Reference Committee B

BOT Report(s)
09  Council on Legislation Sunset Review of 2008 House Policies
12  Advocacy for Seamless Interface Between Physician Electronic Health Records, Pharmacies and Prescription Drug Monitoring Programs
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
15  Advanced Practice Registered Nurse Compact
16  Protection of Clinician-Patient Privilege
17  Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care
18  Medical Liability Coverage Through the Federal Tort Claims Act
19  Health Information Technology Principles
41  Augmented Intelligence in Health Care

Resolution(s)
201  Removing Barriers to Obesity Treatment
202  Universal and Standardized Protocols for EHR Data Transition
203  Updating Federal Food Policy to Improve Nutrition and Health
204  Opposition to Mandated Proficiency in EHR for Licensure
205  Augmented Intelligence
206  Appropriate Use of Telehealth Services
207  Quality Improvement Requirements
208  Prior Authorization Requirements for Post-Operative Opioids
209  Substance Use Disorders During Pregnancy
210  Banning the Sale of Bump Stocks
211  Clarification from U.S. Department of Justice Regarding Federal Enforcement of Medical Marijuana Laws
212  Value-Based Payment System
213  Utilization Review
214  Strengthening the Background Check System for Firearm Sales
215  Regulation of Hospital Advertising
216  FDA Conflict of Interest
217  Reforming the Orphan Drug Act
218  Considering Feminine Hygiene Products as Medical Necessities
219  Improving Medicare Patients' Access to Kidney Transplantation
220  Ban on Semi-Automatic Assault Weapons and High Capacity Ammunition Magazines
221  Maintaining Validity and Comprehensiveness of U.S. Census Data
222#  Evidence Based Treatment in Substance Abuse Treatment Facilities (REVISED)
223  Treating Opioid Use Disorder in Hospitals
224  Legalization of Interpharmacy Transfer of Electronic Controlled Substance Prescriptions
225  Pharmacy Benefit Managers Impact on Patients
226  Model State Legislation for Routine Preventative Prostate Cancer Screening for Men Ages 55-69
227  An Optional National Prescription Drug Formulary
228  Medicare Quality Incentives
229  Green Card Backlog for Immigrant Doctors on H-1B Visa
230  Opposition to Funding Cuts for Programs that Impact the Health of Populations

# Contained in the Handbook Addendum
Reference Committee B

Resolution(s)

231 Online Controlled Drugs
232 Recording Law Reform
233 Support for Reauthorization of the Supplemental Nutrition Assistance Program
234 Support for Primary Care Enhancement Act
235 Hospital Consolidation
236 Reducing MIPS Reporting Burden
237 Safe and Efficient E-Prescribing
238 Reform of Pharmaceutical Pricing: Negotiated Payment Schedules
239 Treating Opioid Use Disorder in Hospitals
240 Treating Opioid Use Disorder in Treatment Facilities
241 Accuracy and Accountability of Physician Compensation Reporting by Drug and Device Companies
242 Pharmacy Benefit Managers and Compounded Medications
243 Report Health Care Provider Sex Crimes to Law Enforcement
244# Increasing the Legal Age of Purchasing Ammunition and Firearms from 18 to 21
245# Opposing NCOIL Attempts to Stop Physician Dispensing
246# Support for Patients and Physicians in Direct Primary Care
247# Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program
248# Opposition to Firearm Concealed Carry Reciprocity
249# Support Any Willing Provider Legislation

# Contained in the Handbook Addendum
Subject: Council on Legislation Sunset Review of 2008 House Policies

Presented by: Gerald E. Harmon, MD, Chair

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

At its 1984 Interim Meeting, the House of Delegates established a sunset mechanism for House policies (Policy G-600.110, “Sunset Mechanism for AMA Policy”). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to retain it.

The objective of the sunset mechanism is to help ensure that the American Medical Association (AMA) Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations.

At its 2002 Annual Meeting, the House modified Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following steps:

• In the spring of each year, the House policies that are subject to review under the policy sunset mechanism are identified.
• Using the areas of expertise of the AMA councils as a guide, the staffs of the AMA councils determine which policies should be reviewed by which councils.
• For the Annual Meeting of the House, each council develops a separate policy sunset report that recommends how each policy assigned to it should be handled. For each policy it reviews, a council may recommend one of the following actions: (a) retain the policy; (b) rescind the policy; or (c) retain part of the policy. A justification must be provided for the recommended action on each policy.
• The Speakers assign the policy sunset reports for consideration by the appropriate reference committees.

Although the policy sunset review mechanism may not be used to change the meaning of AMA policies, minor editorial changes can be accomplished through the sunset review process.

In this report, the Board of Trustees presents recommendations from the Council on Legislation on the disposition of the House policies that were assigned to it. The Council’s recommendations on policies are presented in the Appendix to this report.

RECOMMENDATION

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.
## APPENDIX 1
### RECOMMENDED ACTIONS ON 2008 HOUSE POLICIES

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Text</th>
<th>Recommendation</th>
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<tbody>
<tr>
<td>H-180.972</td>
<td>Increased Third Party Payer Accountability</td>
<td>The AMA will include in its legislative and/or public relations programs the goal of putting an end to inflammatory language contained in third party payer notifications to patients. Citation: (Res. 235, A-92; Reaffirmed: Sub. Res. 106, I-98; Reaffirmation I-98; Reaffirmed: CLRPD Rep. 1, A-08)</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>H-245.971</td>
<td>Home Deliveries</td>
<td>Our AMA: (1) supports the recent American College of Obstetricians and Gynecologists (ACOG) statement that “the safest setting for labor, delivery, and the immediate post-partum period is in the hospital, or a birthing center within a hospital complex, that meets standards jointly outlined by the American Academy of Pediatrics (AAP) and ACOG, or in a freestanding birthing center that meets the standards of the Accreditation Association for Ambulatory Health Care, The Joint Commission, or the American Association of Birth Centers”; and (2) supports state legislation that helps ensure safe deliveries and healthy babies by acknowledging that the safest setting for labor, delivery and the immediate post-partum period is in the hospital, or a birthing center within a hospital complex, that meets standards jointly outlined by the AAP and ACOG, or in a freestanding birthing center that meets the standards of the Accreditation Association for Ambulatory Health Care, The Joint Commission, or the American Association of Birth Centers. Citation: (Res. 205, A-08)</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>H-270.957</td>
<td>FTC Identification Theft Prevention Programs</td>
<td>Our AMA is commended for its efforts to eliminate physicians under the definition of ‘creditors’ as currently interpreted by the Federal Trade Commission (FTC) in its rules implementing the Fair and Accurate Credit Transaction Act of 2003, and will continue its vigorous advocacy opposing the FTC’s efforts to include physicians as creditors under the FACTA 2003. Citation: Res. 222, I-08</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>H-270.965</td>
<td>Physician-Assisted Suicide</td>
<td>Our AMA strongly opposes any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician’s role as healer. Citation: (Sub. Res, 5, I-98; Reaffirmed: CEJA Rep. 11, A-08)</td>
<td>Retain — policy remains relevant.</td>
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<tr>
<td>H-315.977</td>
<td>Abuse of the Medical Record for Regulation or Financing the Practice of Medicine</td>
<td>(1) Our AMA continues to oppose the use of the physician office medical record as a tool of CMS, as well as any other agency or third party, to regulate the financing and practice of medicine. (2) The medical record shall be the property of the physician and the information contained therein, the property of the patient. (3) The physician’s office medical record should be used solely to document the delivery of health care. Citation: (Res. 820, A-99; Reaffirmation I-08)</td>
<td>Rescind — this policy is no longer relevant.</td>
</tr>
<tr>
<td>H-330.893</td>
<td>Medicare Election Period</td>
<td>AMA policy is that physicians should be given the option of a Medicare semi-annual participation election period occurring at the end and the middle of the calendar year. Our AMA will petition the Centers for Medicare &amp; Medicaid Services to permit a semi-annual participation election period occurring at the end and the middle of the calendar year. Citation: (Res. 216, I-08)</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>H-335.963</td>
<td>Member Education on Medicare Recovery Audit Contractors</td>
<td>Our AMA: (1) will educate our membership about the effect of the program’s safeguard contractor activity and Recovery Audit Contractor (RAC) audits on individual physician practices, expansion of the RAC program, and assistance that may be available through our AMA; and (2) will actively support the legislation currently before Congress to require an immediate moratorium on the expansion of the RAC program, and will seek the introduction of subsequent legislation that would limit or exclude physician billings from the authority of RAC audits altogether. Citation: (Sub. Res. 226, A-08)</td>
<td>Retain — policy remains relevant.</td>
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| H-350.961 | Improving the Health of Minority Populations | Our AMA urges Congress to re-evaluate and expand the federal race and ethnicity categories to include additional ethnic subgroups in order to analyze and uncover racial and ethnic health and healthcare disparities. Citation: (Res. 906, I-08) | Rescind — this policy is no longer relevant. The U.S. Department of Health and Human Services does include multiple ethnic subgroups with respect
| H-360.998 | Cardiac Resuscitation by Nurses | With the intent of promoting good patient care, the AMA recognizes the propriety of registered nurses using monitoring, defibrillation, and resuscitative equipment, and instituting immediate life-saving corrective measures, if a licensed physician is not immediately available to do so, providing that: (1) The techniques to be used by a registered nurse in a hospital setting shall have been specified for the hospital by the medical staff on the basis of counsel by a committee representing authoritative medical and nursing opinion; (2) The registered nurse has been competently instructed in the techniques to be used; and (3) The registered nurse performs the authorized procedures: (a) upon the direct order of a doctor of medicine, or (b) pursuant to standing procedures established by the medical staff, these procedures to include provision for immediate summoning of a physician and such other personnel as may be needed. Citation: (Res. 42, I-67; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08) | Retain — policy remains relevant. |
| H-375.983 | Appropriate Peer Review Procedures | (1) Our AMA urges state medical associations to investigate applicable state law to determine if additional state agency supervision of peer review is needed to meet the active state supervision requirement set forth by the Supreme Court. (2) Peer review procedures and actions should, at a minimum, meet the Health Care Quality Improvement Act of 1986 standards for federal immunity: (a) In any situation where it appears that a disciplinary proceeding may be instigated against a physician that could result in the substantial loss or termination of the physician’s medical staff membership and/or clinical privileges, the advice and guidance of legal counsel should be sought. The accused physician should have legal counsel separate from the health care organization or medical staff. The health care organization and the medical staff should each have separate legal counsel. The attorney of the body bringing the peer review action, be it the health care organization or the medical staff, should | Retain — policy remains relevant. |
undertake the procedures needed to prepare for the hearing including the written notice of charges, the marshaling of evidence and the facts, and the selection of witnesses. This health care organization or medical staff attorney should be instructed that his or her role includes assuring that the proceedings are conducted fairly, bearing in mind the objectives of protecting consumers of health care and the physician involved against false or exaggerated charges. The attorney for the body which is not bringing the peer review action should work to ensure that proper peer review processes as outlined in the medical staff bylaws are followed. The role of the attorney for the accused physician is solely to defend his or her client.

(b) The medical executive committee, through its attorney, may consult with the health care organization, through its attorney, regarding appointment of a hearing officer. If an attorney is sought to be the hearing officer, those solo attorneys or attorneys from a firm regularly used by the hospital, medical staff, or the involved medical staff member or applicant for membership for legal advice regarding their affairs and activities, should not be eligible to serve as hearing officers. The hearing officer shall gain no direct financial benefit from the outcome.

(c) The attorney advising the medical staff or, in the limited situation where the hospital is prosecuting the correction action, the attorney advising the health care organization, and the attorney representing the physician involved should be accorded reasonable latitude in cross-examination, but acrimony should not be allowed by the hearing officer.

(d) Substantial latitude should be permitted in the presentation of evidence, medical reference works and testimony, within reasonable time constraints and at the discretion of the hearing officer.

(e) A court reporter should be present to make a record of the hearing proceedings, and the pre-hearing proceedings if deemed appropriate by the hearing officer. The cost of attendance of the court report shall be borne by the hospital, but the cost of the transcript, if any, shall be borne by the party requesting it.

(f) Within the discretion of the hearing officer, witnesses may be requested to testify under oath.

(g) The role of the hearing panel should be defined in the medical staff bylaws. The role of
the hearing panel may include, without being limited to, such duties as: acting as an objective arbiter of evidence, examining witnesses, determining adherence to the standard of care, providing well-reasoned documented opinions and decisions, and other duties noted herein. The hearing panel should only consist of physicians, none of whom are direct economic competitors with the physician involved or who stand to gain through a recommendation or decision adverse to the physician. It is desirable that members of the hearing panel be physicians who have the respect of the medical community, and should include a fair representation of the same specialists/subspecialist physicians as the physician involved, whenever feasible.

(h) Physicians serving on the hearing panel should receive information and training in the elements and essentials of peer review. Clinical guidelines, standards and practices used for evaluation of quality of care should be transparent and available to the extent feasible. Wherever feasible, data collection and analysis, or similar assessment instruments, and multiple reviewers should be used to increase reliability in evaluating whether peer review disciplinary proceedings are warranted. Where feasible, statistical analysis to compare with peers’ performance must be used with appropriate case mix adjustments.

(i) Physicians who are direct economic competitors of the physician involved may testify as witnesses, whether they are called by the physician or the hearing panel or the health care organization, but a physician should not be deprived of his or her privileges solely on the basis of medical testimony by economic competitors. In any proceedings that result in the termination of privileges, there should be testimony from one or more physicians who are not economic competitors or who do not stand to gain economically by an adverse action, but who are knowledgeable in the treatment, patient care management and areas of medical practice or judgment upon which the adverse action is based.

(j) The hearing panel should credit the evidence brought before it in a manner reflective of the specificity of the evidence and the personal or economic biases of witnesses.

(k) When investigation is underway and indicates that a disciplinary proceeding is warranted for the purpose of reducing, restricting, or terminating a
<table>
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<tr>
<th>H-383.999</th>
<th><strong>Formation of a National Negotiating Organization Physician Negotiation</strong></th>
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<td>(1) All activities of our American Medical Association regarding negotiation by physicians maintain the highest level of professionalism, consistent with the Principles of Medical Ethics and the Current Opinions of Council on Ethical and Judicial Affairs; (2) Our AMA immediately implement a national labor organization under the National Labor Relations Act to support the development and operation of local negotiating units as an option for employed physicians; (3) Our AMA immediately implement a national labor organization to support the development and operation of local negotiating units as an option for resident and fellow physicians who are authorized under state laws to collectively bargain; (4) Our AMA continue to support the development of independent house staff organizations for employed, resident and fellow physicians and be prepared to implement a national labor organization to support the development and operation of local negotiating units as an option for all employed, resident and fellow physicians at such time as the National Labor Relations Board determines that resident and fellow physicians are authorized to organize labor organizations under the National Labor Relations Act; (5) Our AMA continue to vigorously support antitrust relief for physicians and medical groups by actively supporting federal legislation consistent with the current principles of the Quality Health Care Coalition Act of 1999 (H. R. 1304 introduced by Representative Tom Campbell, R-CA and John Conyers, D-MI), aggressively working with the Department of Justice and the Federal Trade Commission, and continue providing model legislation and information on the state-action doctrine to state medical associations and members; (6) Our AMA be prepared to immediately</td>
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</table>
implement a national organization to support development and operation of local negotiating units as an option for self-employed physicians and medical groups when the current principles of the Quality Health Care Coalition Act of 1999 (H.R. 1304) become law; and

(7) Our AMA continues to advance its private sector advocacy programs and explore, develop, advocate, and implement other innovative strategies, including but not limited to initiating litigation, to stop egregious health plan practices and to help physicians level the playing field with health care payers;

(8) That should the BOT determine that the Quality Health Care Coalition Act of 1999 (H.R. 1304) or similar legislation will not become law, our AMA immediately pursue the creation or adoption of new antitrust legislation to achieve the same goal; and

(9) Our AMA, concurrent to proceeding with the establishment of any collective bargaining unit, undertake an extensive education program, directed at its member and non-member physicians, as to the possible limits on benefits and the risks to the formation of such a unit.

Citation: (Sub. Res. 901, A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmation A-02; Reaffirmation I-06; Reaffirmation A-08)

**H-390.852 Legislative Action to End Medicare SGR Problems**
1. Our AMA, working with our state and specialty society colleagues, will pursue enactment of legislation that provides for at least two years of positive updates that accurately reflect the increases in costs of caring for Medicare beneficiaries and lays the groundwork for complete repeal in the near future.
2. The AMA’s ultimate goal continues to be complete repeal of the SGR and its replacement with a fair and equitable payment system that adequately reflects increases in the cost of caring for Medicare beneficiaries.

Citation: (BOT Rep. 31, A-07; Reaffirmation I-08)

**Rescind — The Medicare Access and CHIP Reauthorization Act of 2015 replaced the SGR with new payment updates for physicians.**

**H-40.999 Medical Representation of Joint Chiefs of Staff**
Under supervision of qualified medical officers of the three military services, medical representation is essential to effect coordination of the medical and health aspects of tactical, strategic and long range planning in the Joint Staff, the Combined Staff and the Special Command Staffs.

**Retain — policy remains relevant.**
<table>
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<tr>
<th>H-410.956</th>
<th>Fairness and Quality in Medical Imaging Interpretation</th>
<th>Our AMA: (1) actively opposes efforts by federal and state legislators, regulatory bodies, private payers, public payers and radiology business management companies to preauthorize, precertify or otherwise restrict the application of advanced imaging services when such services are provided by qualified physicians in accordance with appropriateness guidelines, practice guidelines and technical standards for the imaging modalities utilized, as developed by specialty societies involved with the diagnosis and treatment of such patients; and (2) will actively work to ensure that all physician specialties involved in the care of patients with specific illnesses who need imaging services have equal participation and authority in the development of quality and efficiency measures for imaging services; and (3) will report back to the House of Delegates on an annual basis with details of actions AMA has taken to oppose efforts by private and public payers, radiology benefits managers and others to deny patients’ access to appropriate, high quality imaging services provided by qualified physicians regardless of their medical specialty. Citation: (Sub. Res. 208, A-08)</th>
<th>Retain — policy remains relevant.</th>
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<tr>
<td>H-410.957</td>
<td>Intraoperative Neurophysiologic Monitoring</td>
<td>Our AMA policy is that supervision and interpretation of intraoperative neurophysiologic monitoring constitutes the practice of medicine, which can be delegated to non-physician personnel who are under the direct or online real time supervision of the operating surgeon or another physician trained in, or who has demonstrated competence in, neurophysiologic techniques and is available to interpret the studies and advise the surgeon during the surgical procedures. Citation: (Res. 201, A-08)</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>H-420.958</td>
<td>Surgical Sterilization and Family PACT Eligibility</td>
<td>Our AMA supports a change in the Family Planning, Access, Care and Treatment (Family PACT) legislation, and the appropriate funding necessary, such that surgical sterilization shall not be a reason for exclusion from the Family PACT program. Citation: (Res. 210, A-08)</td>
<td>Retain — policy remains relevant.</td>
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<td>Bill Number</td>
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<td>Retain Policy Results</td>
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<td>H-435.948</td>
<td>Equality of Civil Liability Preemption for Physicians</td>
<td>Our AMA supports (1) efforts to grant physicians at least the same level of protection as manufacturers, whether by court decision or statute; and (2) state and federal legislation that addresses the civil liability of physicians who use FDA-approved devices and pharmaceuticals in a reasonable and prudent manner, so that physicians have at least the same level of protection offered the manufacturer for adverse events resulting from the use of said products. Citation: (Res. 201, I-08)</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>H-435.950</td>
<td>Apologizing to Patients</td>
<td>AMA policy is that any statements by physicians of apology, confessions of regret, or admission of errors to patients and/or their families regarding less than anticipated clinical outcomes be subsequently inadmissible in court, and will seek to incorporate such policy into medical liability reform legislation. Citation: (Res. 217, A-07; Reaffirmation A-08)</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>H-435.993</td>
<td>Tort Liability Reform</td>
<td>Our AMA: (1) supports the efforts of state medical societies to form coalitions supporting tort reform in each state and representing the numerous interests adversely affected by present escalating tort liability costs; and (2) believes these coalitions should address such issues as reform of laws governing product and professional liability, and development of appropriate public education programs regarding the impact and cost to consumers of present liability laws. Citation: (Sub. Res. 6, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmation A-00; Reaffirmation I-08)</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>H-440.863</td>
<td>Restoring the Independence of the Office of the US Surgeon General</td>
<td>Our AMA: (1) recognizes the Office of the United States Surgeon General as the esteemed position of the “nation’s doctor;” and (2) calls for the Office of the United States Surgeon General to be free from the undue influence of politics, and be guided by science and the integrity of his/her role as a physician in fulfilling the highest calling to promote the health and welfare of all people. Citation: Sub. Res. 434; A-08</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>H-510.989</td>
<td>Health Care for Veterans and Their Families</td>
<td>Our AMA supports the recommendations of the President’s Commission on Care for America’s Wounded Warriors report “Serve, Support,</td>
<td>Retain — policy remains relevant.</td>
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<td>Code</td>
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<td>Proposed Policy</td>
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<tr>
<td>H-70.951</td>
<td>Medical Necessity Coding</td>
<td>(1) The AMA (a) immediately seeks both legislative and judicial relief from ICD-9 coding requirements for reimbursement of medical and laboratory services; and (b) supports only medical record review for medical necessity determinations, and then only when inappropriate or illegal behavior is suspected. (2) That until full implementation of this policy is achieved, our AMA seeks regulatory relief that would give physicians flexibility in assigning ICD-9 codes. (3) Our AMA advocates to all those private payers who do require ICD-9 codes for diagnostic studies that physicians should have the flexibility to assign any clinically appropriate diagnosis code.</td>
<td>Retain, but update ICD-9 to ICD-10 — policy remains relevant.</td>
</tr>
<tr>
<td>D-160.946</td>
<td>Eliminating the Barriers to Surviving Acute Myocardial Infarction</td>
<td>Our AMA will: (1) work with relevant societies to conduct a thorough analysis of the geographic, economic and political barriers to optimal care for the ST-elevation myocardial infarction (STEMI) patient, e.g., the current environment, existing literature, the costs of ambulance ECG hardware, training and transmission; political issues of reimbursing one county for care provided to patients from another county or state, and the financial issues of shifting patients to centers that can perform preferred treatment algorithms; and (2) develop model legislation that would draw upon the successes of existing programs and the data garnered from a comprehensive environmental analysis, to identify workable solutions to breaking down the geographic, economic and political barriers to optimal care for the STEMI patient that currently exist.</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>D-165.946</td>
<td>Presidential Candidates’ Views on Health System Reform</td>
<td>Our AMA will use its communications vehicles such as the AMA website, to publicize the health care positions of the major US Presidential candidates and encourage physicians to become more informed voters.</td>
<td>Retain — policy remains relevant.</td>
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<tr>
<td>Code</td>
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<tr>
<td>D-190.976</td>
<td>Internet Submissions of Medicare Claims</td>
<td>Our AMA: (1) will develop principles describing appropriate use of the Internet in submitting Medicare claims; and (2) supports the use of high speed Internet as a mechanism to file Medicare claims with appropriate safeguards that adhere to federal law and HIPAA standards to ensure the protection of patient health information. Citation: (Res. 836, I-08)</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>D-330.925</td>
<td>Medicare Enrollment and Re-enrollment Delays</td>
<td>Our AMA will seek legislation mandating that the Centers for Medicare &amp; Medicaid Services impose a requirement on its carriers and Medicare administrative contractors (MACs) that enrollment and re-enrollment applications must be processed within thirty days of receipt with appropriate feedback to the applicant, and that financial penalties be imposed on carriers and MACs for unjustified delays in enrollment and re-enrollment. Citation: (Res. 205, I-08)</td>
<td>Retain — policy remains relevant.</td>
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<tr>
<td>D-330.927</td>
<td>Medicare Advantage Program Budget Reduction</td>
<td>Our AMA will express our grave concerns to President Bush, the Executive Branch and Congress that a veto of legislation concerning a budget reduction in the Medicare Advantage Program with a corresponding increase in the Medicare Physician Fee Schedule would be an egregious error. Citation: (Res. 236, A-08)</td>
<td>Rescind — The Bush Administration is no longer in a position to veto this legislation, nor is it a current issue in Congress.</td>
</tr>
<tr>
<td>D-335.988</td>
<td>Audit Equity</td>
<td>Our AMA will seek relief from insurance inequity through legislation which instructs insurers to balance or refund for under-coding against any discovered over-coding during the course of an audit and not through extrapolation. Citation: (Res. 817, I-03; Reaffirmation A-08)</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>D-35.989</td>
<td>Midwifery Scope of Practice and Licensure</td>
<td>Our AMA will: (1) only advocate in legislative and regulatory arenas for the licensing of midwives who are certified by the American College of Nurse-Midwives; (2) support state legislation regarding appropriate physician and regulatory oversight of midwifery practice, under the jurisdiction of state nursing and/or medical boards; (3) continue to monitor state legislative activities regarding the licensure and scope of practice of midwives; and (4) work with state medical societies and</td>
<td>Retain — policy remains relevant.</td>
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<tr>
<td>D-370.987</td>
<td>Study Incentives for Cadaveric Organ Donation</td>
<td>Our AMA will place high on its legislative agenda modification of the National Organ Transplantation Act to rescind prohibition of “valuable consideration” for cadaveric organ donation, so that pilot studies of financial incentives for donation can be carried out.</td>
<td>(Res. 10, A-08)</td>
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</table>
| D-383.989 | Physician Freedom to Collectively Negotiate with Managed Care Plans and Health Insuring Organizations | Our AMA will:  
(1) increase the visibility of its campaign for antitrust relief for physicians, including specific strategies for accomplishing this goal;  
(2) prepare and distribute to its membership educational materials pertaining to current antitrust issues as it affects its members;  
(3) empower its members through these educational materials to embark upon a grassroots legislative campaign to secure antitrust relief for physicians when negotiating with third party payers;  
(4) speak forcefully to its membership that no member should feel compelled to sign any contractual agreement that harms his/her ability to provide compassionate and quality care to his/her patients; and  
(5) advance as part of its patient advocacy campaign that physicians must have the right to enter into group discussions with managed care companies, exempt from antitrust violations, for the purpose of reducing the barriers to patient access and administrative burdens on physicians that delay patient care even if prohibited, by law, from discussing fees and reimbursement rates. | (Sub. Res. 229, A-05; Reaffirmed: BOT Rep. 10, I-05; Reaffirmation A-08) |
| D-383.990 | AMA’s Aggressive Pursuit of Antitrust Reform                          | Our AMA will:  
(1) place a high priority on the level of support provided to AMA’s Public and Private Sector Advocacy Units, which are key to successfully addressing the problems physicians face as a result of the current application of federal antitrust laws;  
(2) through its private and public sector advocacy efforts, continue to aggressively advocate for a level playing field for negotiations between | Retain — policy remains relevant.                     |
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<td>physicians and health insurers by aggressively pursuing legislative relief at the federal level and providing support to state medical society efforts to pass legislation based on the “state action doctrine”; (3) continue to advocate to the Federal Trade Commission and Department of Justice for more flexible and fair treatment of physicians under the antitrust laws and for greater scrutiny of insurers; (4) continue to develop and publish objective evidence of the dominance of health insurers through its comprehensive study, Competition in Health Insurance: Comprehensive Study of US Markets, and other appropriate means; (5) identify consequences of the concentration of market power by health plans to enlist a Senate sponsor for a bill allowing collective negotiation by physicians; and (6) develop practical educational resources to help its member physicians better understand and use the currently available, effective modalities by which physician groups may legally negotiate contracts with insurers and health plans. Citation: (Res. 908, I-03; Reaffirmation, A-05; Reaffirmed: BOT Rep. 10, I-05; Reaffirmation A-06; Reaffirmation A-08)</td>
<td>Retain — policy remains relevant.</td>
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<td>D-385.980</td>
<td>Provision of Payment Schedules and Methodology of Payment as Part of the Contracting Process</td>
<td>Retain — policy remains relevant.</td>
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<td>D-390.969</td>
<td>Parity in Medicare Reimbursement</td>
<td>Retain in part — The Medicare Access and CHIP Reauthorization Act of 2015 replaced the sustainable growth rate system with new payment updates, and the payment reductions from the Deficit Reduction Act have</td>
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in fewer in-patient complications, shorter lengths-of-stays, and fewer hospital readmissions; and (43) advocate for other mechanisms to ensure adequate payments to physicians, such as balance billing and gainsharing. Citation: (BOT Action in response to referred for decision Res. 236, A-06; Reaffirmation I-08) already taken place.

