities
in the private market as well as those supported by public payers, including correctional
settings. Your Reference Committee heard testimony that prior authorization and step
therapy requirements can have deadly consequences for patients. In addition, your
Reference Committee heard testimony supporting a public awareness campaign to not
only help educate patients, but also to help remove the stigma of having a substance use disorder. Your Reference Committee heard additional testimony offering a substitute resolution that maintains the key concepts of Resolutions 222 and 240. Accordingly, your Reference Committee recommends adopting a substitute resolution that combines the intent of Resolutions 222 and 240.

(27) RESOLUTION 223 – TREATING OPIOID USE DISORDER IN HOSPITALS
RESOLUTION 239 – TREATING OPIOID USE DISORDER IN HOSPITALS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 223 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association’s Opioid Task Force work together with the American Hospital Association and other relevant organizations to identify best practices that are being used by develop recommendations and an implementation plan to encourage hospitals and others to treat opioid use disorder as a chronic disease, including identifying patients with this condition; initiating or providing opioid agonist or partial agonist therapy in inpatient, obstetric and emergency department settings; providing cognitive and behavioral therapy as well as other counseling as appropriate; establishing appropriate discharge plans, including education about opioid use disorder; and participating in community-wide systems of care for patients and families affected by this chronic medical disease (Directive to Take Action); and be it further

RESOLVED, That our AMA’s Opioid Task Force advocate for states to collaborate with relevant organizations to evaluate programs that currently exist or have received seek federal or state funding to assist physicians, hospitals and their communities to coordinate care for patients with the chronic disease of opioid use disorder. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 223 be adopted as amended in lieu of Resolution 239.

Resolution 223 asks that our American Medical Association’s Opioid Task Force work together with the American Hospital Association and other relevant organizations to
develop recommendations and an implementation plan to encourage hospitals to treat opioid use disorder as a chronic disease, including identifying patients with this condition; providing opioid agonist or partial agonist therapy in inpatient, obstetric and emergency department settings; establishing appropriate discharge plans; and participating in community-wide systems of care for patients affected by this chronic disease (Directive to Take Action); and be it further, that our AMA's Opioid Task Force collaborate with relevant organizations to seek federal funding to assist hospitals and their communities to coordinate care for patients with the chronic disease of opioid use disorder. (Directive to Take Action) Resolution 239 asks that our American Medical Association adopt a policy in favor of hospitals in the United States treating opioid use disorder with medications approved by the U.S. Food and Drug Administration for that purpose (buprenorphine, methadone and naltrexone) along with appropriate counseling (New HOD Policy); and be it further, that our AMA advocate for legislation, standards, policies and funding to support hospitals in the United States treating opioid use disorder with medications approved by the FDA for that purpose (buprenorphine, methadone and naltrexone) along with appropriate counseling (New HOD Policy); and be it further, that our AMA work together with relevant organizations such as the American Hospital Association, The Joint Commission and the American Society of Addiction Medicine to develop and promote a model hospital policy that would assist hospitals in addressing opioid use disorder as a chronic disease by: a) ensuring that medical and other clinical staff are educated about evidence-based treatment of opioid use disorder in order to appropriately advise and treat their patients, b) providing patient education about and access to all three FDA-approved medications (buprenorphine, methadone and naltrexone) in emergency and inpatient settings, and buprenorphine and methadone in obstetric settings, c) maintaining use of these medications for patients already on them, d) initiating use of these medications for assenting patients affected by the disease, e) establishing comprehensive discharge plans for ongoing medical and behavioral treatment in the community, and f) participating in the development of community-wide systems of care for patients with opioid use disorder to facilitate discharge planning. (Directive to Take Action)

Your Reference Committee heard strong testimony in support of Resolutions 223 and 239 and the need to evaluate current policies and programs designed to end the nation’s opioid epidemic. Whether those policies and practices exist in hospital or community settings, your Reference Committee agrees with testimony that there is excellent work being done in the nation’s hospitals and in other physician-based and community-based settings. Our AMA Opioid Task Force has earned a strong reputation for convening key medical and other stakeholders to identify best practices and share them widely through our AMA opioid microsite. Your Reference Committee is confident that the Task Force can work with the American Hospital Association (AHA) to identify best practices as well as barriers to care (e.g., practice-related, legal, financial, etc.), including solutions on how to address those barriers. Your Reference Committee also agrees that the nation would be well-served by a thoughtful evaluation of federal- and state-funded efforts to end the epidemic and improve care for patients that is physician-focused. Armed with this information, states can make informed choices about future policy and resource decisions. Your Reference Committee also heard testimony that an amendment to Resolution 223 that maintains the substantive elements of Resolution 239 would ensure consistent and strong policy. This is work that can be done now, which is why your Reference Committee does not support referral. Accordingly, your Reference Committee recommends adoption of Resolution 223 as amended in lieu of Resolution 239.
(28) RESOLUTION 224 – LEGALIZATION OF INTERPHARMACY TRANSFER OF ELECTRONIC PRESCRIPTIONS FOR CONTROLLED SUBSTANCES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 224 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate for the removal of state, federal and other barriers that impede legalization of interpharmacy transfers of valid electronic prescriptions for Schedule II-V medications. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 224 be adopted as amended.

Resolution 224 asks that our American Medical Association advocate for the federal legalization of interpharmacy transfers of valid electronic prescriptions for Schedule II-V medications. (New HOD Policy)

Your Reference Committee heard limited testimony on Resolution 224. Your Reference Committee agrees that there are considerable barriers to widespread adoption of electronic prescribing of controlled substances (EPCS). Our AMA is actively working to remove these barriers, whether technical, practice-specific, or regulatory in nature. Your Reference Committee agrees with the resolution’s author intent to broaden the scope of the resolution so as to provide our AMA with additional guidance and flexibility. Accordingly, your Reference Committee recommends adopting Resolution 224 as amended.

(29) RESOLUTION 225 – PHARMACY BENEFIT MANAGERS IMPACT ON PATIENTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 225 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA examine issues survey the membership about experiences with PBM-related clawbacks and direct and indirect remuneration (DIR) fees to better inform existing advocacy efforts.
RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 225 be adopted as amended.