| D-390.976 | Medicare Physician Payment | Our AMA will send all members of Congress a letter, signed by all willing members of the Federation, urging them to enact legislation replacing Medicare’s sustainable growth rate reimbursement formula with a system based on appropriate updates. Citation: (BOT Rep. 35, A-05; Reaffirmation A-06; Reaffirmation I-06; Reaffirmation I-08) Rescind — The Medicare Access and CHIP Reauthorization Act of 2015 replaced the sustainable growth rate system with new payment updates. |
| D-410.996 | Physician Seeking Regulation of Physicians | Our AMA will, with the intent of improving patient care and promoting interspecialty collaboration, develop a process for national specialty groups to urge their state affiliates to work through the state medical association prior to the introduction of any state legislation that seeks to regulate or restrict the practice of other physician groups or specialties. Citation: (Res. 235, A-08) Retain — policy remains relevant. |
| D-435.975 | Blood Centers and Medical Liability | Our AMA will advocate that blood centers be covered under any health care liability reform legislation. Citation: (Res. 209, A-08) Retain — policy remains relevant. |
| D-95.983 | Mandatory Drug Screening Reporting | Our AMA will: (1) work with appropriate state and specialty medical societies and with state legislative bodies to ensure that physicians not be required to report patients with positive aberrant drug screen-test results to the police; and (2) continue to promote education of physicians regarding the importance of referring patients found to have positive aberrant urine drug screen-tests for appropriate medical treatment. Citation: (Res. 406, A-08) Retain — policy remains relevant, but modify terms “positive” to “aberrant” and “drug screen” to “drug testing” and “drug tests” to reflect updated use of terms in this field. The original policy was written before drug monitoring was commonplace. |
APPENDIX 2
AMA Policies Superseding Policies Recommended for Rescission

Policy H-383.999, Formation of a National Negotiating Organization “Physician Negotiation”
(1) All activities of our American Medical Association regarding negotiation by physicians maintain the highest level of professionalism, consistent with the Principles of Medical Ethics and the Current Opinions of Council on Ethical and Judicial Affairs;
(2) Our AMA immediately implement a national labor organization under the National Labor Relations Act to support the development and operation of local negotiating units as an option for employed physicians;
(3) Our AMA immediately implement a national labor organization to support the development and operation of local negotiating units as an option for resident and fellow physicians who are authorized under state laws to collectively bargain;
(4) Our AMA continue to support the development of independent house staff organizations for employed, resident and fellow physicians and be prepared to implement a national labor organization to support the development and operation of local negotiating units as an option for all employed, resident and fellow physicians at such time as the National Labor Relations Board determines that resident and fellow physicians are authorized to organize labor organizations under the National Labor Relations Act;
(5) Our AMA continue to vigorously support antitrust relief for physicians and medical groups by actively supporting federal legislation consistent with the current principles of the Quality Health Care Coalition Act of 1999 (H. R. 1304 introduced by Representative Tom Campbell, R-CA and John Conyers, D-MI), aggressively working with the Department of Justice and the Federal Trade Commission, and continue providing model legislation and information on the state action doctrine to state medical associations and members;
(6) Our AMA be prepared to immediately implement a national organization to support development and operation of local negotiating units as an option for self-employed physicians and medical groups when the current principles of the Quality Health Care Coalition Act of 1999 (H. R. 1304) become law; and
(7) Our AMA continues to advance its private sector advocacy programs and explore, develop, advocate, and implement other innovative strategies, including but not limited to initiating litigation, to stop egregious health plan practices and to help physicians level the playing field with health care payers;
(8) That should the BOT determine that the Quality Health Care Coalition Act of 1999 (H. R. 1304) or similar legislation will not become law, our AMA immediately pursue the creation or adoption of new antitrust legislation to achieve the same goal; and
(9) Our AMA, concurrent to proceeding with the establishment of any collective bargaining unit, undertake an extensive education program, directed at its member and non-member physicians, as to the possible limits on benefits and the risks to the formation of such a unit.
Citation: (Sub. Res. 901, A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmation A-02; Reaffirmation A-06; Reaffirmation A-08)

Policy D-383.990, “AMA’s Aggressive Pursuit of Antitrust Reform”
Our AMA will: (1) place a high priority on the level of support provided to AMA’s Public and Private Sector Advocacy Units, which are key to successfully addressing the problems physicians face as a result of the current application of federal antitrust laws;
(2) through its private and public sector advocacy efforts, continue to aggressively advocate for a level playing field for negotiations between physicians and health insurers by aggressively pursuing legislative relief at the federal level and providing support to state medical society efforts to pass legislation based on the “state action doctrine”;
(3) continue to advocate to the Federal Trade Commission and Department of Justice for more flexible and fair treatment of physicians under the antitrust laws and for greater scrutiny of insurers;
(4) continue to develop and publish objective evidence of the dominance of health insurers through its comprehensive study, *Competition in Health Insurance: Comprehensive Study of US Markets*, and other appropriate means;
(5) identify consequences of the concentration of market power by health plans to enlist a Senate sponsor for a bill allowing collective negotiation by physicians; and
(6) develop practical educational resources to help its member physicians better understand and use the currently available, effective modalities by which physician groups may legally negotiate contracts with insurers and health plans. Res. 908, I-03 Reaffirmed, A-05 Reaffirmed: BOT Rep. 10, I-05 Reaffirmation A-06 Reaffirmation A-08

*Policy H-385.973, “Collective Negotiations”*
It is the policy of the AMA to seek amendments to the National Labor Relations Act and other appropriate federal antitrust laws to allow physicians to negotiate collectively with payers who have market power. Res. 95, A-90 Reaffirmed by BOT Rep. 33, A-96 Reaffirmation A-97 Reaffirmation I-98 Reaffirmation A-00 Reaffirmation I-00 Reaffirmation A-01 Reaffirmation A-04 Reaffirmation A-05 Reaffirmation A-06 Reaffirmation A-08 Reaffirmation I-10 Reaffirmed: Res. 215, A-11 Reaffirmed: BOT action in response to referred for decision Res. 201, I-12

*Policy D-370.987, “Study Incentives for Cadaveric Organ Donation”*
Our AMA will place high on its legislative agenda modification of the National Organ Transplantation Act to rescind prohibition of “valuable consideration” for cadaveric organ donation, so that pilot studies of financial incentives for donation can be carried out. (Res. 10, A-08)

*Policy H-370.958, “Removing Disincentives and Studying the Use of Incentives to Increase the National Organ Donor Pool”*
1. Our AMA supports the efforts of the National Living Donor Assistance Center, Health Resources Services Administration, American Society of Transplantation, American Society of Transplant Surgeons, and other relevant organizations in their efforts to eliminate disincentives serving as barriers to living and deceased organ donation.
2. Our AMA supports well-designed studies investigating the use of incentives, including valuable considerations, to increase living and deceased organ donation rates.
3. Our AMA will seek legislation necessary to remove legal barriers to research investigating the use of incentives, including valuable considerations, to increase rates of living and deceased organ donation. (Res. 7, I-15)
INTRODUCTION

At the 2017 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 212-A-17, “Advocacy For Seamless Interface Between Physician Electronic Health Records, Pharmacies And Prescription Drug Monitoring Programs To Be Created And Financed By The Commercial EHR and Dispensing Program Providers,” which was sponsored by the American College of Legal Medicine, and which directed the AMA to:

Join the American College of Legal Medicine to advocate federally-mandated interfaces between provider/dispenser electronic health record systems in the clinical, hospital and pharmacy environments and state prescription drug databases and/or prescription drug management plans;

Advocate that the cost of generating these interfaces be borne by the commercial EHR and dispensing program providers;

Advocate that the interface should include automatic query of any opioid prescription, from a provider against the state prescription drug database/prescription drug management plan (PDMP) to determine whether such a patient has received such a medication, or another Schedule II drug from any provider in the preceding ninety (90) days;

Advocate that the prescriber and the patient’s EHR-listed dispensing pharmacy should then be notified of the existence of the referenced patient in the relevant PDMP database, the substance of the previous prescription(s) (including the medication name, number dispensed and prescriber’s directions for use) in real time and prior to the patient receiving such medication;

Advocate that the electronic record management program at the pharmacy filling the relevant prescription, contemporaneously as it enters the filling of the prescription by the pharmacist, likewise be required to automatically query the state PDMP as a secondary mechanism to prevent inappropriate prescribing, forgery, duplication and/or too great a frequency of use of the involved controlled medication;

Work with ACLM and other concerned societies to urge Congress to timely enact and implement such a statutory scheme supported by a workable and concise regulatory framework, chiefly concentrating on the interfacing of all applicable electronic health record systems.
and pharmaceutical dispensing systems with every individual state’s PDMP, thereafter
designating a timeframe wherein all treating providers and dispensing pharmacists would be
required to perform such queries, in concert with the routine ordering of and filling of a
controlled substance to be used in the treatment of patients;

Advocate that oversight of the appropriate prescribing of and filling of prescriptions for
controlled substances remain with the involved individual federal and state criminal law
enforcement agencies, the involved state departments of health, or similar entities and the
involved relevant state provider and/or pharmacy licensure authorities; and

Advocate that statistics be maintained and reviewed on a periodic basis by state PDMP
personnel and relayed to state departments of health or agencies similarly situated so as to
identify and possibly treat those patients identified through this screening mechanism as
potential drug abusers and/or at risk of addiction.

This report summarizes the work the AMA has done in support of ensuring accurate, reliable
Prescription Drug Monitoring Programs (PDMPs) that support physicians and their patients. It also
addresses many of the complexities raised in the original resolution, including PDMP evolution,
integration with electronic health records (EHRs) and electronic prescribing of controlled
substances (EPCS). The report also provides relevant AMA policy and presents policy
recommendations.

DISCUSSION

Integrating electronic systems that support efforts to end the opioid epidemic continues to be a
major goal of AMA advocacy. To effectively support physician efforts to end the epidemic of
opioid overdose deaths, electronic systems need to be interoperable and integrated into normal
medical practice workflows. There has been progress, but effective integration remains extremely
rare.

Too often, information exchanged with EHRs is not well incorporated into the physician’s
workflow. Important information, including PDMP data, often requires multiple “clicks,” opening
multiple windows, and requiring separate logins even before the physician finds what he or she is
looking for—and that situation must be repeated for each patient and every prescription for a
controlled substance. Effective PDMP and EHR integration means that the workflow must achieve
“functional interoperability,” or the ability for systems to exchange, incorporate and display data in
a meaningful and contextual manner.

Many consider the ideal practice to be a “one-click” solution with PDMP data and EPCS integrated
into physicians’ EHR systems. However, EHR vendors currently are pulled in too many directions
to focus on this need. Federal regulations require vendors to spend considerable time developing
EHRs that meet administrative requirements. To achieve the ideal, more must be done to reduce the
regulatory pressure on health IT development, allowing vendors flexibility to respond to physician
and patient needs, rather than spending the bulk of their time complying with administrative
demands.

One area where there has been significant progress is interoperability between the various state
PDMPs. According to the National Association of Boards of Pharmacy, 44 states now can securely
share PDMP information across state lines.¹ PDMP use among physicians and other health care
professionals has significantly increased in recent years, with more than 136 million queries taking
place in 2016,² the most recent year for which data are available.
Progress has been considerably slower in achieving EPCS uptake, however, largely due to outdated regulations from the Drug Enforcement Administration (DEA). The combination of personal identification numbers (PINs), passwords, and biometrics required to meet DEA standards for “two-factor authentication” increase EPCS security but add to workflow disruptions and increase costs. DEA EPCS requirements include onerous limits on use of biometric devices, which must comply with federal standards that set an unnecessarily high bar and prevent use of user-friendly consumer electronics already found in physicians’ offices for two-factor authentication. The biometric fingerprint scanners found on these consumer devices, i.e., smart phones, tablets, and laptop computers, are used for secure access to other sensitive information, like banking and medical records, but typically do not comport with rigid rules for EPCS.

The AMA views EPCS as important to support high-quality patient care. Physicians commonly report that they are frustrated that they can e-prescribe non-controlled substance medications but must still use written prescriptions for controlled substances. More than 70 percent of physicians are e-prescribing non-controlled drugs but only 20 percent use EPCS. One reason for this is due to the fact that not all EHR vendors understand or can satisfy EPCS requirements—state EPCS mandates have increased uptake, but implementation has been delayed due to questions about system certification, cost to providers, and patient concerns, i.e., transferring prescriptions between pharmacies. Moreover, EHR vendor processes for EPCS do not always align well with normal e-prescribing workflows—often physicians must start new computer programs and windows each time they use EPCS. Cumbersome workflows and applications that do not take physician needs into account impede EPCS uptake. Finally, although EPCS reduces prescription fraud and diversion, it is less clear how it affects valid prescriptions for opioid analgesics. For example, does the prescriber using EPCS put in a dose and duration or are numbers suggested by the EPCS system and, if so, how are these amounts derived? These are among the questions the AMA has been asking from vendors and physicians.

To help resolve other barriers, the AMA and the President’s Commission on Combating Drug Addiction and the Opioid Crisis have recommended the DEA modify EPCS regulations in order to reduce barriers to EPCS adoption. The AMA asked DEA to reexamine the scope of technology that is compliant with EPCS requirements and allow use of lower-cost, high-performing biometric devices in two-factor authentication. The AMA also believes that there must be further study to evaluate the variations in how EPCS systems handle initial dosing, i.e., are opioid doses or durations auto-populated in EPCS systems and, if so, are the amounts appropriate.

A final point is that the AMA has made clear to the DEA that its requirements for biometric devices limit user-friendly consumer electronics already found in physicians’ offices, such as fingerprint readers on laptop computers and mobile phones, from being utilized for two-factor authentication in EPCS. This and other rules contribute to cumbersome workflows and applications which are an impediment to physician EPCS uptake. Encouraging EPCS uptake and interoperability of PDMP databases and electronic health records would improve the integration of controlled substance use data into practice workflows and clinical decision-making.

The AMA also continues its efforts in support of making PDMPs better clinical tools. The use of PDMPs continues to increase in states with and without mandates—tied mainly to quality of the PDMP as a decision-support tool. Important policies that have led to improved PDMP workflow and data reliability include delegate access, data input by pharmacists within 24 hours, and sharing of PDMP information by 44 states. PDMP usability continues to improve, but access in rural and other areas may be affected by lack of access to broadband and other technologies. Consistent, long-term funding of state PDMPs is also a concern—most states depend on federal grants for ongoing maintenance and improvements. The AMA also continues to try and identify best
practices in designing PDMPs to identify risk including: distinguishing between uncoordinated care, misuse, and “doctor shopping,” identifying opportunities for referrals to specialized care; providing reports to prescribers to better inform prescribing decisions; and conducting public health surveillance.

One best practice is PDMP and EHR integration, but that remains largely elusive. It is not clear, for example, how many PDMPs are integrated into EHRs, which makes identification of best practices challenging given the variety of EHR systems in the market. Each state PDMP may require a slightly different interface to connect to an EHR. With over 600 different EHRs on the market, the number of custom EHR/PDMP interfaces can reach into the thousands. Custom software development is time-consuming and expensive—with costs being passed down onto the physician. Without PDMP and EHR integration, physicians must use multiple usernames and passwords to shuttle between different systems, often having to re-enter login information if one system times out while they are using the other one. This results in increased time to enter information, decreased satisfaction with the technology, and potentially less use of the systems.

In addition, EHRs are generally not interoperable between different organizations, making coordination between primary care physicians, pain medicine physicians, addiction medicine physicians and other providers much more difficult. When PDMP and EHR integration does exist (e.g., Oregon’s EDIE), the patient, public health and cost utilization benefits are extremely positive. This integration requires time and broad, institutional support. For example, the state of Washington’s integration project with the state Health Information Exchange (HIE) began in 2012. As of August 2017, more than 90 percent of emergency departments include PDMP data in the EHR using data through the HIE. The state’s major health systems still are working to accomplish this integration.

To help resolve some of these issues, the AMA advocates for consistent and sufficient appropriations to support state efforts to maintain and improve state-based PDMPs, including broad state-based grants to improve statewide HIEs and the ability to integrate HIE data into the EHR of statewide emergency departments and other providers. The AMA also would support a U.S. Government Accountability Office study on best practices for small and large physician practices on using PDMPs to improve pain care as well as treatment for substance use disorders. This would include identifying how PDMPs can distinguish uncoordinated care from misuse or “doctor shopping” as well as help coordinate care for a patient with a substance use disorder or other condition requiring specialty care. In addition, there is a need to evaluate the variations in state-based PDMP technology and work with the health IT industry to discuss “common understanding” of how each PDMP works—providing transparency for EHR vendors to facilitate development of custom connections between their products and PDMP software. This could include funding for programs that pilot test low-cost technologies to better integrate EHRs and PDMPs as well as efforts to identify burdensome federal regulations that prevent EHRs from being designed and developed to meet physician and patient needs.

The AMA also has been engaged in the SMART project to help EHR systems work better for physicians and patients. A key component of this effort is the development of a flexible information infrastructure that allows for free, open development of plug and play applications (apps) to increase interoperability among health care technologies, including EHRs, in a more cost-effective way. The infrastructure development specific to PDMPs is part of both ongoing research as well as work by states working to achieve more comprehensive data integration. In addition, the Office of the National Coordinator for Health Information Technology has compiled multiple sources and pilot examples for PDMP and EHR integration. The pilot examples, not surprisingly,
found that PDMPs were most helpful when they were integrated into physicians’ workflow as well as EHRs.

AMA POLICY

The AMA House of Delegates has provided strong guidance to the AMA that reflects the issues raised by the original resolution that is the subject of this report. Relevant policies include: H-120.957, “Prescription of Schedule II Medications by Fax and Electronic Data Transmission,” which “encourages the Drug Enforcement Administration to support two factor authentication that is easier to implement than the current DEA and EPCS security requirements; and because sufficient concerns exist about privacy and confidentiality, authenticity, and other security measures, does not support the use of “hard copy” facsimile transmissions as the original written prescription for Schedule II controlled substances, except as currently allowed in Section 1306 of Title 21 of the Code of Federal Regulations.” In addition, H-95.928, “Model State Legislation Promoting the Use of Electronic Tools to Mitigate Risk with Prescription Opioid Prescribing,” provides that the AMA support multiple facets of PDMP development, including interoperability, assisting physicians and pharmacists in identifying “when their patients have received a prescription for controlled substances from multiple prescribers or multiple pharmacies within a short time frame.” In addition, D-478.972, “EHR Interoperability,” calls for the AMA to continue efforts in support of EHR interoperability standards, reducing excessive costs and generally reducing barriers to EHR adoption. Finally, Policy D-478.994, “Health Information Technology,” broadly notes AMA support for “legislation and other appropriate initiatives that provide positive incentives for physicians to acquire health information technology,” which reasonably would include PDMP, EPCS and EHR uptake.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 212-A-17, and that the remainder of the report be filed:

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)

Fiscal Note: Less than $500.
REFERENCES

1 National Association Boards of Pharmacy. Available at https://nabp.pharmacy/initiatives/pmp-interconnect/
8 PDMPConnect. Office the National Coordinator for Health Information Technology. Available at https://www.healthit.gov/pdmp/PDMPConnect
INTRODUCTION

At the 2017 Annual Meeting Resolution 219-A-17, “Integration of Drug Price Information into Electronic Medical Records,” was referred by the House of Delegates (HOD). Resolution 219-A-17 was introduced by the Medical Student Section and asks the American Medical Association (AMA) to support the incorporation of estimated patient out-of-pocket drug costs into electronic medical records (EMR) and collaborate with invested stakeholders, such as physician groups, EMR vendors, hospitals, insurers, and governing bodies to integrate estimated out-of-pocket drug costs into electronic medical records in order to reduce patient cost burden.

At the 2017 Interim Meeting, Resolution 213-I-17, “Barriers to Price Transparency,” was introduced by the American Academy of Dermatology, American Society of Dermatologic Surgery Association, American College of Mohs Surgery, American Society of Dermatopathology, and the Society for Investigative Dermatology. The third resolve of Resolution 213-I-17 was referred by the HOD and asks the AMA to support access to real-time prescription drug pricing and cost transparency at the point of prescribing.

Also at the 2017 Interim Meeting, Resolutions 203-I-17, “Bidirectional Communication for EHR Software and Pharmacies,” and 205-I-17, “Health Plan, Pharmacy, Electronic Health Records Integration,” were referred together.

Resolution 203-I-17 was introduced by the Medical Society of Virginia, the Kentucky Medical Association, the North Carolina Medical Society, the American Urological Association, and the American Association of Clinical Urologists. Resolution 203-I-17 asks the AMA to engage the American Pharmacy Association, and any other relevant stakeholders, to encourage both electronic health record (EHR) and pharmacy software vendors to have bidirectional communication for an accurate and current medication list in the patient’s EHR.

Resolution 205-I-17 was introduced by the Medical Society of Virginia, the Kentucky Medical Association, the American Urological Association, and the American Association of Clinical Urologists. Resolution 205-I-17 asks the AMA to advocate that health plans, pharmacies, and EHR vendors integrate their technology programs so that physicians have current and real time access to covered medications for patients within a specific health plan. Resolution 205-I-17 also requests
that the AMA advocate that health plans make patient cost information readily available via this
technology so that physicians and their patients may work together to choose the most cost-
effective medically appropriate medication for patient care.

All resolutions were referred for report back at the 2018 Annual Meeting. As the referred resolves
in each resolution deal with components of a common issue, this report will address the topic as a
whole, and present recommendations accordingly.

BACKGROUND

Prescription drug costs in the United States are significant and rising. Some research shows the
patient out-of-pocket prescription costs are decreasing, although overall drug spending has
increased and approximately 25 percent of Americans who regularly take prescription medications
saw a price increase from 2016 to 2017. There is significant correlation between increased patient
prescription cost sharing and decreased medication adherence, suggesting an adverse effect on
patient outcomes.

Many physicians report not having access to drug price information at the point of prescribing,
often preventing them from sharing the information with the patient and gaining awareness of
whether a patient can afford the medication. Studies show increased physician awareness of drug
prices changes prescribing behavior and reduces overall medication expenditures. The AMA
recognizes that physicians can enhance patient-centered care by balancing costs and the potential
for patient adherence to prescriptions in their decision-making related to maximizing health
outcomes and quality of care for patients.

Improving drug price transparency would increase patient and physician awareness of the overall
costs associated with different prescription drug treatment options and ultimately facilitate better-
informed, shared treatment decisions that could help reduce prescription drug spending. Integrating
drug price information into EHRs would support point-of-prescription cost transparency that could
increase a physician’s ability to provide price information to patients. Although various barriers
have historically inhibited the provision of drug price information at the point of prescribing, key
stakeholders have taken significant steps in recent months towards overcoming these barriers and
implementing solutions.

AMA POLICY

The AMA is committed to working with federal and state agencies, policymakers and other
relevant stakeholders to identify and promote adoption of policies to address the already high and
escalating costs of generic prescription drugs (Policy H-110.988, “Controlling the Skyrocketing
Costs of Generic Prescription Drugs”). The AMA supports increasing physician awareness about
the cost of drugs prescribed for their patients (Policy H-110.996, “Cost of Prescription Drugs”),
and encourages physicians to become familiar with the cost of drugs in their communities and to
consider prescribing the least expensive drug treatment available (Policy H-110.997, “Cost of
Prescription Drugs”). The AMA emphasizes the importance of value-based decision-making in
health care, and the need for physicians to have easy access to and review the best available data
associated with costs at the point of decision-making, which necessitates cost data to be delivered
in a reasonable and useable manner by third-party payers and purchasers. AMA policy also asserts
that physicians should seek opportunities to improve their information technology infrastructures to
include new and innovative technologies, such as personal health records and other health
information technology initiatives, to facilitate increased access to needed and useable evidence
and information at the point of decision-making (Policy H-450.938, “Value-Based Decision-
Making in the Health Care System”). The AMA also encourages physicians to communicate information about the cost of their professional services, including prescriptions, to individual patients, and encourages EHR vendors to include features that assist in facilitating price transparency for physicians and patients (Policy D-155.987, “Price Transparency”).

The AMA is dedicated to actively engaging with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency, and helping ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide (Policy D-155.987, “Price Transparency”). It is AMA policy that in order to facilitate cost-conscious, informed market-based decision-making in health care, physicians, hospitals, and pharmacies should be required to make information readily available to consumers on fees/prices charged for frequently provided services, procedures, and products, prior to their provision. There should be a similar requirement that insurers make available in standard format information on the amount of payment provided toward each type of service identified as a covered benefit (Policy H-373.998, “Patient Information and Choice”). The AMA encourages implementation of practices that increase price transparency among other stakeholders, including pharmaceutical companies, pharmacy benefit managers and health insurance companies (Policy H-110.987, “Pharmaceutical Costs”). Additionally, the AMA advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay, and is committed to pursuing legislation requiring pharmacies to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication (Policy H-110.991, “Price of Medicine”). The AMA is also committed to working with EHR vendors to enhance transparency and establish processes to achieve data portability (Policy D-478.995, “National Health Information Technology”).

DISCUSSION

Lack of transparency in prescription drug pricing is a major contributor to the increasingly high prices of drugs. Prescription price transparency is an important factor in lowering patients’ out-of-pocket costs and preventing prescription abandonment, a common cause of medication non-adherence, which negatively impacts patient safety and costs an estimated $300 billion each year in avoidable medical spending.

Efforts can be made at multiple levels to improve the visibility of drug prices. For example, transparency of drug prices can be increased at the point-of-purchase level, when patients are interacting with the pharmacist to fill or refill a prescription. Historically, gag clauses in pharmacy benefit manager (PBM) contracts have prevented pharmacists in many states from informing consumers that the drug they want to purchase could be purchased at a lower cost if the consumer paid out of pocket rather than through their insurance plan. Some states are considering legislation, and several have passed laws, that ban restrictive gag clauses in PBM contracts with pharmacies. Eliminating these restrictions allows pharmacists the freedom to inform patients about the least expensive way to obtain the medication they have been prescribed.

At the point of prescribing, when a physician is discussing treatment options during a clinical visit, the price of a drug could be a deciding factor in whether the treatment is pursued; however, prescribers are largely unaware of the prices associated with the medications they prescribe and have difficulty estimating costs with accuracy. Some EHR platforms display limited high-level drug price information, such as co-pay tiers and dollar sign rating scales, giving a general estimate or range for the patient’s portion of a drug’s cost. These data are based on static “flat” files provided by PBMs to EHR vendors using the National Council for Prescription Drug Programs (NCPDP) Formulary and Benefit standard. This information is not always up to date or accurate,
however, since payers or PBMs may change a drug formulary or reclassify a particular prescription without the physician’s or patient’s knowledge and/or without providing updated formulary data to EHR vendors. This can further hinder the provision of accurate drug cost information to patients and physicians, presenting another opportunity for improved transparency.

Universally integrating real-time drug price information, along with improving the reliability and granularity of the currently available formulary and benefit information, into EHR systems would provide physicians with a more accurate estimate of a patient’s potential cost for a given medication. Since 2014, NCPDP has been working on a real-time pharmacy benefit check solution through the work of their Real-Time Benefit Check Analysis Task Group (more recently named the Real-Time Prescription Benefit Standard Task Group). This group’s goal is to develop an electronic standard for communicating real-time drug pricing information to physicians at the point-of-prescribing in EHR systems. Data points would include formulary status, tier structure, restrictions such as prior authorization and step therapy requirements, patient co-pays, and therapeutic alternatives that may be more affordable for the patient. 

While NCPDP continues developing a real-time pharmacy benefit standard, vendors and PBMs are piloting this technology in proprietary formats. In 2017, Surescripts, six major EHR vendors including Allscripts, Cerner, GE, Epic, Practice Fusion and Aprima, along with CVS Health, partnered to deliver a system that provides prescribers with the cost of medications, specifically based on the patient’s insurance coverage, as well as other therapeutic treatment options to ensure the patient and physician can decide together the most appropriate and affordable course of treatment. This collaborative service is planned to be available in 2018. This development is an important step toward a sustainable solution; however, for it to be viable and universally beneficial the data must be available across all EHR vendors for all patients with all payer information.

There is mixed evidence on whether providing prescribers with cost information at the point of prescribing results in significant changes to prescribing behavior, overall costs, or improvements to medication adherence. One study showed evidence that providing physicians with information about drug prices increased generic prescribing and decreased orders for diagnostic tests, and that “gatekeeper” physicians reduced use of hospital and specialist services when regularly presented with prescription cost information. Another study demonstrated that having access to the charges associated with patient care changed practice patterns and decreased patient charges, thereby improving cost containment efforts. An analysis of prescriptions and use of a point-of-care electronic drug reference database for over 125,000 U.S. physicians found that physicians using the database prescribed a significantly more diverse set of products, were faster to begin prescribing new generic drugs, and also had a greater propensity to prescribe generics. The researchers attributed this finding to the database users’ access to non-clinical information such as drug price and insurance formulary data. 

However, a separate study reviewed the total and out-of-pocket cost changes for diabetes patients whose physicians had access to drug formulary and price information and found that while the total drug costs increased at a lower rate, having access to the cost information did not reduce the patient out-of-pocket cost or increase medication adherence rates. Similarly, a study published in JAMA Internal Medicine demonstrated that displaying Medicare allowable fees for inpatient laboratory tests did not lead to a significant change in overall clinician ordering behavior or associated fees. Overall, researchers have found that while access to drug price and coverage data may influence prescriber decisions, providing price information alone is not enough and that more comprehensive approaches are in order. Some conclude that transparency in price is most beneficial when combined with education and an audit/feedback mechanism for prescribers. Others assert that prices for individual components of care provide an incomplete picture of the patient’s out-of-
pocket responsibility, and that seeing prices for episodes or bundles of care could allow patients
and physicians to assess value and treatment together.17

The issue of drug price transparency is one of great importance to the AMA and our current
advocacy efforts reflect our commitment to addressing the issue at the state and federal levels. The
Chair of the AMA Board of Trustees presented testimony at the December 2017 Energy and
Commerce hearing on drug pricing to ensure AMA’s position and the voice of physicians
continues to be represented. Another example of this work is the AMA’s interactive grassroots
website TruthinRx.org, which urges improved drug pricing transparency among pharmaceutical
manufacturers, pharmacy benefit managers, and health plans and offers patients the opportunity to
share their stories of how rising prices affect their physical and financial health. At the state level,
the AMA’s model legislation on drug pricing transparency seeks to provide patients with relevant,
accurate information about the manufacturing, production, advertising, and other associated costs
relating to prescription medications and institute consumer protections for sudden drug price
fluctuations.

The AMA’s advocacy efforts on prior authorization reform address the need for accurate formulary
data in EHRs. In January 2017 the AMA, in collaboration with 16 other organizations representing
physicians, hospitals, pharmacists, medical groups, and patients, released a set of 21 Prior
Authorization and Utilization Management Reform Principles. Of note is Principle 9, which states
“Utilization review entities should provide, and vendors should display, accurate, patient-specific,
and up-to-date formularies that include prior authorization and step therapy requirements in [EHR]
systems for purposes that include e-prescribing.” The AMA has used these principles to spur
conversations with health plans about “right-sizing” prior authorization programs. One outcome of
these discussions was the January 2018 release of the Consensus Statement on Improving the Prior
Authorization Process by the AMA, American Hospital Association, America’s Health Insurance
Plans, American Pharmacists Association, Blue Cross Blue Shield Association, and Medical Group
Management Association. The consensus document reflects an agreement between national
associations representing both providers and health plans on the need to reform prior authorization
programs in multiple ways, including advancing automation to improve transparency and
efficiency. Specifically, the consensus statement “[e]ncourage[s] the communication of up-to-date
prior authorization and step therapy requirements, coverage criteria and restrictions, drug tiers,
relative costs, and covered alternatives . . . to EHR, pharmacy system, and other vendors to
promote the accessibility of this information to health care providers at the point-of-care via
integration into ordering and dispensing technology interfaces.” This reflects the widespread
agreement among providers and health plans about the need for accurate drug pricing information
in EHRs.

The AMA is actively involved in standards development work and direct discussions with vendors
to improve formulary data technology. The AMA participates in meetings of the NCPDP’s Real-
Time Prescription Benefit Standard Task Group and the Formulary and Benefit Task Group to
ensure the physician voice is represented in the development of standards and solutions. The AMA
dedicates significant resources to improving usability, interoperability and value in EHRs.
Incorporating prescription drug price information into EHRs will enhance the AMA’s efforts to
increase the value and utility of these systems.

The AMA recognizes the need for more knowledge about the current availability and accessibility
of the features described in these resolutions, including EHR, pharmacy and payer functionalities
that enable integration of price, insurance coverage, formulary tier and drug utilization
management policies, and patient cost information. As a more robust knowledge base is obtained
as a result of private sector initiatives such as that of Surescripts and others, the AMA will
encourage collaboration with other vendors and other key stakeholders to develop a plan for improving the availability and accessibility of this important information to all physicians. This effort, along with our existing commitment to pursuing legislation to increase price transparency at the payer and pharmacy levels, would further the AMA’s strategic goals to reduce health care costs and improve health outcomes.

RECOMMENDATION

The Board of Trustees 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.


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)

Fiscal note: Modest – Between $1,000 and $5,000
REFERENCES

This report is submitted for the information of the House of Delegates. So as to not expose sensitive advocacy strategies and potential future resources, a fuller accounting of the Scope of Practice Summit (“Summit”) described herein will take place through AMA meetings dedicated to advocacy and scope of practice, as well as the confines of the Scope of Practice Partnership (SOPP).

Policy adopted at the 2017 Interim Meeting called on the American Medical Association to convene an in-person meeting of relevant physician stakeholders to initiate creation of a consistent national strategy to effectively oppose efforts to grant independent practice to non-physician practitioners. (Policy H-35.988, “Independent Practice of Medicine by Advanced Practice Registered Nurses”).

The resultant Summit was held March 20, 2018 at AMA headquarters in Chicago. The SOPP provided funding to support the Summit. In addition, the SOPP awarded 14 scholarships to state medical associations that otherwise would have been unable to attend.

Attendance included 81 physicians, executive staff, and government affairs staff from 32 state medical associations, 16 national medical specialty societies, and the American Osteopathic Association. Representatives of the AMA Board of Trustees and Council on Legislation, and AMA staff from Advocacy, Office of General Counsel, Physician Engagement, and Enterprise Communications and Marketing also attended the Summit.

William E. Kobler, MD, member, AMA Board of Trustees and chair of the SOPP, served as chair of the Summit. Dr. Kobler led a planning committee composed of executive staff of the American Academy of Family Physicians, American Academy of Ophthalmology, American Congress of Obstetricians and Gynecologists, American Psychiatric Association, American Society of Anesthesiologists, California Medical Association, Medical Association of Georgia, New Mexico Medical Society, Ohio State Medical Association, and Medical Society of Virginia. This planning committee was instrumental in shaping the Summit agenda, and the Board of Trustees thanks them for their time and effort.

With the assistance of a strategic research firm prior to the Summit, the AMA Advocacy Resource Center conducted a survey of all associations invited to the Summit. Feedback from 60 respondents about scope of practice advocacy and trends was synthesized in a presentation to kick-off the Summit. This valuable insight was also utilized throughout the Summit’s strategic planning session.
Meeting attendees heard presentations about the considerable scope of practice advocacy resources of the AMA Advocacy Resource Center and SOPP, including the Health Workforce Mapper, Geographic Mapping Initiative, Scope of Practice Data Series Modules, model bills, state law charts, issue briefs, talking points, public opinion research, and comprehensive state legislative campaigns including the Physician-Led Team Campaign and Truth in Advertising Campaign, and grant funding. Attendees also heard a case study from a state medical association that heavily utilized SOPP resources and a SOPP grant to fight a nurse practitioner independence bill; and a panel of national medical specialty society representatives discussing scope priorities and trends.

The afternoon was dedicated to a strategy session, in which facilitated small and large group discussions identified strengths, opportunities, weaknesses, and threats related to scope of practice advocacy. The strategy session also identified ways in which to amplify strengths and opportunities within organized medicine while addressing weaknesses and internal and external threats. A professional facilitator with government affairs expertise moderated the discussion.

Results of a meeting evaluation were positive. Of the responses, 98 percent reported that the conference fully or partially fulfilled their reason for attending, and 85 percent would recommend the meeting to colleagues. 95 percent of attendees were pleased with the quality of the presentation and the scope of the information presented. 88 percent of respondents left with a somewhat or much better view of the AMA; the remainder reported that their opinion of the AMA was unchanged.

The Board of Trustees recommends that Policy H-35.988(2) be rescinded, having been accomplished through the Scope of Practice Summit and this report.

RECOMMENDATION

The Board of Trustees recommends that 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)
REPORT OF THE BOARD OF TRUSTEES

B of T Report 16-A-18

Subject: Protection of Clinician-Patient Privilege (Resolution 237-A-17)

Presented by: Gerald E. Harmon, MD, Chair

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

INTRODUCTION

At the 2017 Annual Meeting, the House of Delegates (HOD) referred Resolution 237-A-17, “Protection of Clinician-Patient Privilege,” for report back at the 2018 Annual Meeting. This resolution was introduced by the Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont Delegations and asked that our American Medical Association (AMA):

Advocate to the relevant national bodies for the clinician-patient privilege to be regulated according to the privacy protections in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) without regard to where care is received.

This report provides information about the privacy protections and exceptions thereto found in the Family Education Rights and Privacy Act (FERPA) in post-secondary educational settings. It also compares such protections and exceptions to those found in HIPAA. Finally, it discusses which of the two standards is more appropriate for the AMA to support.

BACKGROUND

FERPA is a federal law that applies to educational institutions—including most public and private post-secondary institutions—that receive funding from the U.S. Department of Education. It protects the privacy of information found within students’ “education records,” which is broadly defined to mean those records that are (1) directly related to a student, and (2) maintained by an educational agency or institution or by a party acting for the agency or institution. FERPA prohibits a post-secondary institution from disclosing personally identifiable information (PII) from a student’s education records absent that student’s written consent, unless an exception applies. Education records can include medical records (for example, immunization records), but are separate and distinct from “treatment records.” Treatment records are defined in post-secondary institutions as those made or maintained by a physician, psychiatrist, psychologist, or other recognized professional acting in his or her professional capacity and in connection with treatment of a student at the institution. By definition, these records may be disclosed only to individuals providing treatment to the student (not even to the student him or herself), unless the student provides written consent or an exception applies. Once a disclosure is made to anyone other than the student’s treating clinicians, the record is no longer considered a treatment record, but rather an education record subject to FERPA’s general disclosure rules.
As noted above, there are instances in which a school may disclose both education and treatment records even when the student does not provide written consent. Examples include:

- For the legitimate educational interests of other educational institutions;
- To make financial aid determinations;
- To authorized representatives of the United States government;
- To parents of dependent students;
- To comply with a judicial order or lawfully issued subpoena;
- If the educational institution initiates legal action against a parent or student; and
- If a parent or student initiates legal action against the educational institution.

HIPAA, the federal privacy law applicable to most medical records, prohibits the use and disclosure of protected health information (PHI) by covered entities (e.g., clinicians and health care facilities) absent written patient authorization, unless an exception applies. Common exceptions include:

- Treatment (including disclosure of information to other health care providers);
- Payment;
- Health care operations (including for litigation purposes where the covered entity is a party to the proceedings);
- For public health purposes;
- To authorized representatives of the United States government;
- To parents of minors; and
- To comply with a judicial order or lawfully issued subpoena.

DISCUSSION

Both HIPAA and FERPA permit disclosure of medical information without a patient’s written authorization for certain purposes. Specifically, with respect to disclosures for legal proceedings, HIPAA requires that a covered entity disclose only the minimum amount of information necessary to accomplish the intended purpose of the disclosure. Guidance from the U.S. Department of Education also notes that “without a court order or written consent, [educational] institutions that are involved in litigation between the institution and the student should not share, without consent, student medical records with the institution’s attorneys or courts unless the litigation in question relates directly to the medical treatment itself…and even then should disclose only those records that are relevant and necessary to the litigation.” This guidance also notes that “FERPA’s school official exception to consent should be construed to offer protections that are similar to those provided to medical records in the context of litigation between a covered health care provider, such as a hospital, and a patient under [HIPAA].”

CONCLUSION

The patient should always be at the center of any privacy policy adopted by the AMA, and indeed, the AMA has strong policy protecting the privacy of patient information, included in the appendix. Regardless of the clinical care setting, whether it is an educational setting, a substance abuse clinic, or a physician’s office, the AMA should continue to advocate for HIPAA’s privacy protections to be the minimal level of privacy afforded to a patient. This position will permit more stringent privacy laws for patients where appropriate—for example, more protective state laws or federal laws, such as 42 CFR Part 2, which protects patients who seek treatment at substance abuse facilities. The AMA should also continue to ensure that any information disclosed without a
patient’s written consent is the minimum necessary to accomplish the disclosure’s intended purpose.

RECOMMENDATIONS

The Board of Trustees recommends that 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)

Fiscal Note: Less than $500.
REFERENCES

1 34 CFR 99.3; 20 USC 1232g(a)(4)(B)(iv).
2 34 CFR 99.30, 20 USC 1232g(b); 20 USC 1232g(d).
3 34 CFR 99.3; 20 USC 1232g(a)(4)(B)(iv).
4 34 CFR 99.3; 20 USC 1232g(a)(4)(B)(iv).
6 34 CFR 99.31; 20 USC 1232g(b).
7 45 CFR 164.502(a).
8 45 CFR 164.502(b); 45 164.514(d); see also “May a covered entity that is a plaintiff or defendant in a legal proceeding use or disclose protected health information for the litigation?”, available at www.hhs.gov/hipaa/for-professionals/faq/705/may-a-covered-entity-in-a-legal-proceeding-use-protected-health-information/index.html, accessed February 25, 2018.

APPENDIX — AMA POLICY

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.
2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.
3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients,
physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.

4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.

5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.

6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.

7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.

8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.

9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.

10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.

11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures.

12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.
13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.

14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.

15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.

16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.

17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.

18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.

19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.

20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.

Policy H-320.994, “Confidentiality”
Our AMA believes that: (1) there has been an erosion of the confidential relationships between the patient and health professional, which has resulted from growing outside demands for the information shared in this relationship for the purpose of patient care; (2) there is a need to sensitize the public to the intrusions into confidential medical information which can result from increased demands for accountability - in substantiating health insurance claims, in litigation, and in medical care evaluation; (3) much of the erosion has emanated from the public, and properly so; however, an over-emphasis on society's right to know, at the expense of the individual's right to privacy and confidentiality, has resulted and a better balance is needed; (4) one important contribution to restoring such balance would be greater education of patients and the public as to the full range of purposes for which confidential information is used, the policies governing the release of such information, and the individual's rights with respect thereto.

Policy H-315.975, “Police, Payer, and Government Access to Patient Health Information”
1. Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, to define "health care operations" narrowly to include only those activities and functions that are routine and critical for general business operations and that cannot reasonably be undertaken with de-identified information.

2. Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that the Centers for Medicare & Medicaid Services (CMMS) and other payers shall have access to medical records and individually identifiable health information solely for billing and payment purposes, and routine and critical health care operations that cannot reasonably be undertaken with de-identified health information.

3. Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that CMMS and other payers may access and use medical records and individually
identifiable health information for non-billing, non-payment purposes and non-routine, non-critical health care operations that cannot reasonably be undertaken with de-identified health information, only with the express written consent of the patient or the patient's authorized representative, each and every time, separate and apart from blanket consent at time of enrollment.

4. Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation that no government agency, including law enforcement agencies, be permitted access to medical records or individually identifiable health information (except for any discretionary or mandatory disclosures made by physicians and other health care providers pursuant to ethical guidelines or to comply with applicable state or federal reporting laws) without the express written consent of the patient, or a court order or warrant permitting such access.

5. Our AMA continues to strongly support and advocate a minimum necessary standard of disclosure of individually identifiable health information requested by payers, so that the information necessary to accomplish the intended purpose of the request be determined by physicians and other health care providers, as permitted under the final privacy rule.

Policy H-60.965, “Confidential Health Services for Adolescents”
Our AMA: (1) reaffirms that confidential care for adolescents is critical to improving their health; (2) encourages physicians to allow emancipated and mature minors to give informed consent for medical, psychiatric, and surgical care without parental consent and notification, in conformity with state and federal law; (3) encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care; (4) urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements); (5) encourages physicians to offer adolescents an opportunity for examination and counseling apart from parents. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician; (6) encourages state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis; (7) urges undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law and implementation into practice; (8) encourages health care payers to develop a method of listing of services which preserves confidentiality for adolescents; and (9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care.

Policy H-315.965, “Modernizing Privacy Regulations for Addiction Treatment Records”
Our AMA supports: (1) regulatory and legislative changes that better balance patients’ privacy protections against the need for health professionals to be able to offer appropriate medical services to patients with substance use disorders; (2) regulatory and legislative changes that enable physicians to fully collaborate with all clinicians involved in providing health care services to patients with substance use disorders; and (3) continued protections against the unauthorized disclosure of substance use disorder treatment records outside the healthcare system.
Subject: Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care

Presented by: Gerald E. Harmon, MD, Chair

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

INTRODUCTION

At the 2017 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy D-120.935, “Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care,” which directed the AMA to:

(1) Take steps to implement AMA Policies H-120.947 and D-35.981 that prescriptions must be filled as ordered by physicians or other duly authorized/licensed persons, including the quantity ordered.

(2) Work with pharmacy benefit managers, payers, relevant pharmacy associations, and stakeholders to:

   (a) Identify the impact on patients of policies that restrict prescriptions to ensure access to care and urge that these policies receive the same notice and public comment as any other significant policy affecting the practice of pharmacy and medicine, and

   (b) Prohibit pharmacy actions that are unilateral medical decisions; and

(3) Report back at the 2018 Annual Meeting on actions taken to preserve the purview of physicians in prescription origination.

This report summarizes actions that the AMA has taken to preserve physician autonomy, highlights relevant AMA policy, and presents policy recommendations. Because the intent of the resolution and reference committee testimony primarily focused on situations related to the prescribing and dispensing of opioid analgesics, this report will similarly focus on that issue.

DISCUSSION

The AMA has been working closely with the nation’s leading pharmacy and pharmacist organizations for years in support of the therapeutic triad, that is, working to enhance the collaborative roles of physicians, pharmacists and patients to help ensure safe and appropriate medication use. With respect to prescriptions for opioid analgesics, the AMA began receiving increasing reports about pharmacists contacting physicians to request additional information about patient prescriptions for controlled substances (before they would authorize dispensing) as far back as 2013. In response, the AMA and the National Association of Boards of Pharmacy organized a
series of discussions with multiple stakeholders designed to increase awareness of factors
contributing to these types of requests and to improve communication channels. Participating
organizations included:

- American Academy of Family Physicians
- American College of Emergency Physicians
- American Medical Association
- American Osteopathic Association
- American Pharmacists Association
- American Society of Anesthesiologists
- American Society of Health-System Pharmacists
- Cardinal Health
- CVS Health
- Drug Enforcement Administration
- Federation of State Medical Boards
- Healthcare Distribution Management Association
- National Association of Boards of Pharmacy
- National Association of Chain Drug Stores
- National Community Pharmacists Association
- Pharmaceutical Care Management Association
- Rite Aid
- Walgreen Co.

The stakeholders initially met in October 2013, and subsequently met numerous times over the
course of 2013 and 2014 to better understand the shared responsibilities of physicians and
pharmacists to ensure that all controlled substances are prescribed and dispensed for a legitimate
medical purpose. The stakeholders’ focus began with a review of a key provision within the
Controlled Substances Act, which provides:

A prescription for a controlled substance to be effective must be issued for a legitimate
medical purpose by an individual practitioner acting in the usual course of his professional
practice. The responsibility for the proper prescribing and dispensing of controlled
substances is upon the prescribing practitioner, but a corresponding responsibility rests with
the pharmacist who fills the prescription. An order purporting to be a prescription issued not
in the usual course of professional treatment or in legitimate and authorized research is not a
prescription within the meaning and intent of section 309 of the Act (21 U.S.C. 829) and the
person knowingly filling such a purported prescription, as well as the person issuing it, shall
be subject to the penalties provided for violations of the provisions of law relating to
controlled substances.¹ (emphasis added)

Participants engaged in a constructive dialogue and ultimately agreed and released a consensus
statement (signed by nearly all of the organizations) about the challenges that physicians and
pharmacists face in trying to understand and resolve “red flags” that may be apparent, and a
broader array of aberrant behaviors that may manifest and raise concerns among physicians.
Commonly agreed upon “red flags” have been constructed out of U.S. Drug Enforcement
Administration (DEA) administrative actions and most are obvious, such as a clearly forged
prescription or multiple people from out-of-state presenting prescriptions for large quantities of
high-dose opioid analgesics. However, some behaviors (e.g., slurred speech, exhibiting signs of
intoxication) or specific features of the prescription including drug combinations may raise
questions for the pharmacist that may be unresolvable without obtaining further information from
the prescribing physician. In these cases, the organizations agreed that inter-professional dialogue was essential to resolve questions to the patient’s benefit.

Stakeholders shared the consensus statement widely with the intent of increasing understanding of the shared legal responsibilities of physicians and pharmacists for controlled substance prescriptions. Subsequently, when the AMA received complaints from state medical societies or individual physicians, staff have enabled on multiple occasions direct collaboration between a retail pharmacy and the state medical society to investigate and intercede with the individual pharmacist or prescriber when necessary. An overarching goal is to ensure that legitimate inquiries by a pharmacist about a patient’s diagnosis or medical history that are necessary to fulfill their corresponding legal responsibility are not perceived as intrusive or unnecessary, and to foster communications that can help resolve potential contraindications and/or provide physicians with relevant information in a patient’s prescription history about which the physician may not be aware. Without question, such discussions can sometimes be challenging.

Publication of the Centers for Disease Control Guideline For Prescribing Opioids For Chronic Pain (CDC Guidelines) in March 2016, has changed the regulatory and clinical practice environment and led to new challenges for pain management and opioid prescribing, including the likelihood that some patients will have their prescriptions for opioid analgesics dispensed as written. Two of the CDC Guideline’s recommendations—which were developed as voluntary guidance and not a bright line threshold, according to CDC—make specific reference to prescriptions above a certain morphine milligram equivalent amount (Recommendation 5) and above a certain quantity (or days’ supply) (Recommendation 6). In comments to the CDC during the review period, the AMA expressed specific concerns about the unintended consequences of such thresholds—highlighting that future payer and legislative actions would likely align with the CDC Guidelines in ways that would not be patient centric.

Since the publication of the CDC Guidelines, more than 20 states have enacted opioid prescribing limits that include specific dose and/or quantity thresholds. What is notable is that nearly every state prescribing restriction is different, although most purport to have exceptions for patients with cancer; those who are in hospice or receiving palliative care; at end of life; or when the opioid is part of a treatment regimen for a substance use disorder. Furthermore, it is notable that opioid prescribing appears to have reached its zenith in 2012 (259 million prescriptions) with modest decreases every year since yielding a cumulative 17 percent decrease, between 2012 to 2016 (215 million prescriptions). It is beyond the scope of this report to analyze the lack of correlation between decreased opioid prescribing and increased opioid-related mortality, but the AMA remains deeply concerned that policymakers’ focus continues to be on reducing opioid supplies, with little or no emphasis on increasing access to multidisciplinary pain care, including non-opioid, and non-pharmacologic alternatives.