Resolution 225 asks that our American Medical Association gather more data on the erosion of physician-led medication therapy management in order to assess the impact pharmacy benefit manager (PBM) tactics may have on patient’s timely access to medications, patient outcomes, and the physician-patient relationship (Directive to Take Action); and be it further, that our AMA survey the membership about experiences with PBM-related clawbacks and direct and indirect remuneration (DIR) fees to better inform existing advocacy efforts. (Directive to Take Action)

Your Reference Committee heard largely supportive testimony related to the author’s proposed amendment to Resolution 225. Specifically, the author recommended that our AMA examine issues with PBM-related clawbacks and direct and indirect remuneration (DIR) fees to better inform our existing AMA advocacy efforts, as opposed to having our AMA survey membership related to their experiences with such clawbacks and DIR fees. Your Reference Committee agrees with testimony that not only will the author’s proposed amendment reduce the cost impact (approximately $160,000) of requiring our AMA to field a survey, but also result in the collection of information more helpful to our advocacy in this area. Accordingly, your Reference Committee recommends that Resolution 225 be adopted as amended.

(30) RESOLUTION 229 – GREEN CARD BACKLOG FOR IMMIGRANT DOCTORS ON H-1B VISAS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 229:

PERMANENT RESIDENCE STATUS FOR PHYSICIANS ON H1-B VISAS

RESOLVED, That our American Medical Association work with all relevant stakeholders to clear the backlog for conversion from H1-B visas for physicians to permanent resident status. (Directive to Take Action)

Resolution 229 asks that our American Medical Association work with the Office of the Inspector General, the Veterans Affairs Administration, United States Citizenship and Immigration Services and the Executive Branch of the United States Government to create a separate path to obtain green cards and citizenship for physicians which would allow these physicians to work unrestricted and allow them to work within the Veterans Affairs Hospital network to address the current and expected future physician shortage in these institutions. (Directive to Take Action)
Your Reference Committee heard supportive testimony on Resolution 229. Your Reference Committee heard that there is a sizeable backlog of international medical graduates who are actively practicing in the U.S. and waiting to receive a green card. Your Reference Committee also heard testimony that some physicians have been waiting for decades to receive their green cards due to the per-country numerical limitation for employment-based immigrants in the federal Immigration and Nationality Act. The author of Resolution 229 offered a substitute resolution that would provide broader language to work with all relevant stakeholders to clear the backlog for conversion from H1-B visas to permanent resident status. Your Reference Committee agrees with this language and accordingly recommends adoption of a substitute resolution in lieu of Resolution 229.

(31) RESOLUTION 230 – OPPOSITION TO FUNDING CUTS FOR PROGRAMS THAT IMPACT THE HEALTH OF POPULATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends Resolution 230 be amended by addition to read as follows:

RESOLVED, That our American Medical Association actively advocate that Congress, the White House, and senior cabinet officials ensure that programs designed to meet daily needs, support changes in individual behavior, and improve the health of populations remain funded at least at current levels and remain available without additional restrictions or rules. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends Resolution 230 be adopted as amended.

Resolution 230 asks that our American Medical Association actively advocate that Congress, the White House, and senior cabinet officials ensure that programs designed to meet daily needs, support changes in individual behavior, and improve the health of populations remain funded at current levels and remain available without additional restrictions or rules. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 230. Testimony was presented that “Healthy People 2020” highlights the importance of addressing the social determinants of health by including the creation of social and physical environments that promote good health for all. Testimony was also presented that our AMA adopted Policy H-295.874 supporting educating medical students in the social determinants of health (SDOH) and cultural competence, and that our AMA has policy opposing policies and rules that would lead to barriers to access resources that are examples of SDOH. Your Reference Committee further heard that the Administration is proposing funding cuts to the Supplemental Nutrition Assistance Program, education programs, housing subsidies and community development block grants, and other programs. An amendment was
offered to clarify that our AMA advocate for at least maintaining the current funding levels. Having heard support for this amendment, your Reference Committee recommends that Resolution 230 be adopted as amended.

(32) RESOLUTION 231 – ONLINE CONTROLLED DRUGS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 231 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support efforts that advocate for changes to applicable laws and regulations to help the Drug Enforcement Administration and the Food and Drug Administration to better regulate and control the illegal online sales and distributions of drugs, dietary supplements, and herbal remedies controlled substances that lack a valid prescription. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 231 be adopted as amended.

Resolution 231 asks that our American Medical Association advocate for changes to applicable laws and regulations to help the Drug Enforcement Administration and the Food and Drug Administration to better regulate and control the online sales and distribution of controlled substances that lack a valid prescription. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 231. Your Reference Committee heard testimony that indicated that existing laws may not be adequate to cover the current landscape of drugs. Testimony was also presented that there are many products being sold online that fall into a gray area of not being FDA-approved and not being scheduled by the DEA. Your Reference Committee heard testimony to amend Resolution 231 to address these concerns to better clarify the intent. Accordingly, your Reference Committee recommends adopting Resolution 231 as amended.
RESOLUTION 236 – REDUCING MIPS REPORTING BURDEN

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 236 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with the Medicare Payment Advisory Commission (MedPAC) the Centers for Medicare and Medicaid Services (CMS) to advocate for a new replacement voluntary reporting system that has improvements to Merit-Based Incentive Payment System (MIPS) that have significant input from practicing physicians and reduce regulatory and paperwork burdens on physicians (Directive to Take Action); and be it further

RESOLVED, That, in the interim, our AMA work with CMS to shorten the yearly Merit-Based Incentive Payment System (MIPS) data reporting period from one-year to any a minimum of 90-days (of the physician’s choosing) interval within the calendar year (of the physician’s choosing). (Directive to Take Action)

RECOMMENDATION B:

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

Resolution 236 asks that our American Medical Association work with the Medicare Payment Advisory Commission and the Centers for Medicare and Medicaid Services (CMS) to advocate for a new replacement voluntary reporting system that has significant input from practicing physicians and reduces regulatory and paperwork burdens on physicians (Directive to Take Action); and be it further, that, in the interim, our AMA work with CMS to shorten the yearly Merit-Based Incentive Payment System data reporting period from one-year to any 90-day interval within the calendar year (of the physician’s choosing). (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 236. Your Reference Committee heard that most testimony supported the goals of the resolves. Your Reference Committee heard that our AMA has been able to make significant improvements to the MIPS program since its implementation, and is continuing to aggregate physician and specialty society input to improve the MIPS program and reduce the regulatory reporting burden for physicians. Your Reference Committee also heard that our AMA is working with the Centers for Medicare and Medicaid Services (CMS), not MedPAC, to refine and improve the MIPS program. In addition, your Reference Committee heard testimony in support of improving the MIPS program, as opposed to designing a new program. There was also supportive testimony regarding
the second resolve; however your Reference Committee heard testimony that the language should be clarified to specify that our AMA work with CMS to shorten the MIPS reporting period to a minimum of 90 days. Your Reference Committee heard testimony seeking support to refer the first Resolve for further study. Your Reference Committee, however, believes that the weight of the testimony favors adoption of Resolution 236 with an amendment.