In addition to state laws that govern prescribing behavior, there has been significant activity by payers, pharmacies, and pharmacy benefit managers (PBMs) to adopt and implement opioid prescribing restrictions based on CDC Guidelines, including new policies in 2017 from the nation’s largest PBMs, CVS Caremark, Express Scripts, and Optum. This is in addition to prescription review policies that were previously implemented by pharmacies. Many payers also have instituted new prior authorization policies based on CDC Guidelines, including many state Medicaid plans, Blue Cross Blue Shield plans, and plans sponsored by United Health Care, Anthem, Aetna, Cigna, and others. In each case, the pharmacies, PBMs, and payers affirm their commitment to ending the opioid epidemic through increased vigilance regarding opioid prescribing, and many of the plans have touted their success in reducing opioid prescribing. The Board notes that the inevitable effect of any statutory, regulatory or other policy to restrict a practice will, in fact, lead to such a
restriction. What is less clear, however, is whether the restrictive policies have had a concomitant
effect of improving patients’ pain care, or (and beyond the scope of this report) whether those
policies have helped identify patients at risk of overdose and referred them to treatment for a
potential substance use disorder.

The AMA continues to work with pharmacy associations and business entities, including asking
the central question about whether the new policies are helping patients. The actions by
pharmacies, is in addition to legislative and regulatory activity limiting quantity and dose of opioid
analgesics, and in some cases, benzodiazepines. While the AMA remains concerned by actions to
apply one-size-fits-all solutions to the opioid epidemic, we are cognizant that many state medical
societies have been deeply engaged in the legislative process to help craft the resulting laws.
Pharmacy, PBM, and payer policies, however, have not received the benefit of public notice or
comment.

When comment is sought—such as through the federal government—the AMA makes its concerns
clear. One of the most recent examples was in response to the Centers for Medicare & Medicaid
Services (CMS) request for comment on a new electronic quality measure (eCQM) focused on the
degree of potential opioid overuse, and using 90 morphine milligram equivalents as the quality
measure standard, the AMA on February 9, 2018 emphasized:

Identifying those patients for whom opioid prescriptions exceed $\geq 90$ morphine milligram
equivalents (MME)/day may serve as an indicator of whether a patient is at risk of overdose
and should be co-prescribed naloxone, but the AMA believes that significant revisions and
testing are required prior to implementing this measure in any federal program. The measure
as constructed implies that patients who do not receive $\geq 90$ MME/day over a 90-day period
receive higher quality care. We do not believe that the measure, with its broad denominator
population and limited exclusions, adequately captures the recommendations from the
CDC. The recommendations allow for physicians to document a clinical rationale or
justification when 90 MME/day is exceeded; yet, the measure does not capture if a
justification exists nor does it provide a well-defined and targeted denominator.

While it is not yet known when CMS will publish the final measure, the AMA has and will
continue to stress the need for clinical decisions to have a clear rationale informed by the best
available evidence. Furthermore, use of the CDC Guidelines in this manner is also inconsistent
with the intended use of the Guidelines.

For example, the CDC Guidelines states:

Clinical decision making should be based on a relationship between the clinician and patient,
and an understanding of the patient’s clinical situation, functioning, and life context. The
recommendations in the guideline are voluntary, rather than prescriptive standards. They are
based on emerging evidence, including observational studies or randomized clinical trials
with notable limitations. Clinicians should consider the circumstances and unique needs of
each patient when providing care.

Additionally, the AMA has actively engaged with multiple pharmacies, public health, and other
organizations to advance policies increasing access to naloxone. It should be noted that the Board
and AMA Council on Legislation first approved AMA model state legislation, the Help Save Lives
from Overdose Act, in 2013, and revised and updated the model bill in subsequent years. In
partnership with more than two dozen state medical societies, pharmacy associations, and other
stakeholders ranging from the Federation of State Medical Boards, National Association of Boards
of Pharmacy, Walgreens, CVS, National Governors Association, and many others, the AMA model bill—or similar versions—are now law in every state in the nation. This type of collaborative effort has undoubtedly saved tens of thousands of lives. At the same time, the AMA continues to hear reports that some patients may not be able to afford naloxone due to the cost, lack of awareness of patient assistance programs or the ongoing stigma associated with naloxone. The AMA will continue to work to address these barriers to care so that when a patient needs access to naloxone, it will be available.

The AMA also has engaged in efforts by the National Association of Insurance Commissioners (NAIC) to revise their model legislation on the pharmacy benefit. AMA staff worked closely with other stakeholders, including many consumer and patient organizations, to advocate for the need to regulate utilization review (e.g. pharmacy benefit managers) that delay or decrease access to patient care and stand in the middle of the patient-physician decision making process. Additionally, AMA staff sought provisions that prevented continual formulary changes and other cost-saving tactics by payers that undercut physicians’ ability to ensure patients receive appropriate care. While many positive provisions supported by the AMA were incorporated into the final NAIC model, much work remains to be done as state legislatures consider pharmacy benefit regulations.

As such, the AMA has developed model legislation to address the issues of prior authorization, step therapy and other utilization management programs that have regularly impeded the practice of medicine by physicians, and just this year alone, is working with nearly a dozen state medical societies on state bills.

Additionally, over the last year the AMA has assembled a multi-stakeholder group that created a set of highly cited and widely distributed principles on utilization management reforms, all aimed at right-sizing payer involvement in patient care. In addition to policy discussions and changes that these principles have informed, they also served as the basis for a recent consensus statement among the American Medical Association, Blue Cross Blue Shield Association, America’s Health Insurance Plans, American Pharmacists Association, American Hospital Association, and Medical Group Management Association on the need to reform prior authorization programs and processes.

More broadly, the AMA also has engaged with the National Association of Insurance Commissioners and others to support notification of patients and physicians before a health insurance company or PBM may change a patient’s prescription. This situation often occurs as a PBM restricts a formulary during a patient’s plan year. In 2017, two of the nation’s two largest pharmacy benefit managers – Express Scripts and CVS/Caremark, which set the coverage for many health insurers – continue to aggressively remove medications from their formularies.

When health insurers or PBMs decide to exclude certain products, or increase the patients’ cost-sharing, patients are forced to switch to a new medication, which may or may not be as effective. And if the patient wishes to continue taking the medication that he or she used to stabilize a medical condition, the off-formulary cost may not be affordable – and it will not count towards the patient’s deductible. These types of forced-switching and increased patient cost-sharing are associated with declines in medication adherence, which in turn can lead to poorer patient health outcomes. In some cases, patients are forced to choose between necessary treatments and decisions such as expenses for food or shelter.

For physicians and patients, when a prescription for an opioid analgesic—or any other medication—is denied at the pharmacy counter, there may be multiple reasons. In some cases, as described above, the health insurance company or the PBM may be applying a hard edit associated with limits based on the CDC Guidelines. In other cases, it may be the pharmacy chain policy that
determines what the pharmacist may dispense. In these situations, the pharmacist is placed in the
difficult position of having to inform the patient, and often, the physician, that the original
prescription will not be filled. In other cases, also described above, the pharmacist may
determine—per his or her lawful exercise of the pharmacist’s corresponding responsibility—that
the prescription was not issued for a legitimate purpose in the usual course of professional practice.

In these situations, if the pharmacist communicates with the physician to determine how to
proceed, this will take time away from the physician’s practice and the pharmacist’s ability to help
more patients. The AMA supports physician-pharmacist interactions to ensure patient safety, but
in some cases, the decision has been taken out of the pharmacist’s control—frustrating the
physician, pharmacist and likely adversely affecting the patient. And even when the
communication from the pharmacist to the physician is to resolve important questions, there still
may be frustration due to having to take time away from patient care or return a call to the
pharmacy, which may result in the physician being placed on hold for an extended period—further
delaying and impeding patient care.

AMA POLICY

The AMA supports patients having access to the medications prescribed to them by their physician
without interference into the practice of medicine (H-120.947, “Preserving Patients’ Ability to have
legally Valid Prescriptions Filled”; D-35.981, “AMA Response to Pharmacy Intrusion Into Medical
Practice”). For controlled substances, this policy must be tempered with the recognition that
pharmacists share a corresponding responsibility that carries the same legal obligations and risks
for failure to comply. In addition, AMA policy states opposition to “pharmacists being given the
authority to initiate or modify prescription drug treatment except on a case by case basis at the
specific direction of a physician” (H-160.928, “Drug Initiation or Modification by Pharmacists”).
At the same time, the AMA recognizes that “cooperative relationships with law enforcement,
regulatory agencies, pharmacists, and other professional groups” are necessary to identify
situations where a person is attempting to obtain a prescription for fraudulent or otherwise illegal
means (H-95.990, “Drug Abuse Related to Prescribing Practices”). Similarly, AMA policy
“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” (H-95.932, “Increasing Availability of Naloxone”). It is worth
noting that AMA advocacy, including development of model state legislation based on Policy H-
95.932, has helped lead to enactment of naloxone access laws in all 50 states. AMA policy strongly
supports “private and public payers to include all forms of naloxone on their preferred drug lists
and formularies with minimal or no cost sharing.” (H-95.932, “Increasing Availability of
Naloxone”).

AMA policy is clear that health insurance carriers and PBMs must provide accurate information to
patients at the time when plans are put forward for review by consumers. (H-125.979, “Private
Health Insurance Formulary Transparency”). Furthermore, H-125.979 clearly states that “drugs
may not be removed from the formulary nor moved to a higher cost tier within the policy term.” In
addition, AMA policy supports “forbidding insurance carriers from making formulary deletions
within the policy term.” In the event that an insurer or PBM does make a change, AMA policy calls
for “notice of covered formulary alternatives to the prescriber promptly so that appropriate
medication can be provided to the patient within 72 hours.” As directed by our HOD, the AMA has
drafted model state legislation to accomplish these goals, and the AMA strongly urges state
medical societies to work with the AMA to introduce and enact the AMA model state legislation.
RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted and 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 evidence and clinical practice. (New HOD Policy)

3. That our AMA reaffirm Policy H-95.990, “Drug Abuse Related to Prescribing Practices,” which supports cooperative 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)

Fiscal Note: Less than $500.
REFERENCES


4 CDC Guideline For Prescribing Opioids For Chronic Pain, March 18, 2016. Available at https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

5 Recommendation 5 of the CDC Guideline states: “When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.”

6 Recommendation 6 of the CDC Guideline states: “Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed (recommendation category).”


Subject: Medical Liability Coverage Through the Federal Tort Claims Act  
(Resolution 214-A-17)

Presented by: Gerald E. Harmon, MD, Chair

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

At the 2017 Annual Meeting, the House of Delegates (HOD) referred Resolution 214-A-17, “Medical Liability Coverage Through the Federal Tort Claims Act,” for report back at the 2018 Annual Meeting. This resolution was introduced by the New York Delegation and asked:

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

This report provides background on Federal Tort Claims Act (FTCA) medical liability protections and the potential implications of expanding FTCA protection to all federal health insurance plans.

FEDERAL TORT CLAIMS ACT

Congress originally enacted the FTCA in 1946 to provide immunity to federal government employees from tort liability when acting within the scope of their work. Under the FTCA, a patient of a federally employed physician who alleges acts of medical liability cannot sue the provider directly but must instead file the claim against the United States government. The federal government acts as the primary insurer and reviews and/or litigates claims via the U.S. Department of Health and Human Services (HHS) or the Department of Justice.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) extended FTCA protection to certain health professionals at qualifying free clinics, recognizing that these centers rely on volunteers to provide health services to poor and underserved patients. The Affordable Care Act expanded the FTCA liability coverage to the clinic’s board members, officers, paid health professional staff, and certain health professional contract employees.

Currently, the only private physicians who are covered by the FTCA must provide free care at qualified clinics. These private physicians are volunteers and cannot accept any payment from any third party. The liability protections provided by the FTCA are strong and have ensured that physicians and other practitioners are not deterred from volunteering their services at free clinics.

To be eligible for this comprehensive protection, private physicians must comply with explicit statutory requirements. Specifically, the clinic must be operated by a nonprofit entity, not accept reimbursement for providing health care services from any third-party payor (but may accept voluntary donations), and only impose charges on patients according to their ability to pay.

Similarly, the professional must be appropriately licensed or certified, may not receive
compensation from the patients directly or from any third-party payor, and must provide patients with written notification of the limited liability prior to providing services.

DISCUSSION

The existing medical liability system continues to drain health care resources that could be devoted instead to improving quality of care and access for patients. Additionally, medical liability places many physicians at unnecessary emotional, reputational, and financial risk. While expanding FTCA coverage for all physicians who participate in federal health care programs may alleviate high medical liability insurance premiums in certain states, such a broad expansion of the federal government’s sovereign immunity would overall have large consequences across the practice of medicine and could conflict with existing, long-standing, and successful AMA policy on medical liability reform. Based on Medicare alone, Resolution 214-A-17 would impact almost 90 percent of the practicing physicians in the United States.\(^1\) In addition, this protection would cover 37 cents of every dollar of health expenditures in the United States.\(^2\)

Under Resolution 214-A-17, physicians would have no control over the direction of a medical liability case involving a Medicare, Medicaid, or other federal health insurance patient. In a FTCA case, the federal government represents the physician. Thus, physicians would have no choice as to what attorney represents their medical liability case and no ability to decide whether a case goes to trial or is settled, and, in turn, reported to the National Practitioner Data Bank (NPDB). Any court judgments or settlements resulting from medical liability cases are reviewed by HHS’ Medical Claims Review Panel and are reportable to the NPDB. The Panel is a peer review group of federal employees that includes medical staff from HRSA and other HHS agencies and is responsible for: (1) making a final determination as to whether the standard of care was met or not met; and (2) identifying the clinician(s) who provided the treatment giving rise to the claim. If the Panel determines the standard of care was not met, the named practitioner(s) will be reported to NPDB.

Currently, in the private sector, FTCA coverage only applies to health care providers who provide free care at certain facilities, which is supported by AMA policy.\(^3\) Neither the health care provider nor the institution can receive any third-party reimbursement for services rendered (e.g., public or private health insurance). The congressional intent behind expanding the FTCA to these health care providers was to increase the funds available to free clinics without increasing their budgets in order to provide more free care to patients and to encourage volunteerism.\(^4\) In expanding FTCA coverage to all federal health insurance patients, maintaining the requirement of providing free care and not accepting any payment from any health insurance would be impractical for many physicians. Alternatively, allowing for reimbursement from insurance and FTCA protection would be a significant departure from previous federal policymakers’ intent in expanding access to free care and to promote volunteerism. Moreover, such Medicare reimbursement may be decreased because the physician fee schedule payment rate formula includes a Malpractice Resource Value Unit which is intended to reflect the costs of liability insurance.

Resolution 214-A-17 may conflict with AMA policy on medical liability reform. Existing AMA policy is focused on supporting initiatives implementing reforms based on California’s Medical Injury Compensation Reform Act (MICRA)\(^5\) and additional reforms like certificate of merit and expert witness requirements. Moreover, AMA policy expressly states that the AMA “actively oppose” any federal initiatives that endanger state-based reform.\(^6\) Thus, if expanding the FTCA to cover all physicians who participate in Medicare, Medicaid, and all federal health insurance plans endangers state-based reform efforts, AMA policy would lead the AMA to actively oppose such a federal initiative. In allowing for the federal government’s sovereign immunity to pass through to virtually all private physicians, state-based reforms may be endangered. Given that the FTCA
requirements include both federal and state administrative and legal requirements, there is a
substantial risk that applying the FTCA to any health care services that are federally funded could
undermine comprehensive medical liability reforms at the state level. For example, any state
procedural or evidentiary rules could be superseded by the Federal Rules of Civil Procedure and
the Federal Rules of Evidence. Thus, a state evidentiary rule that makes a physician’s apology to a
physician inadmissible in that state’s courts may not apply to a FTCA case and the apology could
be introduced into evidence.

Even if states or individual physicians can opt-out of FTCA coverage, there could still be negative
consequences. If a medical liability case involves an opted-out physician and a FTCA-covered
physician, the federal government can bar the FTCA-covered physician from testifying to any
aspect of the case. Finally, there is no evidence that reflects that physicians and patients would be
better off under the universal application of the FTCA than under comprehensive state medical
liability reforms like California’s MICRA or Texas’ similar law.

The Board has previously considered this issue. At the 2009 Annual Meeting, Resolution 226-A-09,
“Revision of the Federal Tort Claims Act,” also introduced by the New York Delegation, was
referred to the Board for decision. Similar to 214-A-17, the resolution asked our AMA to act on the
proposal to extend the FTCA to any claim and/or health care service that is funded in whole or in
part by federal funds (e.g., Medicare, Medicaid, etc.). The Board considered the resolution at its
November 2009 meeting and decided, in lieu of adopting Resolution 226-A-09, to issue an
informational report (Board Report 24-A-10, “Revision of Federal Tort Claims Act”) explaining the
implications of a broad application of the FTCA. The Board concluded:

There is no evidence, however, that universal application of the FTCA will reduce the filing
of meritless cases. In addition, expansion of the jurisdiction of the FTCA could undermine
effective medical liability reform already in place in certain states, including California and
Texas. An alternative to widespread application of the FTCA would be to assess the benefits
of extending FTCA coverage through demonstrations at the state level or in particular
settings such as federally qualified health centers.

Since this report, there remains no evidence that universal application of the FTCA will reduce the
filing of meritless cases.

Furthermore, at the 2011 Annual Meeting, Resolution 204-A-11, “Sovereign Immunity for
EMTALA-Related Care,” was referred to the Board for decision. This resolution called for FTCA
coverage for EMTALA mandated care. Similar to Resolution 226-A-09, there was mixed
testimony weighing the potential benefits of FTCA coverage against the potential negative effects
for physicians, including loss of control over settlement decisions and increased NPDB reporting.
The Board considered Resolution 204-A-11 at its November 2011 meeting and decided to amend
policy D-130.971, “The Future of Emergency and Trauma Care,” by adding a statement that our
AMA will “support demonstration programs to evaluate the expansion of liability protections under
the Federal Tort Claims Act for EMTALA-related care.” Since this decision, there have been no
demonstration programs implemented.

The Board believes that the AMA, along with the state and specialty medical associations, should
continue to pursue both traditional and innovative medical liability reforms to strike a reasonable
balance between the needs of patients who have been harmed and the needs of millions of
Americans who need affordable, accessible medical care. Traditional reform includes efforts at
both the state and federal levels to enact or maintain reasonable limits on subjective non-economic
damages. Innovative reforms include concepts like health courts, early disclosure and compensation models, expert witness guidelines, and affidavits of merit.

Given the lack of evidence that the application of the FTCA will benefit physicians, the Board concludes that Resolution 214-A-17 should not be adopted. If an FTCA coverage demonstration program were to occur that could show that FTCA coverage would benefit physicians, current AMA policy would support such a demonstration program as an innovative medical liability reform.

RECOMMENDATION

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

Fiscal Note: None.

REFERENCES

2 CMS, National Health Expenditures Accounts (2016). Total national health expenditures (which includes out of pocket expenses) for 2016 totaled $3,337,348,000,000. Resolution 214-A-17 calls for FTCA protection under Medicare, Medicaid, and other federal health insurance expenditures. We interpret “other federal health insurance” to include CHIP. We did not include the Federal Employees Health Benefits program because it is considered private insurance and did not include Tricare or Champva because the majority of the physicians providing care receive FTCA protection as federal employees. Medicare, Medicaid, and CHIP health expenditures for 2016 totaled $1,254,526,000,000.
5 The MICRA model includes a limitation of $250,000 on non-economic damages, mandatory offset of collateral sources of plaintiff compensation, decreasing sliding scale regulation of attorney contingency fees, and periodic payment for future awards of damages.
7 45 C.F.R. Part 2.
8 AMA Policy H-435.978 (Federal Medical Liability Reform); AMA Policy H-435.967 (Report of the Special Task Force and the Advisory Panel on Professional Liability); AMA Policy D435.992 (Liability Reform); AMA Policy D-435.974 (Health System and Litigation Reform).

APPENDIX – CURRENT AMA POLICY

Policy D-435.969, “Liability Related to Referrals from Free Clinics”
That our American Medical Association will work with interested medical associations to enact state legislation that provides medical liability immunity, similar to the protections granted under the Federal Tort Claims Act (FTCA), to physicians who provide charity care in hospitals, offices, clinics or other health care settings to patients referred from free clinics.

Policy H-160.940, “Free Clinic Support”
Our AMA supports: (1) organized efforts to involve volunteer physicians, nurses and other appropriate providers in programs for the delivery of health care to the indigent and uninsured and underinsured through free clinics; and (2) efforts to reduce the barriers faced by physicians volunteering in free clinics, including medical liability coverage under the Federal Tort Claims Act, liability protection under state and federal law, and state licensure provisions for retired physicians and physicians licensed in other United States jurisdictions.

Policy H-435.978, “Federal Medical Liability Reform”
Our AMA: (1) supports federal legislative initiatives implementing the following medical liability reforms: (a) limitation of $250,000 or lower on recovery of non-economic damages; (b) the mandatory offset of collateral sources of plaintiff compensation; (c) decreasing sliding scale regulation of attorney contingency fees; and (d) periodic payment for future awards of damages; (2) reaffirms its support for the additional reforms identified in Report L (A-89) as appropriate for a federal reform vehicle. These are: (a) a certificate of merit requirement as a prelude to filing medical liability cases; and (b) basic medical expert witness criteria; (3) supports for any federal initiative incorporating provisions of this type would be expressly conditional. Under no circumstances would support for federal preemptive legislation be extended or maintained if it would undermine effective tort reform provisions already in place in the states or the ability of the states in the future to enact tort reform tailored to local needs. Federal preemptive legislation that endangers state-based reform will be actively opposed. Federal initiatives incorporating extended or ill-advised regulation of the practice of medicine also will not be supported. Effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform.

1. It is the policy of the AMA that effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform. The AMA's MICRA-based federal tort reform provisions include: (a) a $250,000 ceiling on non-economic damages, (b) the offset of collateral sources of plaintiff compensation, (c) decreasing incremental or sliding scale attorney contingency fees, (d) periodic payment of future awards of damages, and (e) a limitation on the period for suspending the application of state statutes of limitations for minors to no more than six years after birth.
2. Our AMA also supports federal reform to achieve: (a) a certificate of merit requirement as a prerequisite to filing medical liability cases; (b) statutory criteria that outline expert witness qualifications; and (c) demonstration projects to implement potentially effective alternative dispute resolution (ADR) mechanisms.
3. Our AMA supports medical product liability reform, applicable to the producers of pharmaceuticals and medical devices, as an important state and federal legislative reform objective. 4. Any health system reform proposal that fails to include MICRA type reform, or an alternative model proven to be as effective in a state, will not be successful in containing costs, providing access to health care services, and promoting the quality and safety of health care services. Under no circumstances would support for federal legislation be extended or maintained if it would undermine effective tort reform provisions already in place in the states. Federal preemptive legislation that endangers effective state-based reform will be actively opposed.

Policy D435.992, “Liability Reform”
Our AMA: (1) in concert with a coalition for civil liability reform, shall develop a broad-based and sustained grassroots member mobilization campaign to communicate its call for immediate
legislative relief from the current tort system to our congressional representatives and senators; (2) will work for passage of significant legislation in both houses of the US Congress on liability reform in this congressional year; and (3) will work with state and national medical specialty societies to develop and implement a comprehensive strategic plan that will address all aspects of the growing medical liability crisis to ensure that federal medical liability reform legislation continues to move forward through the legislative process.

Policy D-435.974, “Health System and Litigation Reform”
Our AMA will (1) press vigorously and creatively for inclusion of effective medical litigation reforms as part of the comprehensive federal health system/insurance reform debate now underway in Washington, DC; and (2) consider and, as necessary, negotiate with federal policymakers on a wide range of litigation reform policy options to gain inclusion of a remedy in the health system reform package. These options might include traditional tort reforms, recovery limitations similar to those of the Veterans Administration (VA) system, demonstration/pilot programs on alternate dispute resolution systems such as the VA model and health courts, and/or other effective options to preserve patient access to care.
INTRODUCTION

At the 2017 Interim Meeting Resolution 218-I-17, “Health Information Technology Principles,” was referred by the House of Delegates. Resolution 218-I-17, introduced by the Organized Medical Staff Section, asks the American Medical Association (AMA) to adopt and promote the development of effective electronic health records (EHR) in accordance with the following health information technology principles:

1. Whenever possible, physicians should have direct control over choice and management of the information technology used in their practices.
2. Information technology available to physicians must be safe (e.g., electronically secure, and in the case of distributed devices, physically so), effective, and efficient.
3. Information technology available to physicians should support the physician’s obligation to put the interests of patients first.
4. Information technology available to physicians should support the integrity and autonomy of physicians.
5. Information technology should support the patient’s autonomy by providing access to that individual’s data.
6. There should be no institutional or administrative barriers between physicians and their patients’ health data.
7. Information technology should promote the elimination of health care disparities.
8. The cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules on an ongoing basis; payments should ensure sustainability of such systems in practice.

This resolution was referred for report back at the 2018 Annual Meeting.

BACKGROUND

Health information technology (HIT), specifically EHRs, has been plagued with numerous usability, flexibility, and security issues that have negatively impacted the end-user experience. These issues have contributed to high levels of physician burnout and a diminished patient-physician relationship.¹⁻³ Physicians have been vocal about their frustration with these systems and their lack of input into the decision process when purchasing and implementing them in practice. To successfully implement and gain widespread adoption of HIT, physician input and buy-in is crucial.²,⁴
Data issues are commonly cited as a point of dissatisfaction. Physicians are often unable to find the data they need when they need it. It is also not delivered in a way that fits within their workflow or documentation procedures. Another common complaint is that their documentation practices are established in response to external drivers versus what is truly necessary and important to the care of the patient.1

Lack of interoperability is also a source of discontent for many physicians. This is a multifactorial, complex issue that involves cooperation and dedication from many key stakeholders including government, vendors, and health systems. Cost, competing priorities, and misaligned incentives contribute to barriers in achieving full interoperability across health care, negatively impacting the front-line of care.2

The AMA has been successful in making progress toward improving and advancing EHRs and HIT through advocating for policy and collaborating with stakeholders. This resolution proposes further allegiance to this work through formal adoption of clear and concise principles for technology-enabled solutions to ensure physician input is included in the development and use of HIT, specifically EHRs, to improve both the physician and patient experiences.3

AMA POLICY

The AMA is committed to working with federal and state agencies, policymakers, and other relevant stakeholders to improve EHRs and advance HIT. The AMA encourages physician involvement in defining, evaluating, and implementing EHRs for improved usability, access, and security (Policy H-480.971, “The Computer-Based Patient Record”).4

The AMA is steadfast in its efforts to improve EHR usability and enhance access to data for both physicians and patients. The AMA works with the Office of the National Coordinator for Health Information Technology (ONC) and EHR vendors to support interconnectivity and interoperability enabling the efficient and cost effective use and sharing of data across all care settings (Policy D-487.995, “National Health Information Technology”). The AMA also continues to support and encourage Congress to eliminate unnecessary data blocking to improve and expand the exchange of data (Policy D-478.972, “EHR Interoperability”).5

The AMA is committed to actively engaging with federal and state agencies, EHR vendors, and other stakeholder groups in their efforts to reduce the cost burdens often associated with EHRs. The AMA promotes EHR vendor cost transparency around implementation, maintenance, and interface production (Policy D-478.973, “Principles of Hospital Sponsored Electronic Health Records”). The AMA advocates for flexibility related to the adoption and use of HIT across versions and editions as to not cause disproportionate financial burden or penalization to physicians and practices (Policy D-478.996, “Information Technology Standards and Costs”). Additionally, the AMA supports legislation that provides positive incentives for physicians to acquire HIT (Policy D-478.994, “Health Information Technology”).6

DISCUSSION

Lack of physician voice in the development, evaluation, and implementation of HIT has contributed to high rates of physician dissatisfaction with HIT, specifically EHRs. Dissatisfaction among EHR end-users has contributed to physician burnout, a diminished patient-physician relationship, and unrealized cost savings.7
This resolution proposes eight HIT principles for the development of effective EHRs. The AMA released eight EHR usability priorities in 2014, many of which are closely aligned with the principles proposed in Resolution 218-I-17. These priorities were developed by the AMA Advisory Committee on EHR Physician Usability. Members included former president of the AMA Steven Stack, MD, chief medical information officers, practicing physicians, and medical professors. The priorities identified in 2014 by the AMA’s Advisory Committee on EHR Physician Usability are as follows:

1. Enhance physicians’ ability to provide high-quality patient care.
2. Support team-based care.
4. Offer product modularity and configurability.
5. Reduce cognitive workload.
6. Promote data liquidity.
7. Facilitate digital and mobile patient engagement.
8. Expedite user input into product design and post-implementation feedback.

These priorities outline and support the need for better usability, interoperability, and access to data for both physicians and patients. In addition, they reaffirm the importance of considering patient care and physician input in the build and implementation related to EHRs. The AMA works to advance these goals through key stakeholder engagement (i.e., EHR vendors, health systems, and researchers), advocacy, and education. The AMA actively promotes these priorities and several vendors, including athenahealth and MEDITECH, have publicly acknowledged how their products align with these priorities.

Furthermore, these priorities have guided the AMA in its advocacy efforts to adopt and promote the development of effective HIT. For example, these efforts are demonstrated in statutory and regulatory changes made by the federal government:

21st Century Cures Act
- Creating information blocking provisions against EHR vendors including an up to $1,000,000 civil monetary penalty;
- Requiring Certified EHR IT (CEHRT) to incorporate application programing interfaces (API);
- Requiring real-world testing of EHRs;
- Prohibiting restrictions on user communications about EHR usability, interoperability, security, and developer business practices;
- Requiring EHRs to exchange data with clinician-led clinical registries;
- Prompting patient access to their longitudinal health record; and
- Requiring the reduction of regulatory or administrative burdens (such as documentation requirements) relating to the use of EHRs.

ONC Enhanced Oversight and Accountability Rule
- Increasing federal oversight of EHR functionality post-certification.
- Holding health IT developers accountable to certification non-conformities including allowing for ONC corrective action plans and CEHRT certification suspension and/or termination.

ONC 2015 Edition Health IT Certification
- Requiring HIT vendors to disclose fees for EHR functions, including connecting to health information exchanges (HIE) and clinical registries;
• Increasing user-centered design (UCD), i.e., usability requirements, in CEHRT development; and
• Requiring HIT developers to use and test against advanced interoperability standards (which improves data liquidity).

The AMA’s robust research agenda drives its pursuit of a strong evidence base to inform industry-wide HIT innovation and the improvement of EHR development and implementation. The AMA in 2013 partnered with the RAND Corporation to study factors that affect physician professional satisfaction, which resulted in quantitative and qualitative evidence that EHRs are a major source of dissatisfaction for physicians. The AMA led a comprehensive time-motion study that demonstrated for every one hour of face-to-face time with patients, physicians spend nearly an additional two hours doing EHR and administrative deskwork. The AMA has also published multiple journal articles on the topic of EHRs and their contributions to physician dissatisfaction, burnout, and undue administrative burden. In addition to this established work, the AMA is currently collaborating with multiple partners to execute research planned for publication in 2018. These efforts include an observational study aimed at tracking physician actions during EHR use; an evaluation of barriers and facilitators to adoption of digital health solutions; and research aimed at identifying opportunities to improve the usability and safety of EHRs. The AMA will continue to pursue research to help stakeholders, including physicians, payers, regulators, health system leadership, and EHR vendors, make informed improvements to the EHR user experience.

In collaboration with the American Heart Association, HIMSS, and DHX Group, the AMA founded Xcertia in 2016. This collaboration is dedicated to developing guidelines that foster safe, effective, and reputable health technologies. Through engagement from a diverse group of industry stakeholders, Xcertia aims to reduce burden on providers/health care sponsors, give consumers confidence, and help technology developers bring better solutions to the market. Xcertia has already published preliminary guidelines covering four major areas—operability, privacy, security, and clinical content. As HIT solutions continue to evolve, the guidelines provided by Xcertia will be further developed to align with and be applicable to additional forms of HIT, resulting in an inclusive set of guiding principles.

The AMA has established partnerships with the SMART Initiative, AmericanEHR Partners, and Medstar Health’s National Center for Human Factors in Healthcare to help foster innovative HIT design and transparent testing solutions which will ensure EHRs are designed and implemented with physicians and patients in mind. In addition, the AMA actively participates in The Sequoia Project, Carequality, and the CARIN Alliance, all aimed at enhancing interoperability in health care. The AMA is also working to address specific cost drivers, such as connecting to clinical data registries and prohibitive fees that amount to data blocking. The AMA’s Physician Innovation Network is also connecting physicians and health tech entrepreneurs to ensure that the physician voice is integrated into health care technology solutions coming to market.

The AMA is the founder and sole shareholder of Health2047, a Silicon Valley-based innovation enterprise focused on developing and commercializing solutions in the areas of data liquidity, chronic care, productivity, and payments to significantly change U.S. healthcare at the system level. Building on initial work performed within Health2047, including a collaboration with Celgene Corporation, Health2047 created Akiri Switch, a newly spun-off company that will commercialize a blockchain-based private network that enables secure permissions-based sharing of health data among patients, physicians, providers, payers, pharma and other healthcare enterprises. Through this work the AMA further demonstrates its commitment to seeking out and developing HIT solutions for the future and long-term sustainability of health care.
The AMA’s eight EHR usability priorities provide clear and concise requirements for the development of effective EHRs, very similar to this resolution’s proposed principles for the development of effective EHRs. Principles one through five proposed in Resolution 218-I-17 closely align with the direction provided in these established priorities.

The sixth proposed principle states that in the development of effective EHRs “there should be no institutional or administrative barriers between physicians and their patients’ health data.” Administrative and institutional barriers most often stem from decisions made at the organizational level, not in the development of the EHR system. Therefore, it is not recommended that AMA adopt a principle that may misrepresent the extent to which EHR developers influence or control barriers that exist between users and their administrations or institutions.

The proposed principle seven states “information technology should promote the elimination of health care disparities.” Numbers one, three and seven of the eight established EHR usability priorities are “enhance physicians’ ability to provide high-quality patient care; promote care coordination; and facilitate digital and mobile patient engagement.” These priorities, if followed in the development of EHRs and other HIT, will enable the technology to support access to care, facilitate better patient interactions, and ultimately help address health care disparities. Since the proposed principle offers direction similarly provided in the priorities, it is not recommended to adopt this principle as separate policy.

Principle eight of this resolution asks the AMA to provide data that will convince payers to increase payment rates, essentially asking the AMA to take a position that payers are responsible for reimbursing physicians for the costs associated with implementing IT systems. Given the many facets of HIT implementation, systematic compilation of this data would be difficult given the complex state of payment models, ongoing changes with reimbursement, and variations in practice types and their unique IT needs and related costs. Additionally, the AMA previously elected to not adopt a similar resolution (813-I-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.

As evidenced by the preceding discussion, the AMA currently dedicates significant resources to improving usability, enhancing interoperability, and bringing value into EHRs and HIT. The AMA’s already established eight EHR usability priorities provide clear and concise requirements for the development of effective EHRs. In using these priorities, AMA has successfully advocated for the adoption and promotion of the development of effective EHRs as can be seen in the 21st Century Cures Act, ONC Enhanced Oversight and Accountability Rule, ONC 2015 Edition Health IT Certification, and in many other rules and guidance documents from the Department of Health and Human Services. Additionally, Xcertia is currently developing broader guidelines for health care technologies in the areas of content, usability, privacy, security, and operability, inclusive of many key stakeholders across the health technology landscape. Through its current work, the AMA recognizes the value of established standards and guiding principles for many aspects of health care. The AMA will continue its efforts to further develop research, content and guidance for physicians, and will regularly ensure those resources are relevant, timely, and easily accessible.
RECOMMENDATION

The Board of Trustees recommends that our American Medical Association adopt the following in lieu of Resolution 218-I-17, and the remainder of this report be filed:

1. That the following policies be reaffirmed:
   - H-480.971, “The Computer-Based Patient Record”
   - D-478.972, “EHR Interoperability”
   - D-478.973, “Principles for Hospital Sponsored Electronic Health Records”
   - D-478.994, “Health Information Technology”
   - D-478.995, “National Health Information Technology”
   - D-478.996, “Information Technology Standards and Costs” (Reaffirm HOD Policy)

2. That our AMA promote the development of effective electronic health records (EHRs) in accordance with the following health information technology (HIT) principles. Effective HIT should:
   1. Enhance physicians’ ability to provide high quality patient care;
   2. Support team-based care;
   3. Promote care coordination;
   4. Offer product modularity and configurability;
   5. Reduce cognitive workload;
   6. Promote data liquidity;
   7. Facilitate digital and mobile patient engagement; and
   8. Expedite user input into product design and post-implementation feedback. (New HOD 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)

Fiscal note: Modest – Between $1,000 - $5,000
REFERENCES

EXECUTIVE SUMMARY

Interest in augmented intelligence (AI) and its potential to dramatically impact medicine is growing rapidly among Congress, federal agencies, and other health care stakeholders. As a leader in American medicine, our American Medical Association (AMA) is uniquely positioned to ensure that the evolution of AI in medicine benefits patients, physicians, and the health care community. However, the AMA currently has no policy specifically on AI. This report proposes baseline policy to guide AMA’s engagement with a broad cross-section of stakeholders and policymakers to ensure that the perspective of physicians in various practice settings informs and influences the dialogue as this technology develops.

Ensuring the appropriate implementation of AI in health care will require that stakeholders forthrightly address challenges in the design, evaluation, implementation, and oversight of AI systems. Through its strategic partnerships and collaborations, the AMA has the capacity to help set priorities for health care AI; integrate the perspective of practicing physicians into the design, validation, and implementation of high-quality, clinically valuable health care AI; and promote greater understanding of the promise and limitations of AI across the health care community. A strong tradition of advocacy well positions our AMA to explore the legal implications of the emerging technologies of AI in health care and advocate effectively for appropriate professional and governmental oversight for safe, effective, equitable use of and access to health care AI.
A component of the American Medical Association’s (AMA) strategic work in 2018 and beyond is to provide the physician perspective across health care technology sectors by promoting improved usability of and productive access to data used in medical decision making as well as respect for the patient-physician relationship. As our AMA implements this component of its strategic plan, the Board of Trustees has observed a rapidly growing interest in augmented intelligence (AI) technology in health care. In 2018, the AMA Council on Long Range Planning and Development (CLRPD) provided the Board with a primer on the history, definitions and components, and the status of AI in health care that offered a high-level look at this rapidly evolving area and its potential to dramatically impact medicine. The AMA Council on Legislation (COL) and CLRPD have observed increased interest in AI by Congress, federal agencies, and other health care stakeholders. To form a clearer understanding of the expected impact of AI technologies for patients and physicians, as well as key stakeholders who are influencing legislation and regulation in this area, over the past 18 months the COL has met with physician experts immersed in the development and clinical integration of various health care AI technologies.

Both Councils have highlighted to the Board that current AMA policy does not specifically address AI. The Board determined that this gap in policy puts our AMA at a strategic disadvantage in the public debate on health care AI, and therefore strongly believes it is important for our AMA to adopt a base-level of policy on health care AI to guide AMA’s engagement with a broad cross-section of stakeholders and policymakers in order to ensure that the perspective of physicians in various practice settings informs and influences the dialogue as this technology develops.

WHAT IS HEALTH CARE AI?

Computational methods and techniques for data analysis have been evolving for decades [1,2]. A number of these methods have come to be known collectively as “artificial intelligence.” Artificial intelligence constitutes a host of computational methods that produce systems that perform tasks normally requiring human intelligence. These computational methods include, but are not limited to, machine image recognition, natural language processing, and machine learning. However, in health care a more appropriate term is “augmented intelligence,” reflecting the enhanced capabilities of human clinical decision making when coupled with these computational methods and systems.

In December 2017, Senators Maria Cantwell (D-WA), Todd C. Young (R-IN), and Edward Markey (D-MA) and U.S. Representatives John Delaney (D-MD) and Pete Olson (R-TX) introduced S. 2217/H.R. 4625, “Fundamentally Understanding the Usability and Realistic Evolution (FUTURE) of Artificial Intelligence Act of 2017.” The legislation defines “general AI” as computational methods that produce systems that exhibit intelligent behavior at least as advanced as a human across the range of cognitive, emotional, and social behaviors. In contrast, the bill
defines the term “narrow AI” as computational methods that address specific application areas, such as playing strategic games, language translation, self-driving vehicles, and image recognition. Thus, these AI methods and tools for the foreseeable future are better characterized as narrow AI that augments human intelligence (augmented intelligence).

At a February 2018 U.S. House of Representatives Government Oversight Committee Subcommittee on Information Technology hearing, three national experts testified that general AI is decades away and agreed AI is best characterized as augmented intelligence. Consistent with the foregoing, in response to a 2016 Request for Information on Artificial Intelligence issued by the White House Office of Science and Technology Policy, IBM stated that it is “guided by the term ‘augmented intelligence’ rather than ‘artificial intelligence’.” IBM noted further, “It is the critical difference between systems that enhance and scale human expertise rather than those that attempt to replicate all of human intelligence.” [3]

Software algorithms developed using these evolving methods and techniques, coupled with proliferating sources of data (datasets) pertinent to health and medicine, offer the promise of new and more powerful ways to augment human intelligence and expertise in health care.

The American College of Radiology (ACR), which has been at the leading edge of health care AI, addressed its promise in comments to the White House Office of Science and Technology Policy in 2016:

AI could offer various benefits to medical imaging in the future, including augmenting the capabilities of radiologists to enhance their efficiency and accuracy, as well as reducing costs by improving the appropriateness and cost-effectiveness of medical imaging utilization. The use of AI and machine learning in health care in general could be best applied to the areas of precision medicine, predictive analytics, and outcomes assessments. AI can streamline health care workflow and improve triage of patients (especially in acute care settings), reduce clinician fatigue, and increase the efficiency and efficacy of training. Moreover, shortages of medical experts to meet the needs of vulnerable and underserved populations in domestic and international settings could potentially be relieved, in part, by AI [4].

Prime AI applications include clinical decision support, patient monitoring and coaching, automated devices to assist in surgery or patient care, and management of health care systems [5]. AI in health care holds out the prospect of improving physicians’ ability to establish prognosis [6], as well as the accuracy and speed of diagnosis [6,7,8], enabling population-level insights to directly inform the care of individual patients [9], and predicting patient response to interventions [10]. The number of empirical studies of AI applications in medicine is growing rapidly [2].

WHAT’S NEXT IN HEALTH CARE AI?

Commercial entities, including IBM, Google, and others, are driving rapid evolution in AI across the board. In health care, the next three to five years will be marked by efforts to scale AI options involving patient-centered wearables that support clinical care, improved tools for diagnosis and physician training, and health system initiatives to improve patient care and clinical decision support [11]. The following are early examples of such efforts.

Wearable AI

Wearable monitoring devices that can transmit patient data are evolving rapidly. For example, one company has developed the Cardiogram application which is designed to work with the built-in
infrared heart rate sensor of the Apple Watch to detect hypertension and sleep apnea. In a study
 carried out with the University of California–San Francisco that involved over 6,000 patients, the
 application and its machine learning system, DeepHeart, was able to detect hypertension and sleep
 apnea with 82 percent and 90 percent accuracy, respectively [12]. Rapid innovation is expected on
 this front propelled by coverage of payers, including Medicare, of remote patient monitoring and
 management.

New Tools for Diagnosis and Physician Training

The utilization of machine learning algorithms to enhance clinical decision making is increasing,
 but emerging systems take such support a step further. For example, the Human Diagnosis Project
 (Human Dx), organized as a tandem 501(c)(3) nonprofit and public benefit corporation, and created
 with and led by the medical community, allows attending physicians to ask for assistance on
difficult medical cases from an online community of physicians all over the world. Responses from
the medical community are combined with help from machine learning to create a synthesized
collective assessment for each case. This collective insight is designed to augment clinical decision
making with machine intelligence, providing useful information to physicians and patients who
may not otherwise have access to specialist expertise. Human Dx also provides a platform for
medical education through its Global Morning Report teaching cases. Today, residents from over
40 percent of U.S. internal medicine residency programs have access to these cases. Human Dx
vets the quality of responses by comparing how physicians solve reference training cases in order
to calculate a quantitative measure of reasoning called Clinical Quotient, which is now being vetted
in conjunction with the Johns Hopkins School of Medicine.

Health Systems and Data Analytics

Applying AI to health system data to improve care is another area of rapid evolution. The
University of Pittsburgh Medical Center (UPMC) has launched a system-wide effort to reduce
hospital readmissions and enhance clinical decision making while a patient is receiving care.
UPMC has applied machine learning to claims data to predict a patient’s risk of readmission before
the patient arrives. A second algorithm uses laboratory and clinical metrics extracted from clinical
records to update the risk prediction every 15 minutes over the course of the patient’s admission.
Before discharge, if the risk prediction’s two models are in conflict, UPMC uses unsupervised
machine learning to come up with a set of rules that dictate which model takes precedence to
inform clinician discharge decisions [13].

These three relatively nascent efforts are designed to scale, but will require significant additional
research and real world testing. However, they illustrate the types of initiatives beyond condition-
specific efforts to enhance clinical decision support that could produce significant improvements in
health care. Notably, these efforts have active engagement and support of clinicians and seek to
address medical challenges and problems identified by clinicians.

FEDERAL ENGAGEMENT WITH AI

AI has surfaced as a public policy issue at the federal level in a relatively short period of time. In
2016, the White House Office of Science and Technology hosted several public meetings on a
range of public policy issues addressing AI along with a public request for information regarding
potential policy directions. In Congress, the U.S. Senate Commerce Committee held a hearing
titled “The Dawn of Artificial Intelligence” at which the Department Chair for Genomic Medicine
at MD Anderson Cancer Center highlighted the clinical applications of AI and discussed policy
implications.
Shortly thereafter, the 21st Century Cures Act was passed by Congress and became law in December 2016. The Act included provisions modifying the U.S. Food and Drug Administration’s (FDA) oversight of software as a medical device, which has implications for a number of current AI computational methods. The FDA is now actively evaluating whether a new oversight framework is needed for software as a medical device, a precursor to future oversight models.

The bipartisan “FUTURE of Artificial Intelligence Act,” introduced in December 2017, provides for the establishment of a Federal Advisory Committee on the Development and Implementation of Artificial Intelligence. The legislation, if passed, would be the first effort at the federal level to provide a forum for consideration of AI public policy. In 2018, additional legislation has been introduced, and additional congressional hearings held on AI generally, with health care applications receiving particular attention.

ACHIEVING THE PROMISE OF AI IN HEALTH CARE

Fulfilling the promise that “combining machine learning software with the best human clinician ‘hardware’ will permit delivery of care that outperforms what either can do alone” [14] will require that stakeholders forthrightly address challenges in the design, evaluation, implementation, and oversight of AI systems in health care. In the first instance, stakeholders across the board, not the least among them patients and physicians, must hold realistic expectations for the roles AI tools can and cannot play. Machine learning is only one of the AI computational methods and raises particularly thorny challenges. However, many of the public policy issues (including transparency and intellectual property) and clinical issues that will need to be addressed apply to other AI computational methods that are more common currently, such as natural language processing.

Designing and Evaluating Health Care AI

There is a popular tendency to see AI as, at best, a form of neutral, “objective” decision making, a pristine mathematical process that takes only “the facts” into account, independent of human judgment [15,16,17]. The statistical process of AI specifically seeks to derive a rule or procedure from a body of data that explains that data or is able to predict future data [18]. An AI derived algorithm “is only as good as the data it works with” [19,20]. The data sets on which AI algorithms are trained are created by human agents and are imperfect.

The research, patient care, and insurance records available as training data sets for health care AI can be highly variable, reflecting the different purposes for and processes by which they were created [1,21]. Clinical trials systematically include or exclude participants with certain characteristics; patient charts and insurance records capture information only from those individuals who have access to the health care system and rarely contain information about exposure to environmental toxins. Different data sets focus on different kinds of information to the exclusion of other possible data points, and records capture and preserve information with varying degrees of accuracy.

One of the most significant implications for end users of AI systems is that these systems sets can, invisibly and unintentionally, “reproduce and normalize” the biases of their training data sets [16,17]. In health care, the result can be models that “reflect the conditions only of the fortunate” and yield “an aggregate understanding of health and illness that fundamentally excludes the marginalized” [21] in a way that risks exacerbating existing health disparities. Minority populations can be disadvantaged in the context of AI systems in a second way as well in that “by definition, there is proportionately less data available about minority predictions,” while the accuracy of decision making, a proxy for fairness, will be higher for majority groups [17]. Addressing fairness
is essential, even if doing so may be costly for developers when it requires them to seek more complex decision rules [17].

Design issues also encompass how a model is evaluated, as well as relationships between the dataset used to train an algorithm and the dataset used to evaluate the algorithm. In the first instance, evaluation criteria must be clinically relevant and evaluation should be representative of how the algorithm will be applied in practice [22]. For example, evaluating a model to predict risk of hospital-acquired infection over the entire course of a patient’s admission more accurately predicts how the model would be used and would perform in practice [22]. For predictive models, developers must evaluate “how far in advance the algorithm identifies positive cases.” [22] From a clinician’s perspective, the critical concern is “predicting events early enough for a relevant intervention to influence care decisions and outcomes.” [14] Ensuring that all examples in the training dataset are earlier in time than all examples in the evaluation set helps avoid misleading results by limiting the possibility that training data could otherwise reflect structural changes in hospital population, clinical protocols, electronic health record (EHR) systems, or other factors that occurred over time [22].

Developers also have a responsibility to ensure that their work is transparent and can be reproduced by others [23,24]. Proposed guidelines for essential components of publications reporting development of predictive machine-learning algorithms include not only rationale and objectives, but, importantly, the setting, prediction problem, relevant data, and a description of the building of the predictive model [23]. Authors should also provide information about the final model and its performance, and discuss the clinical implications of the work, its limitations, and unexpected results. Scholars have further recommended creating open repositories for long-term storage, archiving, and access to datasets and code to enable replication of published findings [24].

Furthermore, the AMA’s work in the area of EHRs reveals that to be useful and accepted in practice, AI systems need to be developed and evaluated in keeping with best practices in user-centered design [25]. The focus must be on users’ needs and usability should be tested by participants who are demographically representative of end users [26].

**Health Care AI and Patient Privacy**

Commitment to protecting the confidentiality of patient information is central to medicine’s professional ethos. In this respect, AI poses a significant challenge where traditional strategies of notification and consent are no longer adequate [18]. Nor are anonymization, deletion of data, or distinguishing metadata sufficiently robust protections in the context of massive complex data sets [18,20] when machine-learning algorithms can identify a record “easily and robustly” from as few as three data points [20].

The ease of re-identification means that, in important respects, traditional expectations for health care privacy are simply no longer attainable. This significantly raises the bar on the task of ensuring the security and integrity of data. Among proposed technical solutions to the dilemma of privacy in large data sets are “blockchain-style” technology to secure data and track access or data auditing systems that allow secure verification of the contents of large data structures, such as those being explored by DeepMind Health in the UK [1]. Researchers at the University of Pennsylvania have explored the creation of publicly sharable simulated datasets that limit possible re-identification as another approach to protecting data privacy [27]. The recent revelation that the data mining firm Cambridge Analytica siphoned private data from 50 million Facebook users to target them for political campaigns raises confidentiality and privacy questions across the spectrum of digital platforms that collect and curate data. While this report establishes policy that
underscores the necessity to safeguard individuals’ privacy interests and preserve the security and integrity of personal information, the Board recognizes the importance of this issue and will continue to assess our policy as our AMA engages in the public debate and discourse on protecting patient information.

Implementing Health Care AI

The AMA’s ongoing engagement with digital health offers insights for understanding, from physicians’ perspectives, what is at stake in integrating AI systems into the delivery of health care. The organization’s recent survey of 1,300 physicians about barriers to adoption of digital health technologies suggests that physicians are most receptive to digital health tools they believe can be integrated smoothly into their current practice, will improve care, and will enhance patient-physician relationships [28]. Coverage for liability, assurance that data privacy is protected, linkage to their EHR, and billing/reimbursement are key considerations.

Earlier AMA research into physician professional satisfaction found that frustrations with EHRs, especially usability issues, were a major source of dissatisfaction in physicians’ professional lives [29]. The findings led the AMA to identify priorities for ensuring usability in EHR systems, including, among other considerations, ensuring that EHRs are designed to meet the cognitive and workflow needs of physicians, that they support team-based care, promote coordination of care, focus on reducing cognitive workload instead of focusing simply on data collection, and incorporate end user feedback into designing and improving EHR systems [25].

AMA policies addressing the use of telemedicine similarly stress the importance of minimizing disruptive effects on patient-physician interactions, ensuring that technologies promote quality of care and safety, and, importantly, establishing mechanisms to monitor the impact of an innovation both to identify and address adverse consequences and to identify and encourage dissemination of outcomes [30,31].