(34) RESOLUTION 241 – ACCURACY AND ACCOUNTABILITY OF PHYSICIAN COMPENSATION REPORTING BY DRUG AND DEVICE COMPANIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 241 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association adopt advocate as policy that (1) any payment or transfer of value compensation reported as part of the Physician Payments Sunshine Act should include whether be accompanied by a verifiable receipt signed by the physician acknowledging receipt of said payment or transfer of value and (2) each payment or transfer of value on the Open Payments website indicates whether the physician verified the payment or transfer of value (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that a contested reported compensation payment or transfer of value should be removed immediately from the Open PaymentsData.CMS.gov website until the reporting company validates the compensation with verifiable documentation a signed receipt (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that companies reporting physician payments under the Physician Payments Sunshine Act without proper documentation shall be fined $1,000 per occurrence. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 241 be adopted as amended.

Resolution 241 asks that our American Medical Association adopt as policy that any compensation reported as part of the Physician Payments Sunshine Act should be accompanied by a verifiable receipt signed by the physician acknowledging receipt of said compensation (New HOD Policy); and be it further, that our AMA advocate that
contested reported compensation should be removed immediately from the OpenPaymentsData.CMS.gov website until the reporting company validates the compensation with a signed receipt (New HOD Policy); and be it further, that our AMA advocate that companies reporting physician payments under the Physician Payments Sunshine Act without proper documentation shall be fined $1,000 per occurrences. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 241. Your Reference Committee heard testimony that certain drug and device manufacturers are inappropriately reporting payments to the Open Payments website for food, beverages, and other gifts that were never received, not wanted, or inappropriately reported. Your Reference Committee also heard testimony that requiring physician verification of receipt of over $8 billion in annual payments and over 10 million records may be impractical and cause unnecessary administrative burden on physicians. Your Reference Committee also heard that the Centers for Medicare and Medicaid Services has the authority (1) to collect additional information and context from drug and device manufacturers including physician verification and (2) to fine drug and device manufacturers for inaccurate reporting. Accordingly, your Reference Committee recommends adoption of Resolution 241 with amendment.

(35) RESOLUTION 242 – PHARMACY BENEFIT MANAGERS AND COMPOUNDED MEDICATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 242 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association amend Policy H-125.986 by addition as follows:

Pharmaceutical Benefits Management Companies H-125.986

Our AMA: (1) encourages physicians to report to the Food and Drug Administration’s (FDA) MedWatch reporting program any instances of adverse consequences (including therapeutic failures and adverse drug reactions) that have resulted from the switching of therapeutic alternates;
(2) encourages the Federal Trade Commission (FTC) and the FDA to continue monitoring the relationships between pharmaceutical manufacturers and PBMs, especially with regard to manufacturers’ influences on PBM drug formularies and drug product switching programs, and to take enforcement actions as appropriate;
(3) pursues congressional action to end the inappropriate and unethical use of confidential patient information by pharmacy benefits management companies;
(4) states that certain actions/activities by pharmacy benefit managers and others constitute the practice of medicine without a license and interfere with appropriate medical care to our patients; (5) encourages physicians to routinely review their patient's treatment regimens for appropriateness to ensure that they are based on sound science and represent safe and cost-effective medical care; and (6) supports Congressional action to ensure that reimbursement policies established by PBMs are based on medical need; these policies include, but are not limited to, prior authorization, formularies, and tiers for compounded medications; and (7) encourages the FTC and FDA to monitor PBMs' policies for potential conflicts of interests and anti-trust violations, and to take appropriate enforcement actions should those policies advantage pharmacies in which the PBM holds an economic interest. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 242 be adopted as amended.

Resolution 242 asks that our American Medical Association amend policy H-125.986 by addition as follows: Pharmaceutical Benefits Management Companies H-125.986. Our AMA: 1) encourages physicians to report to the Food and Drug Administration's (FDA) MedWatch reporting program any instances of adverse consequences (including therapeutic failures and adverse drug reactions) that have resulted from the switching of therapeutic alternates; (2) encourages the Federal Trade Commission (FTC) and the FDA to continue monitoring the relationships between pharmaceutical manufacturers and PBMs, especially with regard to manufacturers' influences on PBM drug formularies and drug product switching programs, and to take enforcement actions as appropriate; (3) pursues congressional action to end the inappropriate and unethical use of confidential patient information by pharmacy benefits management companies; (4) states that certain actions/activities by pharmacy benefit managers and others constitute the practice of medicine without a license and interfere with appropriate medical care to our patients; (5) encourages physicians to routinely review their patient's treatment regimens for appropriateness to ensure that they are based on sound science and represent safe and cost-effective medical care; and (6) supports Congressional action to ensure that reimbursement policies established by PBMs are based on medical need; these policies include, but are not limited to, prior authorization, formularies, and tiers for compounded medications, and encourages the FTC and FDA to monitor PBMs' policies for potential conflicts of interests and anti-trust violations, and to take appropriate enforcement actions should those policies advantage pharmacies in which the PBM holds an economic interest. (Modify Current HOD Policy)

Your Reference Committee heard testimony concerning the role that pharmacy benefit management companies (PBMs) have played and continue to play. It became
increasingly clear from the testimony that there is a considerable amount of frustration and confusion about the role of PBMs. Your Reference Committee heard testimony that these entities that have such power over the prescriptions that our patients receive need, to have much greater transparency about their tactics and impact. Your Reference Committee also recognizes that our AMA already undertakes considerable advocacy to take PBMs out of the shadows, including the TruthinRx campaign as well as via multiple pieces of model state legislation and advocacy at the National Association of Insurance Commissioners. Your Reference Committee also heard testimony that supporting Congressional action as a specific directive may not be the most appropriate action and that our AMA should preserve flexibility for advocacy efforts. Accordingly, your Reference Committee recommends adopting Resolution 242 with amendment.

(36) RESOLUTION 243 – REPORT HEALTH CARE PROVIDER SEX CRIMES TO LAW ENFORCEMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends adoption of the following resolution in lieu of Resolution 243:

ADDRESSING BARRIERS TO REPORTING HEALTH CARE PROVIDER SEX CRIMES

RESOLVED, that our American Medical Association support the efforts and work with the Federation of State Medical Boards to examine disciplinary data, barriers that delay or prevent reporting of sex crimes, and the cooperation of state medical boards with law enforcement in order to ensure a comprehensive approach to identifying and addressing sexual crimes within medicine. (New HOD Policy)

Resolution 243 asks that our American Medical Association work with the Federation of State Medical Boards to create and encourage state adoption of “model public health code language” that would require all state medical boards to report criminal sexual conduct or predatory sexual behavior to appropriate law enforcement authorities. (Directive to Take Action)

Your Reference Committee heard overwhelming testimony that recent sexual assault scandals have demonstrated that physicians must do more to protect patients from sexual predators in our ranks. As physicians, we have an ethical obligation to report to appropriate authorities behavior that impacts patient health and safety. As Resolution 243 makes clear, the current system has failed patients and changes must be made.

Resolution 243 is intended to fill gaps in the system that allows sexual abusers to go undetected, and your Reference Committee commends the Michigan delegation for taking on this urgent issue. However, your Reference Committee heard testimony suggesting that, while well-intended, our AMA can do more to ensure timely reporting of health care provider sex crimes to law enforcement. Resolution 243 would require
medical boards to report criminal sexual conduct or predatory sexual behavior to law enforcement. But, in fact, testimony stressed that state medical boards cooperate with law enforcement in investigations when an incident may be a criminal violation in addition to unprofessional conduct under each state’s medical practice act. Testimony also stressed that, as recent incidents of egregious violations have demonstrated, often reports are not made to the state medical board of jurisdiction. As such, testimony suggested that adoption of this resolution in its current form will create merely the illusion of action by this body, but will do little to change the current system that has fallen short.

Your Reference Committee agrees with those urging a more comprehensive approach.

Testimony from the Federation of State Medical Boards (FSMB) informed the Reference Committee that a Workgroup on Sexual Boundary Violations will soon convene to identify, evaluate and recommend best practices for reporting violations to state medical boards and law enforcement; address barriers to reporting incidents of sexual misconduct and identify best practices, including investigation, referral, and public outreach; collect and review available disciplinary data, including incidence and spectrum of severity of behavior and sanction, related to sexual boundary violations; evaluate the impact of state medical board public outreach on reporting; review the FSMB’s 2006 policy, Addressing Sexual Boundaries: Guidelines for State Medical Boards; and assess the prevalence of sexual boundary/harassment training in medical schools and graduate medical education and develop recommendations and/or resources to address gaps. That FSMB working group will identify and make recommendations for policy changes so that abusive behavior and misconduct can be detected earlier and stopped.

Your Reference Committee agrees with those who recommended that our AMA participate in FSMB’s process and that the workgroup findings inform our AMA’s future policy making. Your Reference Committee agrees that this support from our AMA honors the spirit and goals of Resolution 243, while offering a more comprehensive and impactful approach.

Therefore, your Reference Committee recommends that a substitute resolution be adopted in lieu of Resolution 243 to state that our AMA will support the efforts of and work with the Federation of State Medical Boards to examine disciplinary data, barriers that delay or prevent reporting of sex crimes, and the cooperation of state medical boards with law enforcement in order to ensure a comprehensive approach to identifying and addressing sexual crimes within medicine.
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 21;
(c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel);
(de) the imposition of significant licensing fees for firearms dealers;
(ed) 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
(fe) 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)

(4) 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.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-145.985 be adopted as amended in lieu of Resolutions 244 and 248.

Resolution 244 asks 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) Resolution 248 asks 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)

Your Reference Committee heard extensive testimony on Resolutions 244 and 248. Your Reference Committee heard testimony that our AMA has urged Congress to take immediate action on common sense solutions to reduce the epidemic of gun violence in America. Our AMA believes that gun violence in America is a public health crisis that needs comprehensive, multi-faceted public health solutions. As physicians, our AMA sees first-hand the devastating consequences of gun violence to victims and their
families and friends. Accordingly, your Reference Committee recommends amending
Policy H-145.985 to incorporate Resolutions 244 and 248 with amendments.

While your Reference Committee heard testimony in opposition to Resolution 244, your
Reference Committee heard testimony in favor of increasing the legal age of purchasing
ammunition and firearms from 18 to 21. Testimony was heard that while current federal
law limits the purchase of handguns to age 21 and purchase of long guns to age 18 from
a licensed firearms dealer, unlicensed persons may sell a long gun to a person of any
age and handguns to individuals 18 and older; and 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. Your Reference Committee also heard
testimony expressing concerns about the ability of certain categories of individuals being
able to purchase or possessing firearms, such as, 18 to 20 year olds who are law
enforcement and military personnel. This testimony also recommended amending
Resolution 244 to add these categories. Accordingly, your Reference Committee
recommends that Resolution 244 be amended to include these categories.

Your Reference Committee heard strong testimony in favor of adoption of Resolution
248. Testimony was presented that 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. Your Reference Committee also
heard testimony that 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
have opposed “concealed carry reciprocity” because of the danger it poses to law
enforcement agents, to victims of domestic violence, and to the public. Your Reference
Committee believes Resolution 248 would appropriately fill a gap in existing AMA policy,
and accordingly, recommends adoption of the language of Resolution 248 by
incorporating the language into Policy H-145.985.

(38) RESOLUTION 245 – OPPOSING NCOIL ATTEMPTS TO
STOP PHYSICIAN DISPENSING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends
that Policy H-120.990 be amended by addition to read as
follows.

Physician Dispensing H-120.990
Our AMA supports the physician’s right to dispense drugs
and devices when it is in the best interest of the patient
and consistent with AMA’s ethical guidelines.

Our AMA oppose legislative and other efforts that are in
conflict with AMA policies concerning patient access to
physician-dispersed drugs and devices.
RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-120.990 be adopted as amended in lieu of Resolution 245.