To reap the benefits for patient care, physicians must have the skills to work comfortably with health care AI. Just as working effectively with EHRs is now part of training for medical students and residents [32], educating physicians to work effectively with AI systems, or more narrowly, the AI algorithms that can inform clinical care decisions, will be critical to the future of AI in health care.

Physicians need to understand AI methods and systems sufficiently to be able to trust an algorithm’s predictions—or know how to assess the trustworthiness and value of an algorithm—as a foundation for clinical recommendations. The challenge may be more easily met with advances in “explainable AI,” that is, algorithms that can “explain” to users why a particular prediction is made [33,34]. Technology to predict the risk of 30-day readmission for cardiac patients being tested by Boston-based Partners Connected Health provides clinicians with a readmission prediction score and identifies the top factors contributing to that score, providing information that is actionable for clinicians [35].

A LEADERSHIP ROLE FOR AMA

To realize its potential to support improved patient care and health outcomes and enhance physician professional satisfaction, the health care AI enterprise should be informed and guided by the expertise, experience, and leadership of physicians and organized medicine in developing and implementing these tools. Physicians are well positioned to advocate for health care AI solutions that support healthier lifestyles and reduce disease burden, improve access to care, enhance
diagnostic accuracy, inform individually tailored treatment plans, and improve patient self-
management, adherence, and health outcomes. Physicians are likewise well placed to apply their
experience to drive improved design and implementation of health care AI that will strengthen
clinicians’ relationships with patients; enhance communication among the health care team and
between team members, patients, and family members; simplify the coordination of care; minimize
administrative burdens; and help the health care team to better deliver care to those patients and
populations in greatest need.

As a leading voice in American health care, the AMA is uniquely positioned to help ensure that
emerging technologies best serve the nation’s patients and physicians. In addition to the work of
COL and CLRPD, at the 2017 Interim Meeting all seven AMA councils met jointly with experts
from IBM Watson and HumanDx to discuss issues in health care AI. Likewise, the AMA’s
ongoing engagement with key stakeholders from across the spectrum of clinical care, health care
administration, implementation science, and AI product development enables the organization to
play a distinctive role in contributing to the overarching vision for health care AI in the U.S.

Through its strategic partnerships and collaborations, the AMA has the capacity to offer the insight
that is critical to the development of clinically sound AI systems that will enhance the quality of
care and sustain the integrity of patient-physician relationships. The AMA’s strong tradition of
advocacy positions the organization to promote meaningful oversight of AI as it is integrated into
clinical practice.

CONCLUSION

Patients, physicians, and the health care system in the U.S. face enormous challenges in the
combined impact of a rapidly aging population, a relative decline in the working population that
reduces revenue essential for safety net programs [36], and persistent high costs of care that will
strain the nation’s ability to support affordable, accessible, high quality care. With the engagement
of physicians to identify needs and set priorities for design, development, and implementation,
health care AI can offer a transformative set of tools to help patients, physicians, and the nation
face these looming challenges. Given the number of stakeholders and policymakers involved in the
evolution of AI in health care, it is important that our AMA not only adopt a base level of policy to
guide our engagement, but equally continue to refine our policy as an organization to ensure that
the perspective of physicians in various practice settings informs and influences the dialogue as this
technology develops.

RECOMMENDATION

In light of these considerations, your Board of Trustees 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)

Fiscal Note: $5000.
REFERENCES


Whereas, Obesity has been recognized by our AMA as a disease (AMA Policy H-440.842); and

Whereas, There are many evidence-based, effective and safe treatment options for obesity including intensive lifestyle intervention\(^1\),\(^2\),\(^3\), pharmacotherapy\(^4\), and surgery\(^5\); and

Whereas, Our AMA "will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions) (D-440.954);" and

Whereas, Weight-bias is a significant problem in our society, at the state and federal level, and even in our health-care system with most patients affected by obesity often being victims of weight-bias including from their health care provider (H-440.821); and

Whereas, Our AMA has recognized that medical education regarding evidence-based treatment is inconsistent and inadequate\(^6\); and

Whereas, Pharmacotherapy for obesity has been proven to safely and effectively double to triple the odds of losing 5-10% body weight, an amount that has been proven to prevent diabetes, improve blood pressure and decrease health care costs\(^7\); and

Whereas, Current state and federal regulations make it even more difficult for healthcare providers to provide treatment:

- Medicare does not allow payment for any anti-obesity medication (AOM) due to an out-of-date policy, which prohibits Medicare from covering any “drugs for weight loss or weight gain.”
  Medicare further restricts payment for intensive lifestyle intervention to primary care providers in the primary care setting. For this reason, this benefit is scarcely being used.
- Our AMA has already supported the Treat and Reduce Obesity Act (TROA)\(^8\) in the 114th Congress, and will continue to support the bill in the 115th congress, H.R. 1953/S. 830 – legislation that would eliminate the Medicare Part D prohibition on weight loss medications and allow other qualified health care providers such as registered dietitians and social workers to provide behavioral treatment.
- Most states allow physicians to utilize FDA medications for off-label uses to treat chronic conditions should these practices be viewed as within the standard of care for that

\(^2\) Centers for Medicare and Medicaid Services (CMS), November 29\(^{\text{th}}\), 2011
\(^4\) https://doi.org/10.1210/jc.2015-1782, accessed 1/15/2018
\(^6\) Counsel on Medical Education Report CME-3, Obesity Education at a17
condition. However, this is not the case in some areas of the country regarding off-label prescribing for AOMs⁹,¹⁰. For example, some older drug labels state that the medications are for “short-term” use only, which is now inconsistent with what we know about the chronic nature of obesity. It has been proven that treatment is only effective so long as it is continued as is the case with all chronic disease such as diabetes and heart disease. Current publications including one from our Endocrine colleagues¹¹ call for chronic prescribing of all AOMs, and include guidelines to be used for safe prescribing of these older medications; and

Whereas, The use of AOMs long-term for obesity has been approved by the FDA for our 4 newest drugs, and recent studies of our older drugs shows that “abuse or psychological dependence (addiction) does not occur…”¹², and

Whereas, Due to these issues and many others, patients affected by obesity are unlikely to receive proper evidence-based treatments including behavioral intervention and medication. Current research shows that only 2% of patients affected by obesity with an on-label indication for pharmacotherapy are receiving medication. In contrast, 86% of patients affected by type 2 diabetes receive pharmacotherapy¹³, therefore be it

RESOLVED, 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

RESOLVED, 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)

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

Received: 03/21/18

RELEVANT AMA POLICY

Recognition of Obesity as a Disease H-440.842 - Our AMA recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention. Res. 420, A-13

Addressing Obesity D-440.954 - 1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention. 2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions). BOT Rep. 11, I-06 Reaffirmation A-13 Appended: Sub. Res. 111, A-14 Modified: Sub. Res. 811, I-14

Person-First Language for Obesity H-440.821 - Our AMA: (1) encourages the use of person-first language (patients with obesity, patients affected by obesity) in all discussions, resolutions and reports regarding obesity; (2) encourages the use of preferred terms in discussions, resolutions and reports regarding patients affected by obesity including weight and unhealthy weight, and discourage the use of stigmatizing terms including obese, morbidly obese, and fat; and (3) will educate health care providers on the importance of person-first language for treating patients with obesity; equipping their health care facilities with proper sized furniture, medical equipment and gowns for patients with obesity; and having patients weighed respectfully. Res. 402, A-17 Modified: Speakers Rep., I-17
Whereas, There are numerous electronic health record (EHR) vendors in the medical marketplace for physicians and health systems to use; and

Whereas, Physicians and health care systems may determine that a new EHR vendor is more cost effective, provides enhanced functionality to clinical workflows and patient data management, and offers superior service and support; and

Whereas, The high cost and extensive time required to transition health IT data to a new EHR system is often a barrier preventing such a change; and

Whereas, Patient data is often lost during EHR transition due to a lack of standardized data and transition protocols among EHR vendors; and

Whereas, These barriers that physicians and health systems face when considering EHR vendor transition often have the practical effect of locking physicians and health systems into continuing to use the same EHR, despite of known EHR deficiencies; and

Whereas, These barriers enable EHR vendors to benefit from lack of open competition in the marketplace; therefore be it

RESOLVED, 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)

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

Received: 04/03/18
**RELEVANT AMA POLICY**

**National Health Information Technology D-478.995 - 1.** Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care. 2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.; and (D) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems. 3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs. 4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery. 5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process. 6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability. 7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability. 8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records. Citation: Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified: BOT Rep. 17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed: BOT Rep. 24, A-13; Reaffirmed in lieu of Res. 724, A-13; Appended: Res. 720, A-13; Appended: Sub. Res. 721, A-13; Reaffirmed: CMS Rep. 4, I-13; Reaffirmation I-13; Appended: BOT Rep. 18, A-14; Appended: BOT Rep. 20, A-14; Reaffirmation A-14; Reaffirmation A-14; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmation I-15; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 227, A-17; Reaffirmed in lieu of: Res. 243, A-17

**Principles for Hospital Sponsored Electronic Health Records D-478.973 - 1.** Our AMA will promote electronic health record (EHR) interoperability, data portability, and health IT data exchange testing as a priority of the Office of the National Coordinator for Health Information Technology (ONC). 2. Our AMA will work with EHR vendors to promote transparency of actual costs of EHR implementation, maintenance and interface production. 3. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) and ONC to identify barriers and potential solutions to data blocking to allow hospitals and physicians greater choice when purchasing, donating, subsidizing, or migrating to new EHRs. 4. Our AMA will advocate that sponsoring institutions providing EHRs to physician practices provide data access and portability to affected physicians if they withdraw support of EHR sponsorship. Citation: (BOT Rep. 1, I-15)

**Information Technology Standards and Costs D-478.996 - 1.** Our AMA will: (a) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (b) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (c) review the following issues when participating in or commenting on initiatives to create a NHII: (i) cost to physicians at the office-based level; (ii) security of electronic records; and (iii) the standardization of electronic systems; (d) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (e) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems. 2. Our AMA advocates that physicians: (a) are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards; and (b) not be financially penalized for certified EHR technology not meeting current standards. Citation: Res. 717, A-04; Reaffirmation A-05; Appended: Sub. Res. 707, A-06; Reaffirmation A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation I-08; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed: Res. 205, A-11; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed in lieu of Res. 724, A-13; Reaffirmation I-13; Reaffirmation A-14; Reaffirmed: BOT Rep. 03, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 204, I-17; Reaffirmation: I-17

See also: EHR Interoperability D-478.972
Whereas, Prior to the mid-1960s, lactose intolerance was believed to be a rare, abnormal
condition causing abdominal pain and diarrhea after milk consumption; and

Whereas, Research since the 1960s has shown that lactose intolerance (lactase non-
persistence) is normal and is present in the majority of African Americans, Asian Americans,
and Native Americans, with a lower prevalence in whites, often beginning in childhood; and

Whereas, Children with lactose intolerance may not request an alternative to cow’s milk unless
they provide documentation from a medical authority, parent, or guardian of a medical or special
dietary need, and even with such documentation, schools may refuse such requests; and

Whereas, Requiring children to obtain documentation of a “medical or special dietary need”
when they have a normal condition may stigmatize children and discourage them from
requesting foods they can safely digest and unnecessarily consumes physicians’ time and
families’ time and resources; and

Whereas, African Americans are at particularly high risk for prostate cancer, colorectal cancer,
and cardiovascular mortality; and

Whereas, Prostate and colorectal cancer are strongly linked to dairy consumption and
processed and red meat consumption, respectively, which are promoted in federal nutrition
policies, and these same products contribute to cardiovascular risk; and

Whereas, Dairy and meat products are not nutritionally required; therefore be it

RESOLVED, That our American Medical Association amend existing AMA Policy D-440.978,
“Culturally Responsive Dietary and Nutritional Guidelines,” by addition to read as 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
African Americans, especially African Americans, Asian Americans, and Native Americans, with a lower
prevalence in whites, often manifesting in childhood; and (34) 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
RESOLVED, 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

RESOLVED, 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)

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

Received: 04/13/18

RELEVANT CITATIONS


RELEVANT AMA POLICY
Racial and Ethnic Disparities in Health Care H-350.974 - 1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care is an issue of highest priority for the American Medical Association. 2. The AMA emphasizes three approaches that it believes should be given high priority: A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform. B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities. C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities 3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons. 4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

Combating Obesity and Health Disparities H-350.974 - 1. Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of foods and beverages low in fat, added sugars, and cholesterol. Res. 413, A-07 Reaffirmation A-12 Reaffirmation A-13 Modified: CSAPH Rep. 03, A-17

Culturally Responsive Dietary and Nutritional Guidelines D-440.978 - 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; and (3) 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. BOT Rep. 6, A-04 Modified: CSAPH Rep. 1, A-14

See also: Obesity as a Major Health Concern H-440.902
Whereas, The State of Massachusetts requires that on or after January 1, 2015, a renewing full 
licensee must demonstrate proficiency in the use of electronic health records, as required by 
M.G.L. c. 112, § 2 and 243 CMR 2.06(2)(d); and

Whereas, The Louisiana State Medical Society has policy supporting an exception for the 
requirements that physicians use secure electronic communication with patients; and

Whereas, The Louisiana State Medical Society has policy stating that no physician should be 
denied a medical license solely on the grounds of failure to use an electronic health record, or 
failure to demonstrate proficiency in use of an electronic health record; therefore be it

RESOLVED, 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)

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

Received: 04/11/18

RELEVANT AMA POLICY

Licensure for Physicians Not Engaged in Direct Patient Care H-275.921 - Our AMA: (1) opposes laws, 
regulations, and policies that would limit the ability of a physician to obtain or renew an unrestricted state or territorial 
medical license based solely on the fact that the physician is engaged exclusively in medical practice which does not 
include direct patient care; (2) advocates that the Federation of State Medical Boards support provision of 
unrestricted state or territorial medical licenses to physicians engaged in medical practice that does not include direct 
patient care; (3) urges constituent state and territorial medical societies to advocate with their respective medical 
boards to establish policy that will facilitate provision of unrestricted state or territorial medical licenses to physicians 
in medical practice that does not include direct patient care; and (4) opposes activities by medical licensure boards to 
create separate categories of medical licensure solely on the basis of the predominant professional activity of the 
practicing physician. Citation: Res. 923, I-10

Discrimination Against Physicians Under Supervision of Their Medical Examining Board H-275.949 - 1. Our 
AMA opposes the exclusion of otherwise capable physicians from employment, business opportunity, insurance 
coverage, specialty board certification or recertification, and other benefits, solely because the physician is either 
presently, or has been in the past, under the supervision of a medical licensing board in a program of rehabilitation or 
enrolled in a state-wide physician health program. 2. Our AMA will communicate Policy H-275.949 to all specialty 
boards and request that they reconsider their policy of exclusion where such a policy exists. Citation: Sub. Res. 3, A- 
412, A-12 Reaffirmed: BOT action in response to referred for decision Res. 403, A-12

Physician Licensure Legislation H-275.955 - Our AMA reaffirms earlier policy urging licensing jurisdictions to adopt 
laws and rules facilitating the movement of physicians between states, to move toward uniformity in requirements for

**Medical Licensure H-275.978** - The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent; (2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure; (3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends; (4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice; (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public; (6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94); (7) urges licensing boards to maintain strict confidentiality of reported information; (8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board; (9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician; (10) urges all physicians to participate in continuing medical education as a professional obligation; (11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine; (12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient; (13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review; (14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation; (15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public; (16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses; (17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses; (18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination; (19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education; (20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement; (21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and (22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license. Citation: CME Rep. A, A-87Reaffirmed: Sunset Report, I-97Reaffirmation A-04Reaffirmed: CME Rep. 3, A-10Reaffirmation I-10Reaffirmed: CME Rep. 6, A-12Reaffirmed: Res. 305, A-13Reaffirmed: BOT Rep. 3, I-14

**Implementing Electronic Medical Records H-478.993** - It is the policy of our AMA that public and private insurers should not require the use of electronic medical records. Citation: Sub. Res. 707, A-06Reaffirmation A-07Reaffirmed in lieu of Res. 237, A-12Reaffirmation A-14

**Allocation of Privileges to Use Health Care Technologies H-480.988** - The AMA (1) affirms the need for the Association and specialty societies to enhance their leadership role in providing guidance on the training, experience and knowledge necessary for the application of specific health care technologies; (2) urges physicians to continue to ensure that, for every patient, technologies will be utilized in the safest and most effective manner by health care professionals; and (3) asserts that licensure of physicians by states must be based on scientific and clinical criteria. Citation: BOT Rep. F, I-88Reaffirmed: CME Rep. 8, I-93Reaffirmed: CME Rep. 2, A-05Reaffirmed: CME Rep.1, A-15
Whereas, Our AMA has recently become involved in efforts to figure out how to incorporate Augmented Intelligence (AI) into the health care system; and

Whereas, There are advantages to the utilization of AI in the day-to-day care of patients; and

Whereas, It will be very expensive to incorporate AI into the day-to-day care of patients; and

Whereas, Physicians can take care of most patients without the assistance of AI; and

Whereas, The cost of implementing AI may take money away from the financing of essential health services; and

Whereas, At this time, many patients do not have 24-7 access to a primary care physician who can see the medical records of the patients; and

Whereas, The American Academy of Pediatrics believes that it is very important for all people to be enrolled in a medical home so that all patients can have 24-7 access to a primary care physician who can see their medical records; therefore be it

RESOLVED, 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

RESOLVED, 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)

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

Received: 04/19/18
Whereas, The patient centered medical home is considered the optimal way to provide high quality, cost-effective, comprehensive, and continuous primary care to patients; and

Whereas, The use of telehealth services, providing healthcare remotely to patients via computer and video links, has been proposed as an extension of physician healthcare services with the potential to supplement the medical home and provide care where health care services are not easily accessible; and

Whereas, The use of telehealth services has seen rapid growth in the past few years, supported and promoted by insurance companies, for-profit health care businesses, and hospital systems primarily as cheaper, easier, and faster than an in-person physician visit; and

Whereas, Some telehealth systems lure patients to telehealth care by providing patients with financial incentives (lower fees and co-pays); and

Whereas, The use of telehealth services outside the medical home of the patient, as currently promoted by for-profit health care entities, undermines the medical home as the optimal source for provision and coordination of patient care; and

Whereas, It is understood that there are emergency medicine and critical care telehealth modalities, and other applications of telehealth (save and forward radiology, pathology, and dermatology) that occur outside the realm of the primary care medical home; and

Whereas, Telehealth care cannot involve a personal, face-to-face interview and physical examination (even in those systems which use instruments at the patient’s site manipulated by the patient or another person) and laboratory testing, which may be crucial to making an accurate diagnosis; and

Whereas, Telehealth systems are providing diagnoses for patients with sore throat, dysuria, congestion/cough and other symptoms without performing adequate physical and laboratory assessments, resulting in inappropriate antibiotic prescribing; and

Whereas, Certain patient populations (including infants and children, developmentally disabled individuals, and patients with complicated medical histories) may not be able to adequately provide accurate history or participate in any limited telehealth physical examination or decision making, leading to inaccurate, and potentially harmful, prescribing and treatment practices by telehealth providers; therefore be it
RESOLVED, That our American Medical Association work with relevant stakeholders to ensure that all telehealth services are provided by and organized within the confines of the medical home, including financial incentives to utilize the telehealth modality outside the medical home (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate at both the state and national level that all telehealth vendors be required to collect and report quality measures in the context of clinical guidelines developed by reputable national specialty organizations (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant stakeholders to accumulate quality of care, patient satisfaction, and outcome data to compare telehealth with face-to-face care. (Directive to Take Action)

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

Received: 04/19/18
Whereas, One of the major causes of physician burn-out is the redundancy and time involved in meeting quality improvement requirements to prove to hospitals, payers, licensing agencies, and specialty boards that physicians are practicing good medicine; and

Whereas, It is very expensive for physicians to meet the quality improvement requirements of payers, hospitals, licensing agencies, and specialty boards; and

Whereas, Our AMA could do more to help physicians convince payers, hospitals, licensing agencies, and specialty boards that physicians should be able to utilize one menu of quality improvement activities in order to meet the quality improvement requirements of the multiple entities that need proof that physicians are practicing good medicine; therefore be it

RESOLVED, That our American Medical Association develop a quality improvement initiative so that if physicians complete quality improvement requirements of their specialty boards, that payers, hospitals, and licensing agencies will accept the specialty board certification evidence that physicians are practicing good medicine and will not require physicians to meet separate quality improvement requirements of payers, hospitals, and licensing agencies. (Directive to Take Action)

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

Received: 04/19/18
Whereas, Physicians and practitioners who care for patients strive to give timely, compassionate and evidence based medical care that may involve narcotic prescriptions; and

Whereas, Insurers do not know the circumstances prompting the narcotic prescription; and

Whereas, Postoperative patients often require brief opioid prescriptions for pain management; and

Whereas, Some patients have been denied postoperative pain relief due to time consuming and inappropriate prior authorization; therefore be it

RESOLVED, 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)

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

Received: 04/24/18
Whereas, Three states consider substance use in pregnancy a crime and another three states consider substance abuse grounds for civil commitment\(^1\); and

Whereas, Twenty-four states and DC consider drug use in pregnancy child abuse\(^1\); and

Whereas, Women have been prosecuted for drug use in pregnancy in 43 states\(^1\); and

Whereas, The mandatory reporting or toxicology testing requirements for suspected substance use in certain states may result in women concealing their use or foregoing prenatal care\(^2\); and

Whereas, Incarceration of pregnant women is not associated with improved pregnancy outcomes. Rather, opioid agonist therapy in conjunction with prenatal care decreases the risk of obstetric complications\(^3\); therefore be it

RESOLVED, That our American Medical Association 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

RESOLVED, 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

RESOLVED, 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)

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

Received: 04/24/18

\(^1\) https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy
RELEVANT AMA POLICY

Perinatal Addiction - Issues in Care and Prevention H-420.962
Our AMA: (1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy and breastfeeding and to routinely inquire about alcohol and drug use in the course of providing prenatal care.

Legal Interventions During Pregnancy H-420.969
Court Ordered Medical Treatments And Legal Penalties For Potentially Harmful Behavior By Pregnant Women: (1) Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus. If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases which do not present such exceptional circumstances. (2) The physician's duty is to provide appropriate information, such that the pregnant woman may make an informed and thoughtful decision, not to dictate the woman's decision. (3) A physician should not be liable for honoring a pregnant woman's informed refusal of medical treatment designed to benefit the fetus. (4) Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate. (5) Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs. (6) To minimize the risk of legal action by a pregnant patient or an injured fetus, the physician should document medical recommendations made including the consequences of failure to comply with the physician's recommendation.

Opiate Replacement Therapy Programs in Correctional Facilities H-430.987
1. Our AMA endorses: (a) the medical treatment model of employing opiate replacement therapy (ORT) as an effective therapy in treating opiate-addicted persons who are incarcerated; and (b) ORT for opiate-addicted persons who are incarcerated, in collaboration with the National Commission on Correctional Health Care and the American Society of Addiction Medicine. 2. Our AMA advocates for legislation, standards, policies and funding that encourage correctional facilities to increase access to evidence-based treatment of opioid use disorder, including initiation and continuation of opioid replacement therapy in conjunction with counseling, in correctional facilities within the United States and that this apply to all incarcerated individuals including pregnant women. 3. Our AMA supports legislation, standards, policies, and funding that encourage correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including pregnant women, are released to offer post-incarceration treatment plans for opioid use disorder, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths and help ensure post-incarceration medical coverage and accessibility to medication assisted therapy.
Whereas, Mass Shootings of innocent victims have become more prevalent in America; and
Whereas, Shooters in such episodes are increasingly using semi-automatic weapons (1 pull of trigger produces one bullet and reloads the chamber, but the next shot requires a 2nd pull of the trigger) and/or weapons altered to make them function in an automatic manner (1 pull of the trigger continuously fires bullets until the trigger is released); and
Whereas, Ownership of fully-automatic weapons (aka “machine guns”), noise suppressors, short barreled rifles, short barreled shotguns as well as explosive devices such as bombs and grenades have been highly restricted in the United States of America since passage of the 1934 National Firearms Act (revised in 1968 and 1986); and
Whereas, A bump stock is a device, available for under $200, that converts a semi-automatic rifle to function like a fully-automatic weapon; and
Whereas, Examples of recent mass shootings that involved either a semi-automatic weapon or a semi-automatic weapon modified to function in an automatic mode include:
- At an elementary school in school in Newtown, CT, a man armed with a semi-automatic rifle killed 28 people and wounded two others;
- In a movie theater in Aurora, CO, a man armed with a semi-automatic rifle killed 12 people and wounded 58 others;
- At a holiday party in San Bernadino, CA, a man and woman armed with semi-automatic rifles killed 14 people and wounded 20 others;
- At a nightclub in Orlando, FL, a man armed with a semi-automatic rifle killed at least 50 people and wounded 53 others;
- At an outdoor country music festival in Las Vegas, NV, a man armed with a rifle modified with a bump stock killed 59 people and wounded 545 others; and
Whereas, Physicians pledge their careers to saving lives, promoting health, and preventing injury or premature death; therefore be it
RESOLVED, That our American Medical Association support legislation that blocks the sale of any device or modification, including but not limited to bump stocks, that functionally converts a firearm into a weapon that mimics fully-automatic operation (New HOD Policy); and be it further
RESOLVED, That our AMA support legislation that would ban the sale and/or ownership of high capacity magazines or clips and high-speed-high-destruction rounds. (New HOD Policy)
Fiscal Note: Minimal - less than $1,000.