Resolution 245 asks that our American Medical Association oppose the National Conference of Insurance Legislators “Workers’ Compensation Pharmaceutical Reimbursement Rates Model Act.” (New HOD Policy)

Your Reference Committee heard limited testimony on this resolution. Your Reference Committee notes that current policy provides guidance to our AMA to support a physician’s right to dispense drugs and devices when it is in the best interest of the patient and consistent with AMA’s ethical guidelines (see Code of Medical Ethics 9.6.6 Prescribing & Dispensing Drugs & Devices). Your Reference Committee also agrees with the resolution’s author that our AMA should actively oppose efforts that would conflict with this right, whether legislative, regulatory or in other venues. Accordingly, your Reference Committee recommends amending existing policy by addition in lieu of Resolution 245.

(39) RESOLUTION 246 – SUPPORT FOR PATIENTS AND PHYSICIANS IN DIRECT PRIMARY CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 246:

SUPPORT FOR PATIENTS AND PHYSICIANS IN DIRECT PRIMARY CARE

RESOLVED, That our AMA reaffirm Policy H-385.912, Direct Primary Care (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA support efforts to ensure that patients in Direct Primary Care practices have access to specialty care, including efforts to oppose payer policies that prevent referrals to in-network specialists. (New HOD Policy)

Resolution 246 asks 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, 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)
Your Reference Committee heard supportive testimony on Resolution 246. Your Reference Committee also heard testimony that our AMA has already expressed its support for the Primary Care Enhancement Act (H.R. 365/S. 1358) in a letter dated January 27, 2017 to the House of Representatives sponsors of the legislation. Moreover, your Reference Committee heard testimony describing payer policies that prevent patients in Direct Primary Care practices from accessing specialty care, even when the specialist is in the patient’s provider network. Moreover, your Reference Committee heard that many health insurers will not provide coverage for specialty care when the patient is referred to the specialist by a DPC physician.

Your Reference Committee believes that the DPC model will not remain viable if patients are unable to combine it with health insurance policies that cover specialty care or includes specialists. Your Reference Committee also heard testimony for supporting a substitute resolution in lieu of Resolution 246 that allows for our AMA to engage on various solutions to this issue, whether they be legislative, regulatory, or other, rather than developing a model bill as called for in Resolution 246. Accordingly, your Reference Committee recommends that a substitute resolution be adopted in lieu of Resolutions 234 and 246.

(40) RESOLUTION 247 – OPPOSED REPLACEMENT OF THE MERIT-BASED INCENTIVE PAYMENT SYSTEM WITH THE VOLUNTARY VALUE PROGRAM

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 247 be amended by addition and deletion to read as follows:

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 needs 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 Adequate recognition of and adjustments for socioeconomic and demographic factors that contribute to variation in patient outcomes as well as geographic variation, and
5. Limiting public reporting of physician performance to those measures used for scoring in the MIPS program; and

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)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 247 be adopted as amended.

Resolution 247 asks that our American Medical Association oppose the replacement of the Merit-1 Based Incentive Payment System (MIPS) with the Voluntary Value Program (VVP) as currently defined (New HOD Policy); and be it further, 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, 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, that our AMA determine if population measures are appropriate and fair for measuring physician performance (Directive to Take Action); and be it further, 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)

Your Reference Committee heard mostly supportive testimony on Resolution 247. Your Reference Committee heard testimony that was supportive of the intent of Resolution 247 to oppose the Voluntary Value Program, and to ask our AMA to continue to advocate to improve the Merit-based Incentive Payment System (MIPS) program to ensure electronic health record data transparency, safe harbor protections for entities providing clinical data, and limited use of public reporting of physician performed to measures used for scoring in the MIPS program. However, your Reference Committee also heard testimony that the final Resolve should be removed, as the fourth Resolve
which asks our AMA to determine if population measures are appropriate and fair for measuring physician performance is sufficient at this time. Moreover, your Reference Committee also heard that the fourth point of the fourth Resolve should be broadened. Therefore, your Reference Committee recommends adoption of Resolution 247 as amended.

(41) RESOLUTION 250 – CLARIFICATION OF GUIDELINES FOR ONLINE PRESCRIBERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 250 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support national efforts to amend federal law and federal Drug Enforcement Administration regulations to allow for the e-prescribing of a medication, including a controlled substance, needed by a patient with a mental health or behavioral health diagnosis when a valid patient-physician relationship has been established through telemedicine and in accordance with state law and accepted standards of care.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 250 be adopted as amended.

Resolution 250 asks that our American Medical Association support national efforts to amend federal law and federal Drug Enforcement Administration regulations to allow for the e-prescribing of a medication, including a controlled substance, needed by a patient with a mental health or behavioral health diagnosis when an appropriate patient-physician relationship has been established through telemedicine and in accordance with state law and accepted standards of care. (New HOD Policy)

Your Reference Committee heard limited testimony on Resolution 250. Your Reference Committee heard testimony that as telemedicine and e-prescribing of controlled substances continue to evolve, so must our AMA policy to support continuity of care and new ways of ensuring patients' access to care. Your Reference Committee also heard testimony that this resolution highlights the need to further augment our AMA policy with respect to e-prescribing of medications, including controlled substances—but do it in such a way as to build on our policy with the appropriate balance for recognizing evolving modes of care with ensuring a valid patient-physician relationship exists. Your Reference Committee also heard testimony that a technical edit should be made to Resolution 250 to match existing policy regarding a valid patient-physician relationship. Accordingly, your Reference Committee recommends adoption of Resolution 250 as amended.
RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Fourth Resolve of Resolution 251 be amended by addition and deletion to read as follows:

RESOLVED, that the AMA study the impact of scope of practice expansion on medical student choice of specialty decisions to enter into primary care.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 251 be adopted as amended.

Resolution 251 asks (1) that our American Medical Association (AMA) continue to work with relevant stakeholders to recognize physician training and education and patient safety concerns produce advocacy tools and materials for state level advocates to use in scope of practice discussions with legislatures, including but not limited to infographics, interactive maps, scientific overviews, geographic comparisons, and educational experience (Directive to Take Action); and be it further; (2) that the AMA advocate for the inclusion of non-physician scope of practice characteristics in various analyses of practice location attributes and desirability (New HOD Policy); and be it further; (3) that the AMA advocate for the inclusion of scope of practice expansion into measurements of physician well-being; (New HOD Policy) and be it further; (4) that the AMA study the impact of scope of practice expansion on medical student decisions to enter into primary care (Directive to Take Action).

Your Reference Committee heard supportive testimony on Resolution 251. Your Reference Committee heard testimony that through resources, research, and the Scope of Practice Partnership, our AMA has what physicians need to advance your scope of practice advocacy agenda. Your Reference Committee also heard testimony that state policy makers face increasing pressure to expand the scope of practice of non-physician practitioners as a means to address the physician workforce shortages. Your Reference Committee agrees with testimony that scope of practice expansions likely have an impact on medical students’ decision of whether to pursue a career in primary care, but that scope of practice expansions can also potentially influence a medical student’s decision to pursue certain specialty care. Your Reference Committee believes that a comprehensive report that broadly examines the impact of scope of practice on medical students’ choice of specialty would be informative and a welcome addition to your AMA’s scope of practice arsenal. Accordingly, your Reference Committee recommends adoption of Resolution 251 as amended.
RESOLUTION 254 – OPPOSITION TO REGULATIONS THAT PENALIZE IMMIGRANTS FOR ACCESSING HEALTH CARE SERVICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 254 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA, upon the release of and a proposed rule, or regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition, and be it further

RESOLVED, That our AMA amend AMA Policy H-20.901 by addition and deletion to read as follows: Our AMA: (1) supports enforcement of the public charge provision of the Immigration Reform Act of 1990 (PL 101-649) provided such enforcement does not deter legal immigrants and/or their dependents from seeking needed health care and food nutrition services such as SNAP or WIC; (2) recommends that decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (3) recommends that non-immigrant travel into the United States not be restricted because of HIV status; and (34) recommends that confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 254 be adopted as amended.

Resolution 254 asks AMA, upon the release of a proposed rule or regulations that would deter immigrants and/or their dependents from utilizing non-cash public benefits including Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition; and be it further, that our AMA amend AMA policy H-20.901 by addition and deletion to read as follows: Our AMA (1) supports enforcement of the public charge provision of the Immigration Reform Act of 1990 (PL 101-649) provided such enforcement does not deter legal immigrants and/or their dependents from seeking needed health care and food nutrition services such as SNAP or WIC; (2) recommends that decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (3) recommends that non-immigrant travel into the United States not be restricted because of HIV status; and (34) recommends that confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.
States not be restricted because of HIV status; and (4) recommends that confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.

Your Reference Committee heard supportive testimony on Resolution 254. Your Reference Committee heard that under existing AMA policy, the AMA supports the public charge provision of the Immigration Reform Act of 1990 (PL 101-649), but that when our AMA adopted that policy the federal government was seeking to address those individuals coming into the United States with communicable diseases. Now the administration is seeking to expand the public charge definition to include non-cash public benefits such as Medicaid, the Children’s Health Insurance Program, and food stamps. Your Reference Committee heard that existing AMA policy should be amended to address these potential changes to the definition of public charge that will significantly impact the ability of families seeking a green card to receive medical services from Medicaid, the Children’s Health Insurance Program, and other critical programs. Accordingly, your Reference Committee recommends that Resolution 254 be adopted as amended.

(44) RESOLUTION 255 – 340B DRUG DISCOUNT PROGRAM

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that first, second, and fourth Resolves of Resolution 255 be adopted.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 255 be referred for report back at the 2018 Interim Meeting of the House of Delegates.

Resolution 255 asks (1) that our American Medical Association advocate for 340B Drug Discount Program (340B program) transparency, including an accounting of covered entities’ 340B savings and the percentage of 340B savings used directly to care for underinsured patients and patients living on low-incomes (New HOD Policy); (2) that our AMA support recommendations to equip the Health Resources and Services Administration (HRSA) with more authority, resources and staff to conduct needed 340B program oversight (New HOD Policy); (3) that our AMA support discontinuing the use of the Disproportionate Share Hospital adjustment as a determining measure for 340B program eligibility (New HOD Policy); and be it further (4) that our AMA recognize the 340B program does not support the extent of care provided by ineligible physician practices to the medically indigent or underserved, and work with HRSA to establish 340B eligibility for all practices demonstrating a commitment to serving low-income and underserved patients. (New HOD Policy).

Your Reference Committee heard generally supportive testimony on Resolution 255. Your Reference Committee heard testimony that there should be more transparency in the 340B programs and low income patients should benefit from this rebate. The
Committee also heard testimony that the federal agency responsible for administering the program needs more resources and oversight authority and that physician practices that provide a commensurate amount of care to low income and indigent patients comparable to federal qualified health centers and other safety net programs should also be eligible for the 340B discount. The Reference Committee, however, heard testimony that additional research and analysis is needed to assess how to address those DSH hospitals that should not benefit from 340B rebates and those that should benefit. Therefore, your Reference Committee recommends adopting Resolves 1, 2, and 4, and referral of Resolve 3 of Resolution 255 with report back at Interim 2018.

(45) RESOLUTION 256 – FEDERAL AVIATION ADMINISTRATION BASICMED EXAMS TO BE DONE BY PHYSICIANS WITH PRESCRIPTIVE AUTHORITY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends the following resolution be adopted in lieu of Resolution 256:

DEFINING PHYSICIAN FOR THE FEDERAL AVIATION ADMINISTRATION, THE DEPARTMENT OF TRANSPORTATION, AND CONGRESS

RESOLVED, That our American Medical Association advocate for the Federal Aviation Administration, the Department of Transportation, and Congress to define a “physician” as an individual possessing degree of either a Doctor of Medicine or Doctor of Osteopathic Medicine. (New HOD Policy)

Resolution 256 asks that our American Medical Association advocate for the Federal Aviation Administration to restrict BasicMed examinations for pilots to physicians with prescriptive authority (Directive to Take Action); and be it further that AMA Policy H-160.949, “Practicing Medicine by Non-Physicians,” be amended by addition to read as follows: Practicing Medicine by Non-Physicians H-160.949 Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given; (2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers; (3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision; (4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision; (5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician
Your Reference Committee heard overwhelmingly supportive testimony on Resolution 256. Your Reference Committee heard testimony that the Federal Aviation Administration and the Department of Transportation are interpreting the term “physician” to include individuals who are not doctors of medicine or osteopathy. Your Reference Committee also heard that this interpretation goes against well-established AMA policy. Your Reference Committee further heard testimony that Resolution 256 should be amended to complement existing AMA policy and to not introduce the term “physician non-prescribers,” which may cause confusion in interpreting current policy. Testimony also supported expanding the scope of Resolution 256 to include Congress. Accordingly, your Reference Committee recommends that a substitute resolution be adopted in lieu of Resolution 256.