Received: 04/25/18

RELEVANT AMA POLICY

Ban on Handguns and Automatic Repeating Weapons H-145.985
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;
(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.
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(A-18)

Introduced by: New York

Subject: Clarification from US Department of Justice Regarding Federal Enforcement of Medical Marijuana Laws

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

Whereas, The Obama administration recognized marijuana as still illegal under the federal
Controlled Substances Act, but gave federal prosecutors permission to focus resources
elsewhere, as long as the states didn’t threaten other priorities, such as preventing the
distribution of the drug to minors or targeting cartels; and

Whereas, Earlier this year, Federal Attorney General Jeff Sessions rescinded the Obama
Administration guidelines which allowed those states authorizing the use of marijuana for
medical purposes under state law to do so without fear of federal prosecution; and

Whereas, The action by Attorney General Sessions may allow federal prosecutors to more
aggressively enforce marijuana laws, but it remains unclear how this action will impact states
where marijuana is legal for medical purposes; therefore be it

RESOLVED, 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)

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

Received: 04/25/18
Whereas, The Merit-based Incentive Payment System (MIPS) was created as part of the Quality Payment Program (QPP) under the Medicare Access CHIP Reauthorization Act of 2015 (MACRA) to institute a new “value-based” payment system for physicians; and

Whereas, MIPS adjusts payments based on performance in the categories of: Quality; Cost; Meaningful Use; and Improvement activities; and

Whereas, Compliance with this program involves the navigation of a labyrinth of rules and regulations; and an alphabet soup of acronyms that constitutes an unreasonable burden on physicians; taking time and energy away from the care of patients; and

Whereas, The “value-based” payment system involves a huge bureaucracy which results in the waste of health care dollars; and

Whereas, There is no evidence that this system of payment helps physicians to care for patients or improves the health of patients, which is the true mission of our profession; therefore be it

RESOLVED, 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

RESOLVED, 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)

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

Received: 04/25/18
RELEVANT AMA POLICY

MACRA and the Independent Practice of Medicine H-390.837
1. Our AMA, in the interest of patients and physicians, encourages the Centers for Medicare and Medicaid Services and Congress to revise the Merit-Based Incentive Payment System to a simplified quality and payment system with significant input from practicing physicians, that focuses on easing regulatory burden on physicians, allowing physicians to focus on quality patient care.
2. Our AMA will advocate for appropriate scoring adjustments for physicians treating high-risk beneficiaries in the MACRA program.
3. Our AMA will urge CMS to continue studying whether MACRA creates a disincentive for physicians to provide care to sicker Medicare patients.
Alt. Res. 206, A-17

MIPS and MACRA Exemption H-390.838
Our AMA will advocate for an exemption from the Merit-Based Incentive Payment System (MIPS) and Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for small practices.
Res. 208, I-16 Reaffirmation: A-17 Reaffirmation: I-17
Whereas, Retrospective chart review is commonly used by insurers and others to determine their perspective on appropriateness of hospital admission, length of stay in other payment parameters; and

Whereas, Guidelines for hospital admission and length of stay in other clinical parameters are set by the Centers for Medicare and Medicaid Services (core measures, quality metrics, etc.); and

Whereas, These guidelines are constantly changing and being updated by CMS; and

Whereas, Retrospective chart review may occur two years or more after the service has been rendered and paid for; and

Whereas, Insurance companies, peer review organizations and others retrospectively review two-year-old charts using current guidelines, resulting in adverse determinations based on these new guidelines that were not in place at the time that the care was provided; and

Whereas, Unfair judgments are being rendered on payment for services provided in a different regulatory environment than when the service was provided; therefore be it

RESOLVED, That our American Medical Association seek legislation/regulation that requires insurance companies, peer review organizations and the Centers for Medicare and Medicaid Services to use the review criteria that existed at the time that services were provided when making their determinations. (Directive to Take Action)

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

Received: 04/25/18
RELEVANT AMA POLICY

Physicians’ Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans H-320.948
It is the policy of our AMA, when a health plan or utilization review organization makes a determination to retrospectively deny payment for a medical service, or down-code such a service, the physician rendering the service, as well as the patient who received the service, shall receive written notification in a timely manner that includes: (1) the principal reason(s) for the determination; (2) the clinical rationale used in making the determination; and (3) a statement describing the process for appeal.


Physicians’ Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans D-320.995
(1) Our AMA will re-distribute its model legislation that would prevent the retrospective denial of payment for any claim for services for which a physician had previously obtained authorization.
(2) Our AMA will work with private sector accreditation organizations to ensure that their health plan and utilization management accreditation standards adequately address fair and appropriate mechanisms for retrospective review. (3) AMA's Private Sector Advocacy unit will work with state medical associations, county medical societies, and national medical specialty societies to (a) develop a survey instrument for use by the Federation to gather information from physicians who experience retrospectively denied and/or down-coded claims, (b) seek information on a regular basis from those associations that collect such information, and (c) respond with appropriate legislation, advocacy, and communication initiatives.


See also: Managed Care H-285.998
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(A-18)

Introduced by: New York

Subject: Strengthening the Background Check System for Firearm Sales

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

Whereas, Mass shootings of innocent victims have become more prevalent in America; and
Whereas, Most mass shooters have obtained pistols, long guns and explosives legally, though some shooters might have been prevented from obtaining weapons had background checks been properly performed; and
Whereas, Many states have a background check system to block criminals and persons with severe mental health problems from being able to purchase pistols, long guns and explosives (such as grenades, rocket propelled grenades, dynamite, C4, etc.); and
Whereas, Incomplete use of the background check system in private sales, gun show and online sales makes it much easier for individuals to obtain guns without undergoing a background check; therefore be it

RESOLVED, That our American Medical Association support legislation that requires a waiting period and background checks prior to the purchase of all firearms, including the person-to-person transfer, internet sales, and interstate transactions of all firearms. (New HOD Policy)

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

Received: 04/25/18

REFERENCES:
Sources of weapons used in mass shootings https://www.nytimes.com/interactive/2015/10/03/us/how-mass-shooters-got-their-guns.html
OMH Automated Background Check System https://www.omh.ny.gov/omhweb/mhbc/
National Instant Background Check System https://www.fbi.gov/services/cjis/nics
RELEVANT AMA POLICY

Waiting Periods for Firearm Purchases H-145.991
The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country.

Firearm Availability H-145.996
Our AMA: (1) Advocates a waiting period and background check for all firearm purchasers; (2) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (3) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
Whereas, Hospitals in the United States spend an estimated 1.5 billion dollars per year in advertising; and furthermore, it is likely that hospital advertising drives up healthcare costs even more by promoting inefficient, inappropriate and/or unnecessary healthcare utilization; and

Whereas, The content of hospital advertising is generally devoid of information that helps consumers make meaningful choices about their health care, is often misleading and does not lead to improved health outcomes; and

Whereas, Well over 50% of hospital revenue is received from Medicare and Medicaid which ought to make hospital advertising an obligatory subject of public scrutiny and government oversight; and

Whereas, The Supreme Court has upheld an FTC ruling which invalidated the long-standing AMA ban on physician and hospital advertising, making an immediate outright prohibition of hospital advertising unlikely; therefore be it

RESOLVED, That our American Medical Association advocate for regulations which promote responsible hospital and medical advertising. (New HOD Policy)

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

Received: 04/25/18
Whereas, The Food and Drug Administration (FDA) relies on Advisory Committees, composed of pharmacology and other healthcare experts, to review scientific studies of a proposed new drugs or medical devices,1,2,3 and

Whereas, The FDA formally prohibits the hiring of Advisory Committee members with conflicts of interest including employment by the sponsor of the drug under review and stock in the sponsoring company but routinely grants waivers instead of disqualifying such individuals;1-3 and

Whereas, The FDA only considers individuals to be conflicted if they have conflicts of interest that occurred in the past 12 months, which is shorter than the standard 36 month period that is customary in the scientific community;3,4,5,6 and

Whereas, The FDA in 2007 imposed a cap on the number of conflict of interest waivers that may be granted to Advisory Committee members through the FDA Amendments Act (FDAAA),3,4 and

Whereas, The FDA loosened conflict of interest restrictions with the passage of the Food and Drug Safety and Innovation Act (FDASIA) in 2012 by lifting the 2007 cap imposed by the FDAAA on the number of available conflict of interest waivers;3,4 and

Whereas, The FDASIA deprioritized conflicts of interest by eliminating the weight a financial disclosure had on a candidate’s selection;3,4,7,8,9,10,11 and

Whereas, The impact of Advisory Committee conflicts of interest on voting tendencies introduces bias to the review process and has led to the passage of drugs that were later

recalled due to safety concerns or linked to significant adverse effects such as with the Vioxx and Yaz/Yasmin scandals, respectively.\textsuperscript{3,4,7-12} and 

Whereas, The use of Advisory Committee Members with direct conflicts of interest undermines public trust in drug safety and presents a possible danger to the public health and safety.\textsuperscript{13,14} and 

Whereas, Research suggests there are a sufficient number of non-conflicted medical experts to fill Advisory Committee vacancies;\textsuperscript{3,15} and 

Whereas, Our AMA has policy advocating for the use of sound scientific evidence as the basis of drug evaluations (AMA Policy H-100.992) and policy stating that it will monitor and respond to drug safety practices at the FDA (D-100.978); therefore be it 

RESOLVED, 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 

RESOLVED, That our AMA advocate for a reduction in conflict of interest waivers granted to Advisory Committee candidates. (New HOD Policy)

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

Date Received: 04/26/18

RELEVANT AMA POLICY

H-100.992 FDA

(1) Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials and/or postmarket incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications.

(2) The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA's decision-making process in the course of FDA devising either general or product specific drug regulation.

(3) It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history.

Citation: (Res. 119, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-06; Appendixed: Sub. Res. 509, A-06; Reaffirmation I-07; Reaffirmation I-09; Reaffirmation I-10)

See also: FDA Drug Safety Policies D-100.978

\textsuperscript{12}Lenzer J EK. The Yaz Men: Members of FDA panel reviewing the risks of popular Bayer contraceptive had industry ties. Washington Monthly. \textsuperscript{13}Kowitt SD, Schmidt AM, Hannan A, Goldstein AO. Awareness and trust of the FDA and CDC: Results from a national sample of US adults and adolescents. *PloS one.* 2017;12(5):e0177546.


\textsuperscript{15}Zinner DE, Bolic-Jankovic D, Claridge B, Blumenthal D, Campbell EG. Participation of academic scientists in relationships with industry. *Health Aff (Millwood).* 2009;28(6):1814-1825.
Whereas, Congress passed the Orphan Drug Act (ODA) of 1983 in response to declining pharmaceutical investment of “orphaned” drugs through clinical trials following the Kefauver-Harris amendments of 1962 because of increased development costs;1,2,3 and

Whereas, The “orphan” designation is intended to incentivize the creation of drugs that target rare conditions affecting fewer than 200,000 Americans which are often deemed “unprofitable” due to the difficulty of recuperating development and marketing costs;4,5,6,7 and

Whereas, Although the ODA has been credited for introducing over 400 orphan drugs since becoming law, physicians, researchers, and policymakers have raised concerns about potential abuses of the Act;1-3,8,9,10 and

Whereas, Though the Act’s original intent was to incentivize the development of “non-profitable” therapies treating fewer than 200,000 Americans, several drugs have obtained “blockbuster” status indicating >$1 billion in sales annually, sometimes through a multitude of loopholes;1,4,9 and

Whereas, One such loophole is the approval for “orphan designation” - and therefore, ODA benefits - of existing compounds and mass-market drugs, as is the case for 3,4-DAP, ascorbic acid, calcium carbonate, Humira, and Crestor;8,11,12,13 and

Whereas, A pharmaceutical company may strategically submit a drug for approval of a single indication - “one that is narrow enough to qualify for orphan drug benefits” - and once approved, the drug is utilized for a variety of off-label uses, as demonstrated by the drugs rituximab, modafinil, and a variety of oncology drugs;9,14,15 and

Whereas, The exploitation of loopholes within the Act have resulted in both exorbitant price hikes and increasing sales, contributing up to one-fifth of global prescription sales by 2020 despite the original purpose of treating small populations;9,16,17 and

Whereas, Multiple pieces of legislation pertaining to the Orphan Drug Act have been submitted by both parties in the 115th Congress, which along with recent action by the FDA, indicates legislative and regulatory awareness of improvements that can be made and a will to do so;16,17 therefore be it

RESOLVED, 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

RESOLVED, That our AMA support increased transparency in development costs, post-approval regulation and overall earnings for pharmaceuticals designated as “Orphan Drugs” (New HOD Policy); and be it further

RESOLVED, 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)

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

Received: 04/26/18

RELEVANT POLICY:
Pharmaceutical Cost H-110.987
Cost of Prescription Drugs H-110.997
Cost of New Prescription Drugs H-110.998
Viability of Clinical Research Coverages and Reimbursement H-460.965

WHEREAS, Feminine hygiene products are defined as “tampons, pads, liners, cups, sponges, douches, wipes, sprays, and similar products used by women with respect to menstruation or other genital-tract secretions”;¹ and

WHEREAS, Our AMA defines medical necessity as a product a physician “would provide for the purpose of preventing” an illness, disease, or its symptoms (AMA Policy H-320.953) and supports the evaluation of medical necessity “based on established and evidence-based clinical criteria” (H-320.942); and

WHEREAS, Poor menstrual hygiene is correlated with significant adverse health effects, including increased urogenital infections and cervical cancer;² ³ ⁴ ⁵ ⁶ ⁷ and

WHEREAS, Poor menstrual health is associated with significant healthcare costs and a reduced quality of life, especially in women with heavy menses;⁸ and

WHEREAS, The biggest barriers to adequate feminine hygiene are affordability and accessibility;⁹ ¹⁰ and

WHEREAS, Women who are incarcerated, homeless, or of low socioeconomic status often resort to cheaper and less sanitary alternatives such as newspapers and used rags, and are therefore particularly vulnerable to health complications caused by poor menstrual hygiene;⁶ ⁷ ¹¹ ¹² ¹³ and

¹ H.R. 1708 to amend the Public Health Service Act to establish a program of research regarding the risks posed by the presence of dioxin, synthetic fibers, chemical fragrances, and other components of feminine hygiene products, H.R. 2015. HR 1708, 114th Cong.
³ Anand, E. et al. Menstrual hygiene practices and its association with reproductive tract infections and abnormal vaginal discharge among women in India. Sexual & Reproductive Healthcare. 2015 Dec; 6(4);249-54.
Whereas, Women who qualify for the Supplemental Nutrition Assistance Program (SNAP) do not receive financial assistance for feminine hygiene products and women often resort to trading food stamps in order to buy menstrual products;\textsuperscript{5,14} and

Whereas, The Internal Revenue Service (IRS) does not classify feminine hygiene products, such as pads and tampons, as medical necessities, wrongfully implying that menstrual products are not required for prevention, treatment, or diagnosis of a medical condition;\textsuperscript{15} and

Whereas, The Food and Drug Administration (FDA) classifies menstrual products as medical devices, and they are regulated as such;\textsuperscript{15} and

Whereas, AMA policy recognizes access to feminine hygiene products as a public health issue and supports the removal of sales tax on all feminine hygiene products (H-270.953); therefore be it

RESOLVED, That our American Medical Association encourage the Internal Revenue Service to classify feminine hygiene products as medical necessities. (New HOD Policy)

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

Received: 04/26/18

RELEVANT AMA POLICY:

Tax Exemptions for Feminine Hygiene Products H-270.953
Our AMA supports legislation to remove all sales tax on feminine hygiene products. Citation: Res. 215, A-16;

Medical Necessity and Utilization Review H-320.942
Our AMA supports efforts to: (1) ensure medical necessity and utilization review decisions are based on established and evidence-based clinical criteria to promote the most clinically appropriate care; and (2) ensure that medical necessity and utilization review decisions are based on assessment of preoperative symptomatology for macromastia without requirements for weight or volume resected during breast reduction surgery. Citation: Res. 810, I-16;

See also:
Health Care While Incarcerated H-430.986
Definitions of “Screening” and “Medical Necessity” H-320.953


Whereas, Kidney transplantation is often the best and most cost-effective treatment for Medicare patients with End Stage Renal Disease (ESRD); and

Whereas, The Dialysis PATIENTS Demonstration Act of 2017 (S. 2065) (HR 4143)—appears to remove control of kidney transplantation decision-making from many physicians and their Medicare patients; and

Whereas, The PATIENTS Act is duplicative of the more comprehensive and patient-oriented Center for Medicare and Medicaid Innovation Comprehensive ESRD Care Model; and

Whereas, Dialysis and transplant professional as well as patient-centered groups oppose the PATIENTS Act because it limits physician and patient choice in ESRD treatment options; therefore be it

RESOLVED, 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

RESOLVED, That our AMA actively oppose the “Dialysis PATIENTS Demonstration Act of 2017” (S. 2065) (HR 4143) (Directive to Take Action); and be it further

RESOLVED, 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)

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

Received: 04/27/18

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2 Center for Medicare and Medicaid Innovation Comprehensive ESRD Care Model: [https://innovation.cms.gov/initiatives/comprehensive-esrd-care/](https://innovation.cms.gov/initiatives/comprehensive-esrd-care/)
6 The FAIR Foundation: [www.FAIRFoundation.org](http://www.FAIRFoundation.org) : Policy adopted 28 January, 2018
RELEVANT AMA POLICY

Equal Access to Organ Transplantation for Medicaid Beneficiaries H-370.962
Our AMA supports federal funding of organ transplants for Medicaid patients.
Citation: (BOT Rep. 15, A-13)

Ethical Procurement of Organs for Transplantation H-370.967
Our AMA will continue to monitor ethical issues related to organ transplantation and develop additional policy as necessary.
Citation: (BOT Rep. 13, A-08)

UNOS Kidney Paired Donation Program H-370.960
Our AMA: (1) encourages the continued expansion of the United Network for Organ Sharing’s (UNOS) Kidney Paired Donation program which provides a national registry of living donors, carries out ongoing data collection on key issues of concern in transplantation from living donors, and through its operational guidelines provides consistent, national standards for the transplant community; and (2) encourages voluntary coordination among private donor registries and UNOS to enhance the availability of organs for transplantation.
Citation: (BOT Action in response to referred for decision Res. 2, A-13)

Cost-Saving Public Coverage for Renal Transplant Patients H-370.963
1. Our AMA supports private and public mechanisms that would extend insurance coverage for evidence-based treatment of renal transplant care for the life of the transplanted organ.
2. Our AMA will continue to offer technical assistance to individual state and specialty societies when those societies lobby state or federal legislative or executive bodies to implement evidence-based cost-saving policies within public health insurance programs.
Citation: (Res. 104, A-13)
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(A-18)

Introduced by: California

Subject: Ban on Semi-Automatic Assault Weapons and High Capacity Ammunition Magazines

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

Whereas, The United States struggles with an epidemic of firearm violence; in 2015, there were 34,997 deaths in the U.S. that were caused by firearms. Mass shootings account for a small percentage of firearm violence deaths yet result in unnecessary morbidity and mortality; and

Whereas, Firearms employing “high velocity” firepower were designed for the military to provide massive tissue destruction and obliteration of the enemy. The classic military model is the M-16 and the common civilian counterpart is the AR-15; and

Whereas, Such weapons have no appreciable value to U.S. civilians for use to defend themselves and have been repudiated by law enforcement for such use; and

Whereas, Major sports and hunting organizations have not supported the use of assault weapons for their members’ goals; and

Whereas, In 1994, Congress passed a ban on assault weapons and high capacity ammunition magazines and it lasted 10 years until it expired in 2004 and was not renewed. Compared with the 10-year period before the ban, the number of firearm massacres during the ban period fell by 37 percent, and the number of people dying from firearm massacres fell by 43 percent; and

Whereas, Assault weapons have increasingly been used in mass killing episodes since the federal ban lapsed in 2004. The use of assault weapons and high capacity magazines have increased by 183 percent in massacres and 239 percent in massacre deaths. Another study shows that assault-style weapons are showing up more often not only in mass shootings, but in ordinary crimes of violence and attacks on police officers. (Klarevas, LM Ramage Nation: Securing American from Mass Shootings. Amherst, New York; Pomeheus Books, 2016. Koper, C.S., Johnson, W.D., Nichols, J.L. et al. J. Urban Health (2017). https://doi.org/10.1007/s11524-017-0205-7.); and

Whereas, Major states, such as California, have shown a diminution of killing episodes since permanently banning semi-automatic assault weapons in 1989 and high-capacity ammunition magazines in 1999; and

Whereas, There is no intent to infringe on current ownership of legally purchased firearms of any kind in this resolution; therefore be it

RESOLVED, That our American Medical Association urge Congress to pass legislation to ban the sale, transfer, manufacture, and importation of assault weapons and high-capacity ammunition magazines to the American public. (New HOD Policy)
Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/30/18

RELEVANT AMA POLICY

Ban on Handguns and Automatic Repeating Weapons H-145.985
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;
(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.

Citation: (BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-14)

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

Citation: Res. 1011, A-16;

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance abuse disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16;

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

Citation: (CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13)

See also: Physicians and the Public Health Issues of Gun Safety D-145.997; Prevention of Unintentional Shooting Deaths Among Children H-145.979
Resolution: 221
(A-18)

Introduced by: American Academy of Family Physicians
American Academy of Pediatrics
American College of Obstetricians and Gynecologists
American College of Physicians

Subject: Maintaining Validity and Comprehensiveness of U.S. Census Data

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

Whereas, The U.S. Census data determines the allocation of more than $675 billion in federal funding to states and communities annually; and

Whereas, These funds provide for community development, public health, education, transportation and other community resource investments that are vital to decreasing the health, social and economic disparities experienced by vulnerable populations; and

Whereas, The 2020 Census is facing unprecedented challenges, such as a leadership void in the absence of an acting director, as well as insufficient funding; and

Whereas, There are resulting concerns about introduction of an internet-based format, scaled-back preparations and cybersecurity threats; and

Whereas, An inaccurate count will have significant consequences as the demographic data from the count are the bases for surveys that are benchmarks for major businesses, governments and researchers; therefore be it

RESOLVED, 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)

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

Received: 05/01/18
Whereas, The opioid epidemic has become a critical threat to public health in the U.S.; and

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

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

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

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

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

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

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

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

Received: 05/02/18

References
3 “Where multiple modes of medication-assisted treatment are available,” Health Affairs Blog, January 9, 2018. DOI: 10.1377/hblog20180104.835958.
Whereas, The opioid epidemic has become a critical threat to public health in the U.S.\(^1\); and
Whereas, Hospitalizations have been rapidly increasing for opioid overdose and for infectious complications of injection drug use such as hepatitis C, HIV and deep-tissue bacterial infections, reaching 1.27 million emergency room and inpatient stays in 2014\(^2\); and
Whereas, Inpatient costs among those with opioid use disorder almost quadrupled to $15 billion between 2002 and 2012\(^3\); and
Whereas, There is a high risk of repeated hospitalization\(^4\) and overdose death following hospitalization due to loss of opioid tolerance\(^5\), and hospitals rarely address the underlying chronic disease of opioid use disorder\(^6,7\); and
Whereas, Medications approved by the Food and Drug Administration for treating opioid use disorder (buprenorphine, methadone and naltrexone) reduce illicit opioid use\(^1\); opioid agonist therapy (buprenorphine or methadone) reduces opioid overdose death by 50 percent\(^6\) in part by preventing loss of opioid tolerance; and buprenorphine provides further protection because of its high receptor affinity and ceiling effect on respiratory depression\(^8\); and

References

Whereas, Initiation of buprenorphine in the emergency department\(^9\) and inpatient setting\(^10\) and linkage to ongoing comprehensive treatment as an outpatient is an effective means for engaging patients and reducing illicit opioid use\(^11-13\); and

Whereas, Our AMA has many policies regarding treatment of opioid use disorder, yet no policy addresses the central role that hospitals should play in treating opioid use disorder as a chronic disease; therefore be it

RESOLVED, 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

RESOLVED, 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)

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

Received: 05/0218

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WHEREAS, Opioid supply quotas and slow action from the Drug Enforcement Agency (DEA) have contributed to hospital shortages of injectable medications; and

WHEREAS, Supply reductions may cause temporary shortages of oral opioid medications at specific community pharmacies; and

WHEREAS, Certain states mandate electronic prescribing of all controlled substances; and

WHEREAS, Ongoing federal legislation may mandate electronic prescribing of all controlled substances nationwide; and

WHEREAS, Unlike traditional paper prescriptions, unsuccessful electronic prescriptions are not physically portable; and

WHEREAS, Increased use of Prescription Drug Monitoring Programs (PDMPs) and electronic prescribing will better allow physicians and pharmacies to prevent pharmacy shopping by patients for whom the intent is prescription opioid diversion; and

WHEREAS, U.S. Drug Enforcement Administration regulations do not allow transfer of original electronic opioid prescriptions for Schedule II-V medications between pharmacies, allowing only one-time transfers of Schedule III-V medication refills; and

WHEREAS, An unanticipated inability of a patient with bona fide pain to fill an opioid medication at a particular pharmacy after hours or on weekends constitutes a serious barrier to needed care, and may increase unnecessary emergency department utilization; therefore be it

RESOLVED, 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)

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

Received: 05/02/18

RELEVANT AMA POLICY

Third Party Payers Mandating Doctor and Patient Transfers of Prescriptions H-120.927
Our AMA will advocate that: (1) insurers or other third party payers must provide 60 days advance notice of changes in retail pharmacy networks to both patients and all physicians treating these patients; (2) insurers or other third party payers making changes to their pharmacy network must allow patients to designate a new pharmacy of choice within the network; and (3) when an insurance company or other third party payer mandates prescription transfers due to a change in their retail pharmacy network, that the payer and pharmacies within network have mechanisms in place to seamlessly transfer the prescription, as initially prescribed with regard to refills, substitutions, and other pertinent prescription details, to the patients pharmacy of choice without the need for the patient/physician to initiate such transfer, as well as safety mechanisms to ensure that the formulation which has been established and tolerated is available to the patient without a lapse in dispensing.
Citation: Res. 701, A-17
Whereas, The cost of prescription drugs is increasing and now accounts for between 10-17% of national health care spending.\textsuperscript{1,2} As the ‘middlemen’ between patients, prescribers, and pharmacies, pharmacy benefit managers (PBMs) play an increasingly prominent role in the US health care system; and

Whereas, As the PBM industry has grown and consolidated over time, it has become more involved in the treatment of patients. The combined business of three PBM companies (CVS Caremark, Express Scripts and United Health’s Optum) control 85\% of the entire US market.\textsuperscript{1} This includes essentially all Part D Medicare beneficiaries\textsuperscript{2}; and

Whereas, PBM companies have created access barriers which target patients, providers and pharmacies in the form of prior authorization requirements, step-therapy/fail first policies, specialty tiers, increased cost-sharing, non-medical drug switching, and other burdensome utilization management policies; and

Whereas, Providers have also expressed concerns with drug wastage, errors and the increasing time burden on their staff to find cost sharing assistance directly connected with PBM-policies; and

Whereas, The Centers for Medicare and Medicaid Services (CMS) has taken notice and recently requested comments specifically on PBM practices in a proposed regulation on Medicare Advantage and Part D\textsuperscript{3}; and

Whereas, There are a number of bills before Congress and state legislatures to address the impact of PBMs on patient care and pharmacy or physician practice; and

Whereas, Contractual arrangements may not clearly outline the costs to providers and patients related to PBM policies. There are growing concerns about PBM’s imposition of direct and indirect remuneration (DIR) fees and clawbacks on pharmacies, which may be tied to quality metrics, despite not having appropriate measures in certain medical specialties\textsuperscript{4-5}; and

Whereas, PBMs have increasingly created barriers to physicians providing medication therapy management and dispensing drugs by directing/requiring patients to use pharmacies, including mail order pharmacies, owned by or associated with PBMs thereby negatively impacting patient care and access\textsuperscript{5}; and

Whereas, These concerns regarding PBM’s are significant and represent a potential threat to high quality patient care; therefore be it
RESOLVED, 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

RESOLVED, 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)

Fiscal Note: Estimated cost of $160,000 to implement resolution.