(46) RESOLUTION 217 – REFORMING THE ORPHAN DRUG ACT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolutions 217, 227, and 238 be referred.

Resolution 217 asks that our American Medical Association support efforts to reform the Orphan Drug Act by closing loopholes identified by the Food and Drug Administration in order to protect the Act’s original intent of promoting therapies targeting rare diseases (New HOD Policy); and be it further, that our AMA support increased transparency in development costs, post-20 approval regulation and overall earnings for pharmaceuticals designated as “Orphan Drugs” (New HOD Policy); and be it further, that our AMA support modifications to the exclusivity period of “Orphan Drugs” to increase access to these pharmaceutical drugs for patients with rare diseases. (New HOD Policy) Resolution 227 asks that our American Medical Association develop a set of principles for a National Prescription Drug Formulary (NPD Formulary) that are designed to lower prescription drug prices to the patient, and be transparent, independent, non-profit, and fee-based, with a report back to the AMA HOD at the 2018 Interim Meeting (Directive to Take Action); and be it further, that our AMA produce model legislation for an NPD Formulary with input from appropriate stakeholders based on a set of principles for such a Formulary that the AMA will develop, and that our AMA join with appropriate stakeholders to advocate that Congress authorize the establishment of this NPD Formulary that will be available to all Americans as an option to their healthcare...
insurance program in an actuarially appropriate manner. (Directive to Take Action)
Resolution 238 asks that our American Medical Association support federal legislation
that modifies the Hatch-Waxman Act and the Biologics Price Competition and Innovation
Act (Biosimilars Act) to institute the replacement of time-specific patent protections with
negotiated payment schedules and indefinite exclusivity for U.S. Food and Drug
Administration-approved drugs in the Medicare Part D Program. (New HOD Policy)

Your Reference Committee heard varying testimony on Resolutions 217, 228, and 238.
Your Reference Committee strongly supports advocacy and initiatives that will reduce
the cost of prescription drugs and expand access. Your Reference Committee heard
testimony that the AMA is currently advocating for measures to increase market
competition as well as greater transparency of cost price along the pharmaceutical
supply chain.

Your Reference Committee heard testimony on Resolution 217 that incentives are
needed to support innovation in drug development for rare diseases and generally
supports the intention of the Orphan Drug Act. Your Reference Committee also heard
testimony that congressional concerns with and public reports on drug developers’
potential manipulation of the ODA incentives are not consistent with the original intent of
ODA and may be driving higher drug costs and increased sales. Your Reference
Committee also heard testimony that this area of law is highly complex and complicated
and that our AMA should work with the FDA to further study this report.

Your Reference Committee heard testimony on Resolution 227 that a national formulary
would not promote innovation and competition and could substantially limit patient
access to medically necessary options. Your Reference Committee heard testimony on
Resolution 238 that modifying various provisions of the Food, Drug, and Cosmetic Act as
well as other federal laws such as the Social Security Act and the U.S. Patent Act in
order to institute the replacement of time-specific patent protections with negotiated
payment schedules and indefinite exclusivity for FDA-approved drugs in the Medicare
Part D Program could limit patient access to clinically necessary alternative options and
depress innovation while interjecting significant confusion and complexity in the patent
system and the FDA regulatory regime.

All three resolutions are either a potentially complex solution to, or contain novel
suggestions to address, the high cost of prescription drugs. Given these concerns, your
Reference Committee recommends that Resolutions 217, 227, and 238 be referred.

(47) RESOLUTION 226 – MODEL STATE LEGISLATION FOR
ROUTINE PREVENTATIVE PROSTATE CANCER
SCREENING FOR MEN AGES 55-69

RECOMMENDATION:

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

Resolution 226 asks that our American Medical Association develop model state
legislation for screening of asymptomatic men ages 55-69 for prostate cancer after
informed discussion between patients and their physician without annual deductible or co-pay. (Directive to Take Action)

Your Reference Committee heard mixed testimony about Resolution 226. Your Reference Committee heard testimony about the importance of shared decision-making between patients and their physicians about the benefits and risks associated with screening for prostate cancer in asymptomatic men. Your Reference Committee also heard testimony identifying other preventive services that are covered without annual deductible or co-pay. Your Reference Committee notes that the US Preventive Services Task Force recently gave PSA-based screening a C grade, recommending selectively offering or providing screening to asymptomatic men aged 55–69 based on professional judgment and patient preferences. Testimony was supportive of coverage for patients who, in consultation with their physicians, understand the risks and decide to undergo screening. Testimony also stated that the Council on Medical Services (CMS) and Council on Science and Public Health (CSAPH) are working on a joint report for the Interim Meeting in 2018 that addresses value-based insurance design for preventative interventions. Your Reference Committee believes that further study into first dollar coverage is necessary before model legislation should be considered and that our AMA should not adopt policy prior to the CMS and CSAPH joint report is issued. Accordingly, your Reference Committee recommends that Resolution 226 be referred.

(48) RESOLUTION 235 – HOSPITAL CONSOLIDATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 235 be referred.

Resolution 235 asks that our American Medical Association actively oppose future hospital mergers and acquisitions in highly concentrated hospital markets (New HOD Policy); and be it further, that our AMA study the benefits and risks of hospital rate setting commissions in states where highly concentrated hospital markets currently exist. (Directive to Take Action)

Your Reference Committee heard testimony expressing concern about the negative impact that hospital mergers in already highly concentrated hospital markets are having on competition, the practice of medicine and patient care. Your Reference Committee heard testimony calling for our AMA to challenge any further hospital mergers in such markets. However, testimony also pointed out that many hospital mergers in highly concentrated markets are announced every year, sometimes involve multiple hospitals, and that each such merger raises complex economic and antitrust issues that require careful and complete analysis. Your Reference Committee acknowledges that our AMA does not have the resources to perform the extensive economic and antitrust analyses necessary to oppose each and every one of these mergers. Finally, while some testified in favor or studying the benefits and risks of hospital rate setting, some expressed concern that adoption of the second resolve might place our AMA in an awkward advocacy position if adoption were perceived as our AMA’s favoring rate regulation for hospitals but having an special exemptions for physicians. Accordingly, due to the complexity of the issues raised in testimony related to both resolves, your Reference Committee recommends that Resolution 235 be referred.
(49) RESOLUTION 252 – REPEAL OF GROUP PURCHASING ORGANIZATIONS AND PHARMACY BENEFIT MANAGERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 252 be referred.

Resolution 252 asks that our AMA educate its members on how safe harbor exemption for GPOs and PBMs affects drug prices and drug shortages (Directive to Take Action); and be it further that our AMA reaffirm Policy H-100.956, which states in part that “Our AMA will collaborate with medical specialty partners in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.” (Reaffirm HOD Policy).

Your Reference Committee heard mixed testimony on Resolution 252. Your Reference Committee heard testimony that in 2016, a similar resolution was brought and referred for decision. The Board of Trustees decided to not adopt the resolution. Testimony furthered indicated that there is little empirical evidence to definitively assess the impact of the vendor-fee-based funding structure protected under the anti-kickback safe harbor. Your Reference Committee heard testimony that repealing the GPO safe harbor will impact the entire health care system and could negatively impact access to needed supplies to our patients. Furthermore, your Reference Committee heard testimony that Resolution 252 may also contradict AMA policy to pursue a collaborative and evidence-based approach, and it may not effectively address the underlying issue, while simultaneously producing unintended consequences. Accordingly, given these concerns, your Reference Committee recommends that Resolution 252 be referred.

(50) RESOLUTION 219 – IMPROVING MEDICARE PATIENTS’ ACCESS TO KIDNEY TRANSPLANTATION

RECOMMENDATION:

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

Resolution 219 asks that our American Medical Association work with professional and patient-centered organizations to advance patient and physician-directed coordinated care for End Stage Renal Disease (ESRD) patients (Directive to Take Action); and be it further, that our AMA actively oppose the “Dialysis PATIENTS Demonstration Act of 192017” (S. 2065) (HR 4143) (Directive to Take Action); and be it further, that the House of Delegates receive a report back at the 2018 Interim Meeting regarding our AMA actions in opposing the PATIENTS Act (Directive to Take Action).

Your Reference Committee heard mixed testimony on Resolution 219. Your Reference Committee heard testimony from members whose specialty societies have publicly supported and opposed the specific piece of legislation that is the subject of Resolution 219. According to the testimony, there appears to be potential benefits and drawbacks to
this legislation that need further deliberation. Accordingly, your Reference Committee
recommends that Resolution 219 be referred for decision.

(51) RESOLUTION 212 – VALUE-BASED PAYMENT SYSTEM

RECOMMENDATION:

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

Resolution 212 asks that our American Medical Association work to repeal the law that
conditions a portion of a physician’s Medicare payment on compliance with the Medicare
Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APM)
programs (Directive to Take Action); and be it further, that our AMA continue advocating
for a reduction in the administrative burdens of compliance with value-based programs
and that these programs comply with evidence-based standards. (Directive to Take
Action)

Your Reference Committee heard mostly negative testimony on Resolution 212. Your
Reference Committee heard testimony that it is too soon to repeal the Quality Payment
Programs, as the program just began in 2017. Your Reference Committee agrees that
our AMA should continue to work with the Centers for Medicare and Medicaid Services
(CMS) to improve the Merit-based Incentive Payment System (MIPS) program and
create additional Alternative Payment Models (APM) opportunities for physicians. Your
Reference Committee also heard testimony that our AMA was successful, through the
Bipartisan Budget Act of 2018, in including five key MACRA improvements that will allow
CMS and physicians three additional years to gradually transition into the MIPS
program. Moreover, your Reference Committee heard testimony that our AMA is
already engaging in continuous advocacy efforts to improve the program for physicians.
Accordingly, your Reference Committee recommends that Resolution 212 not be
adopted.

(52) RESOLUTION 249 – SUPPORT ANY WILLING
PROVIDER LEGISLATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends
that Resolution 249 not be adopted.

Resolution 249 asks 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)
Your Reference Committee heard testimony against adoption of Resolution 249. Testimony described concerns with physicians being removed from networks and narrow networks. However, current AMA policy acknowledges that health plans or networks may develop and use criteria to determine the number, geographic distribution, and specialties of physicians needed. Therefore, your Reference Committee heard testimony that the model legislation in Resolution 249 would direct our AMA to develop would likely be in conflict with existing policy. However, in response to many of the concerns your Reference Committee heard regarding networks, our AMA has already developed model legislation requiring transparent and fair processes when physicians are removed from a network or not credentialed by a payer. Our AMA also has model legislation addressing network adequacy and ensuring that patients have access to in-network care. Finally, your Reference Committee heard testimony that our AMA has model legislation that prevents all products clauses from being included in physician contracts that covers the second resolve of this resolution. Accordingly, for the above reasons, your Reference Committee recommends that Resolution 249 not be adopted.

(53) BOARD OF TRUSTEES REPORT 21 – OWNERSHIP OF PATIENT DATA

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 21 be filed.

Your Reference Committee heard limited testimony to Board of Trustees Report 21. Your Reference Committee heard testimony that the report provides an overview of the current laws and regulations at the state and federal levels that address ownership, access and use of patient data including under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations. It also looks at controls and processes in place to address physician and healthcare industry access and use of patient information. Your Reference Committee heard testimony to add a recommendation to Board Report 21 to have our AMA develop model state legislation concerning the ownership of patient data. Your Reference Committee believes that our AMA has taken a leadership role in ensuring appropriate use and access of these data by (1) working with ONC and HHS to encourage operational implementation of provisions in the 21st Century Cures Act to prohibit EHR vendors from blocking access to data and limiting a physician’s ability to effectively utilize their EHR system; (2) providing physicians and practices with resources on negotiating employment and independent contractor agreements to assist in clarifying ownership of and access to patient information upon termination of employment or contracting; (3) supplying physicians and practices with educational tools about favorable EHR vendor contract terms covering ownership of, access to, and use of patient information; (4) educating physicians and practices on how to file a HIPAA complaint with the OCR; and (5) providing the Federation of Medicine with model legislation that ensures appropriate handling and access to patient data. Accordingly, your Reference Committee does not believe that a model state legislation is appropriate and recommends that Board of Trustees Report 21 be filed.
Madam Speaker, this concludes the report of Reference Committee B. I would like to thank Edward P. Balaban, DO, Erin Harnish, MD, Mark Kogan, MD, William Monnig, MD, Gary Pushkin, MD, Luis Seija, and all those who testified before the Committee.

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