Received: 05/02/18

Whereas, Prostate Cancer is the third leading cause of death in American men behind Lung and
Colorectal Cancer; and

Whereas, Screening for Breast Cancer and Colonoscopies are Covered Preventative Services
for Patients without an annual deductible or co-pay; and

Whereas, New York introduced in 2017 legislation NY SB 6882/AB 8683 which calls for
insurance coverage for Prostate Cancer screening without cost sharing to patients; and

Whereas, The American Urological Association recommends men age 55 to 69 years of age
consider the benefits and harms associated with screening, and engage in shared decision
making with their physician when considering PSA screening; and

Whereas, The American Medical Association has previously expressed support for the
appropriate screening of prostate cancer (AMA Policy H-425.980); therefore be it

RESOLVED, 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)

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

Received: 05/02/18
RELEVANT AMA POLICY

Screening and Early Detection of Prostate Cancer H-425.980
Our AMA believes that:
(1) All men who would be candidates for and interested in active treatment for prostate cancer should be provided with information regarding their risk of prostate cancer and the potential benefits and harms of prostate cancer screening, sufficient to support well-informed decision making.
(2) Prostate cancer screening, if elected by the informed patient, should include both prostate-specific antigen testing and digital rectal examination.
(3) Men most likely to benefit from tests for early detection of prostate cancer should have a life expectancy of at least 10 years and include: (a) Men 40 years of age or older of African American descent; (b) Men 40 years of age or older with an affected first-degree relative; and (c) Men 50 years of age or older.
Citation: (CSA rep. 9, A-00; Modified: CSAPH Rep. 1, A-10)
Whereas, The three largest Pharmaceutical Benefit Managers (PBMs) now have more than 180 million customers and control approximately 80% of the U.S. market with combined operating profits of these three PBMs increasing from $3.4 billion in 2007 to $12.4 billion in 2016\(^1\); and

Whereas, The size of the manufacturer's rebate to a PBM for some therapeutic classes may be 50% or more of the manufacturer's list price, with the PBM retaining 10%, 15%, or more of the rebate as profit. Since the PBM will generate more profit as the manufacturer increases its list price, the business model has been widely cited as a contributor to the steady increase in prescription drug prices\(^1\); and

Whereas, U.S. pharmaceutical expenditures are $1,443 per capita versus $667 per capita in Germany with essentially the same drugs being available for the respective citizens with the difference being almost entirely due to higher drug prices in America\(^2\); therefore be it

RESOLVED, 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

RESOLVED, 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)

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

Received: 04/30/18
Whereas, There are significant numbers of physicians over the age of 55, and physicians in small group practices; and

Whereas, Small group practice physicians and more senior physicians are inherently encouraged to leave practice sooner given penalties imposed due to Medicare quality initiatives and;

Whereas, Participation in Medicare quality initiatives represent significant costs small group practices and to senior physicians particularly, and at a time when a physician shortage is increasingly evident; and

Whereas, The patient population has been expanded both by growth in the senior population, population growth in general, and greater accessibility, negative incentives will serve to drive physicians out of practice earlier at a time when they are most needed, and indeed represent a pool of experience and knowledge that is hard to duplicate; and

Whereas, Quality incentives in the payment system may, or may not be justifiable, in this instance they work against the system by narrowing the workforce both in terms of numbers and experience; and

Whereas, By eliminating penalties, by offering financial rewards for remaining in practice, some of that narrowing of the workforce may be mitigated; therefore be it

RESOLVED, That the American Medical Association work with the Department of Health and Human Services in incentivizing small groups, and more senior physicians, regardless of their volume of patients total billing in dollars, with “small group”, and “senior” deferments against penalties and bonuses for continued practice. (Directive to Take Action)

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

Received: 05/01/18
RELEVANT AMA POLICY

Measurement of Drug Costs to Assess Resource Use Under MACRA H-385.911
1. Our AMA will work with Congress and the Centers for Medicare and Medicaid Services to exempt all Medicare Part B and Part D drug costs from any current and future resource use measurement mechanisms, including those that are implemented as part of the Merit-Based Incentive Payment System (MIPS) or resource use measurement used by an Alternative Payment Model to assess payments or penalties based on the physician's performance and assumption of financial risk, unless a Physician Focused Alternative Payment Model (incorporating such costs) is proposed by a stakeholder organization and participation in the model is not mandatory.
2. Our AMA will continue work with impacted specialties to actively lobby the federal government to exclude Medicare Part B drug reimbursement from the MIPS payment adjustment as part of the Quality Payment Program (QPP).
Citation: Res. 218, A-16; Appended: Res. 225, I-17;

MACRA and the Independent Practice of Medicine H-390.837
1. Our AMA, in the interest of patients and physicians, encourages the Centers for Medicare and Medicaid Services and Congress to revise the Merit-Based Incentive Payment System to a simplified quality and payment system with significant input from practicing physicians, that focuses on easing regulatory burden on physicians, allowing physicians to focus on quality patient care.
2. Our AMA will advocate for appropriate scoring adjustments for physicians treating high-risk beneficiaries in the MACRA program.
3. Our AMA will urge CMS to continue studying whether MACRA creates a disincentive for physicians to provide care to sicker Medicare patients.
Citation: Alt. Res. 206, A-17;

Protecting Patients Rights H-450.944
Our AMA opposes Medicare pay-for-performance initiatives (such as value-based purchasing programs) that do not meet our AMA's "Principles and Guidelines for Pay-for-Performance," which include the following five Principles: (1) ensure quality of care; (2) foster the patient/physician relationship; (3) offer voluntary physician participation; (4) use accurate data and fair reporting; and (5) provide fair and equitable program incentives.
Citation: Sub. Res. 902, I-05; Reaffirmation A-06; Reaffirmation I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17;
Whereas, We are facing a shortage of physicians in this country and international medical graduates provide health care to millions of people in rural and underserved communities; and

Whereas, One in four physicians in the U.S. is an immigrant physician; and

Whereas, Immigrant physicians do not replace American workers, instead, we fill the missing gaps in U.S. healthcare, create more jobs, serve mostly the rural and underserved areas; and

Whereas, At the time of writing of the 2017 VA report by Office of Inspector General there continues to be a physician shortage in the VA hospital system that is most critical for Medical Officers; and

Whereas, The physician shortage has already affected multiple hospitals in the Veterans Affairs causing postponement of surgeries and challenges in providing timely care to Veterans; and

Whereas, There are physicians currently available in the United States to meet this shortage, such as the nearly 15,000 international medical graduates from India who are actively practicing in the U.S. stuck in the green card backlog waiting to get a green card, which may take up to 20 years at the current rate; and

Whereas, Physicians apply for green cards under the employment-based category 2 (EB2), which have more 20+ years for green card, causing multiple challenges, including unable to work at additional location, limited job opportunities and career advancements and unable to invest or start new businesses; therefore be it

RESOLVED, 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)

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

Received: 05/01/18
RELEVANT AMA POLICY

Impact of Immigration Barriers on the Nation's Health D-255.980
1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.
7. Our AMA will update the House of Delegates by the 2017 Interim Meeting on the impact of immigration barriers on the physician workforce.

Access to Health Care for Veterans H-510.985
Our American Medical Association: (1) will continue to advocate for improvements to legislation regarding veterans' health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the Veterans Administration health care system; (2) will monitor implementation of and support necessary changes to the Veterans Choice Program's "Choice Card" to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the Veterans Administration health care system; (3) will call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans; (4) will advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician; (5) will advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans; and (6) will support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation's veterans.

Citation: Alt. Res. 308, A-17; Sub. Res. 111, A-15; Reaffirmed: CMS Rep. 06, A-17;

See also:
Expansion of US Veterans’ Health Care Choices H-510.983
Ensuring Access to Care for our Veterans H-510.986

References:
U. S. Citizen & Immigration Services, Green Card Processes & Procedures.
The Economic Times, "Why children of H-1B workers may now have to leave America", October 2017
Department of Veterans Affairs Office of Inspector General, OIG Determination of VHA Occupational Staffing Shortages FY 2017Off
VA Hospitals Still Struggling With Adding Staff Despite Billions from Choice Act.
Doctor shortage forces Colorado VA hospital to postpone surgeries.
https://www.fiercehealthcare.com/healthcare/doctor-shortage-forces-colorado-va-hospital-to-postpone-surgeries
Whereas, The World Health Organization\(^1\) defines the social determinants of health (SDOH) as the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life; and

Whereas, These forces and systems include economic policies, development agendas, social norms, social policies and political systems; and

Whereas, Healthy People 2020 “highlights the importance of addressing the social determinants of health by including “create social and physical environments that promote good health for all”\(^2\); and

Whereas, Our American Medical Association (AMA) policies support efforts to ensure that individuals have access to safe, high-quality and patient-centered health care; and

Whereas, Our AMA adopted policy H-295.874, “Educating Medical Students in the Social Determinants of Health and Cultural Competence”; and

Whereas, Our AMA opposes polices and rules that would lead to barriers to access resources that are examples of SDOH such as housing applicants who consent to the disclosure of medical information about alcohol and other drug abuse treatment as a condition of renting or receiving Section 8 assistance or Temporary Assistance for Needy (TANF) and work requirements for Supplemental Nutrition Assistance Program (SNAP); and

Whereas, The federal government is proposing budget cuts to the U.S. Department of Agriculture’s discretionary budget by $3.5 billion, or 15 percent by eliminating $17 billion in funds available to SNAP (food stamps); and

Whereas, The federal government seeks to cut more than $3 billion from the U.S. Department of Education; and

\(^1\) World Health Organization, [http://www.who.int/social_determinants/sdh_definition/en/](http://www.who.int/social_determinants/sdh_definition/en/), accessed March 22, 2018

Whereas, The federal government seeks to substantially reduce Section 8 federal housing subsidies, eliminate the $1.9 billion fund for public housing capital repairs, zero out community development block grants, discontinue grants to states and local governments to increase homeownership for the lowest-income Americans, and institute work requirements for individuals receiving housing subsidies; and

Whereas, The federal government seeks to decrease funding for National Dislocated Worker Grants -- support for those who lose their jobs in natural disasters or factory closures -- from $219.5 million in 2017 to $51 million in 2019; and

Whereas, The federal government seeks to decrease funding for Adult Employment and Training Activities, which serve veterans, Native Americans and young people who have dropped out of high school, by nearly half, from $810 million in 2017 to $490.3 million in 2019; and

Whereas, Our AMA seeks to maximize opportunities for collaboration among federal-, state-, and local-level partners related to social determinants of health; therefore be it

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 current levels and remain available without additional restrictions or rules. (Directive to Take Action)

References:


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

Received: 05/02/18

RELEVANT AMA POLICY

Healthy Lifestyles H-425.972
1. Our AMA: (A) recognizes the 15 competencies of lifestyle medicine as defined by a blue ribbon panel of experts convened in 2009 whose consensus statement was published in the Journal of the American Medical Association in 2010; (B) will urge physicians to acquire and apply the 15 clinical competencies of lifestyle medicine, and offer evidence-based lifestyle interventions as the first and primary mode of preventing and, when appropriate, treating chronic disease within clinical medicine; and (C) will work with appropriate federal agencies, medical specialty societies, and public health organizations to educate and assist physicians to routinely address physical activity and nutrition, tobacco cessation and other lifestyle factors with their patients as the primary strategy for chronic disease prevention and management.
2. Our AMA supports policies and mechanisms that incentivize and/or provide funding for the inclusion of lifestyle medicine education and social determinants of health in undergraduate, graduate and continuing medical education.

Citation: Res. 423, A-12; Appended: Res. 959, I-17;

See also:
Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874
Improvements to Supplemental Nutrition Programs H-150.937
Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982
AMERICAN MEDICAL ASSOCIATION HOUSE OF DElegates

Resolution: 231
(A-18)

Introduced by: Ohio

Subject: Online Controlled Drugs

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

Whereas, Physicians are under extreme regulatory control when prescribing medications classified as "controlled"; and

Whereas, Any search of the internet will reveal hundreds of sites to purchase oxycodone, hydromorphone, and other controlled drugs without a prescription; and

Whereas, Selective androgen receptor modulators (SARM's) were not approved by the FDA because of lack of efficacy side effects, a recent web-based search found 44 products marketed and sold as SARM's; and

Whereas, Of these 44 products when tested, 48% did not contain any of the advertised drug, 59% contained an amount different than what was on the label, and 91% contained other various combinations of other unapproved drugs including anabolic steroids, growth hormone secretagogues, and other nuclear hormone receptor modulators; and

Whereas, Many dietary supplements sold on the Internet contain hormones, drugs and known toxins very often not listed on the label; therefore be it

RESOLVED, 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)

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

Received: 05/02/18

References:
Institute of Medicine (US) Committee on the use of Complementary and Alternative Medicine by the American Public, National Academies Press (US); 2005, Dietary Supplements.
Boghani, P., Can Regulators keep up with the Supplement Industry, pbs.org/wgbh/frontline/film/supplements.
Whereas, The provider-patient relationship is intimate and sacred; and
Whereas, Confidentiality of patient information is protected under the Health Insurance Portability and Accountability Act (HIPAA) of 1996; and
Whereas, HIPAA precludes sharing of patient information without the consent of the patient or their healthcare proxy; and
Whereas, Okla. Stat. Ann. tit. 13, § 176.4 states an individual who is a party to either an in-person conversation or electronic communication, or who has the consent of one of the parties to the communication, can lawfully record it or disclose its contents, unless the person is doing so for the purpose of committing a criminal or tortious act; and
Whereas, Recording in a public part of a doctor’s office could violate other patients’ privacy while making a recording in secret could both lead to a fundamental breach in the trust relationship between the health professional and the patient; and
Whereas, Open communication about the need for the recording will help ensure that recordings will not threaten the privacy of other patients and staff or affect the trust between physician and patient; and
Whereas, Twelve states have adopted laws specifically banning the use of video and still cameras where the subject has an expectation of privacy; therefore be it
RESOLVED, 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)

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

Received: 05/01/18

References
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 233
(A-18)

Introduced by: Oklahoma

Subject: Support for Reauthorization of the Supplemental Nutrition Assistance Program

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

Whereas, No one should go hungry; and

Whereas, Job loss, medical or family emergency, or temporary hardship has resulted in food insecurity for 632,030[1] individuals in Oklahoma, of which approximately 214,890[2] are children; and

Whereas, The Supplemental Nutrition Assistance Program (SNAP) helps alleviate food insecurity for Oklahoma families, children, elderly, and disabled and currently helps put food on the table for over 598,722[3] Oklahomans; and

Whereas, SNAP also has a positive economic impact in Oklahoma: every $1 spent in SNAP benefits puts $1.70 back into Oklahoma’s economy[4] and, in 2016 alone, Oklahoma SNAP retailers redeemed about $866 million[5] in SNAP benefits; and

Whereas, SNAP protects families, stimulates local economies, and supports Oklahoma’s farmers, ranchers, and businesses; and

Whereas, Increasing food insecurity results in increased chronic illness and subsequent higher healthcare costs[6] and leads further leads to worsened health outcomes[7], reduced workforce productivity, and poorer educational outcomes[8]; and

Whereas, According to the United States Department of Agriculture, there is only about 1.3% of waste, fraud, and abuse within the SNAP program, meaning 98.7% of recipients are meaningfully alleviated of food insecurity; and

Whereas, SNAP is a provision of the federal Farm Bill, which is up for reauthorization in 2018; therefore be it

RESOLVED, 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

RESOLVED, 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
RESOLVED, 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)

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

Received: 05/01/18


RELEVANT AMA POLICY

Improvements to Supplemental Nutrition Programs H-150.937

1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.

2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.

Citation: Res. 414, A-10; Reaffirmation A-12; Reaffirmation A-13; Appended: CSAPH Rep. 1, I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Appended: Res. 407, A-17;

Eligibility of Sugar-Sweetened Beverages for SNAP D-150.975

Our AMA will: (1) publish an educational brief to educate physicians about the effects of sugar-sweetened beverages (SSBs) on obesity and overall health, and encourage them to educate their patients in turn, (2) encourage state health agencies to include educational materials about nutrition and healthy food and beverage choices in routine materials that are currently sent to Supplemental Nutrition Assistance Program (SNAP) recipients along with the revised eligible foods and beverages guidelines, and (3) work to remove SSBs from SNAP.

Citation: (Res. 238, A-13; Reaffirmation A-14)
Whereas, The Primary Care Enhancement Act (H.R. 365 and S. 1358) is a bipartisan bill which expands access to high-functioning primary care services for Americans of all income and age levels. The legislation clarifies to the tax code to remove a major federal regulatory barrier keeping patients, providers and employers who use Health Savings Accounts (HSAs) from using innovative Direct Primary Care (DPC) medical homes to improve health outcomes and reduce costs; and

Whereas, Internal Revenue Service (IRS) rules prohibit individuals with HSAs paired with high deductible health plans (HDHPs) from having an agreement with a DPC provider; and

Whereas, The IRS incorrectly interprets DPC arrangements as health plans under Section 223(c) of the Internal Revenue Code; furthermore IRS says the law is unclear whether or not primary care services are qualified health expenses under Section 213(d) of the code, if services are paid for with a capitated periodic fee rather than fee for service; and

Whereas, The Primary Care Enhancement Act clarifies the tax code, making it clear that patients with HSAs paired with HDHPs have access to great primary care with a DPC medical home; and

Whereas, Department of Health and Human Services (HHS) regulations already define DPC medical homes as primary care services – HHS rules note that they are an important delivery reform being defined in state laws; and

Whereas, Current IRS policy inappropriately interprets DPC arrangements as a form of health plan--despite other interpretations in state and federal law; and

Whereas, As long as IRS interprets DPC as a health plan, simply having an agreement with a DPC provider bars an individual from funding an HSA; and

Whereas, IRS rules also need to be clarified to allow fees for periodic fee-based DPC to be paid for using HSA funds; and

Whereas, IRS regulations are clear: HSAs must be paired with an HDHP, and the HSA holder may not have a second health plan; and

Whereas, Twenty-three states have enacted statutes defining DPC outside of state insurance regulation and many others offer guidance which concurs that DPC Medical Homes are medical services, not health plans; and
Whereas, DPC is currently offered in exchanges, with self-insured employers, unions, in
Medicare Advantage and Medicaid MCOs; and

Whereas, Individuals with HSAs are the only people with health coverage who are barred by
federal regulations from having a DPC provider; therefore be it

RESOLVED, That our American Medical Association, pursuant to H-385.912, actively lobby
Congress to pass the Primary Care Enhancement Act. (Directive to Take Action)

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

Received: 05/01/18

RELEVANT AMA POLICY

Direct Primary Care H-385.912
Our AMA supports inclusion of Direct Primary Care as a qualified medical expense by the
Internal Revenue Service.
Citation: Res. 103, A-16
Whereas, Hospital consolidation has increased substantially over the last 5 years and as many as 20% of all US hospitals will seek a merger in the next 5 years; and

Whereas, None of the geographic health care markets in the US are considered “highly competitive,” and 90 percent of metropolitan areas have highly concentrated hospital markets;¹ and

Whereas, Highly concentrated hospital markets increase hospital prices, reduce choice, and reduce physician practice options;² and

Whereas, The market power of hospital conglomerates in many, if not most, geographic health care markets far exceeds health insurance plans’ market power resulting in excessive hospital cost inflation; and

Whereas, Conglomerate chain hospitals can make decisions about the regional care offerings without respect for the individual patient’s preferences; and

Whereas, Hospital rate setting commissions, like in Maryland, can reduce total expenditures and excessive hospital cost inflation without shifting costs to other parts of the health care system;³ therefore be it

RESOLVED, That our American Medical Association actively oppose future hospital mergers and acquisitions in highly concentrated hospital markets (New HOD Policy); and be it further

RESOLVED, 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)

REFERENCES
² CMS Rep. 5, A-17

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

Received: 05/02/18
RELEVANT AMA POLICY

Specialty Hospitals and Impact on Health Care H-215.968
Our AMA supports and encourages competition between and among health facilities as a means of promoting the delivery of high-quality, cost-effective health care.
Citation: BOT Rep. 15, I-04; Reaffirmation A-09; Reaffirmed: CMS Rep. 05, A-17
Whereas, The Medicare Payment Advisory Commission (MedPAC) announced a proposal to drop the Merit-Based Incentive Payment System (MIPS) program in its annual report to Congress on needed changes to Medicare payment policies (March 2018); and

Whereas, MedPAC commissioners have concluded that MIPS will not fulfill its goals and therefore should be replaced with a voluntary value program (VVP) whereby clinicians would not have to report quality data themselves; and

Whereas, Our AMA has policy advocating for an exemption from MIPS and Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for small practices (AMA Policy H-390.838); and

Whereas, Our AMA has longstanding policy encouraging the Centers for Medicare and Medicaid Services to revise MIPS to a simplified quality and payment system with significant input from practicing physicians, that focuses on easing regulatory burden on physicians, allowing physicians to focus on quality patient care (H-390.837); therefore be it

RESOLVED, 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

RESOLVED, 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)

REFERENCES
March 2018 MEDPAC Report to the Congress: Medicare Payment Policy; Chapter 15: Moving Beyond the Merit-Based Incentive Payment System http://www.medpac.gov/-documents-/reports

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

Received: 05/02/18

RELEVANT AMA POLICY
Measurement of Drug Costs to Assess Resource Use Under MACRA H-385.911
1. Our AMA will work with Congress and the Centers for Medicare and Medicaid Services to exempt all Medicare Part B and Part D drug costs from any current and future resource use measurement mechanisms, including those that are implemented as part of the Merit-Based Incentive Payment System (MIPS) or resource use measurement used by an Alternative Payment Model to assess payments or penalties based on the physician’s performance and assumption of financial risk, unless a Physician Focused
Alternative Payment Model (incorporating such costs) is proposed by a stakeholder organization and participation in the model is not mandatory.

2. Our AMA will continue work with impacted specialties to actively lobby the federal government to exclude Medicare Part B drug reimbursement from the MIPS payment adjustment as part of the Quality Payment Program (QPP).

Citation: Res. 218, A-16; Appended: Res. 225, I-17;

Physician Payment Reform H-390.849

1. Our AMA will advocate for the development and adoption of physician payment reforms that adhere to the following principles:
   a) promote improved patient access to high-quality, cost-effective care;
   b) be designed with input from the physician community;
   c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions;
   d) not require budget neutrality within Medicare Part B;
   e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice;
   f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process;
   g) make participation options available for varying practice sizes, patient mixes, specialties, and locales;
   h) use adequate risk adjustment methodologies;
   i) incorporate incentives large enough to merit additional investments by physicians;
   j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols;
   k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization;
   l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and
   m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.

2. Our AMA opposes bundling of payments in ways that limit care or otherwise interfere with a physician's ability to provide high quality care to patients.

3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data.

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

5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

Citation: CMS Rep. 6, A-09; Reaffirmation A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-12; Modified: CMS Rep. 6, A-13; Reaffirmation I-15; Reaffirmation: A-16; Reaffirmed in lieu of: Res. 712, A-17;

Preserving a Period of Stability in Implementation of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA) D-390.950

1. Our AMA will advocate that Centers for Medicare and Medicaid Services (CMS) implement the Merit-Based Payment Incentive Payment System (MIPS) and Alternative Payment Models (APMs) as is consistent with congressional intent when the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) was enacted.

2. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA, which includes assurances that CMS has conducted appropriate testing, including physicians' ability to participate and validation of accuracy of scores or ratings, and has necessary resources to implement provisions regarding MIPS and APMs.

3. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA that includes a suitable reporting period.

Citation: Res. 242, A-16;

MIPS and MACRA Exemption H-390.838

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

Citation: Res. 208, I-16; Reaffirmation: A-17; Reaffirmation: I-17;

Electronic Health Records and Meaningful Use D-478.971

Our AMA: (1) will continue to work with the Centers for Medicare and Medicaid Services and other relevant stakeholders to allow for partial credit for eligible professionals in the Meaningful Use and Merit-Based Incentive payment programs; and (2) will compile and continue to educate physicians on the available guidance related to different types of EHRs, system downtime, and technology failures, including mitigation strategies, continuity training solutions, and contracting solutions.

Citation: BOT Rep. 10, A-16;

Support for the Quadruple Aim H-405.955

1. Our AMA supports that the "Triple Aim" be expanded to the Quadruple Aim, adding the goal of improving the work-life balance of physicians and other health care providers.

2. Our AMA will advocate that addressing physician satisfaction count as a Clinical Practice Improvement Activity under the Merit-Based Incentive Payment System (MIPS).

Citation: Res. 104, A-16;
Whereas, E-prescribing is a process enabled by electronic medical records (EMRs) that gets widespread support as a benefit of the EMR for patient safety and provider process benefit, and

Whereas, The process for e-prescribing was designed in large part by automating preexisting paper, voice and fax processes; and

Whereas, E-prescriptions are sent from prescriber systems to a central clearinghouse to resolve formulary and other issues prior to dispensing, and

Whereas, The goal should be a strategically designed efficient process that allows each participant to perform the roles they must perform and not perform those they don’t need to perform while leveraging evolving technology; and

Whereas, Good processes can always be made better; and

Whereas, E-prescribing makes the process of obtaining refills less cumbersome for prescriber and patient alike, making e-prescribing of controlled substances a significant opportunity for physicians to fight the opioid crisis by prescribing smaller initial amounts of opioid medications; and

Whereas, The current cumbersome requirement for two-factor authentication to e-prescribe controlled substances has tragically delayed widespread adoption of e-prescribing for controlled substances; and

Whereas, Widespread adoption of e-prescribing for controlled substances would make physician contributions to this problem and its solutions more transparent and accountable; and

Whereas, Using the same process for prescribing controlled substances as for all other medications deserves consideration as the alternative to doing the same thing we are doing and expecting a different result; and

Whereas, Making it easier to do the right thing will make it more likely the right thing will be done; and

Whereas, The steps requiring the expertise and license of the physician include the choice of drug, form, dose, instructions, duration and refills; and
Whereas, Prescriber expertise is not required to designate which pharmacy should ultimately fill the prescription when the prescription is e-prescribed using a nationwide clearinghouse (in most cases Surescripts); and

Whereas, Patients could authorize the pharmacy of their choice to retrieve the information needed to fill a prescription from the clearinghouse rather than involving the physician or staff in the error-prone choice of pharmacy, particularly when the pharmacy is outside the prescriber’s community; and

Whereas, Patients could authorize the physician to send their prescription directly to a specific specialty or compounding pharmacy (bypassing the clearinghouse) for purposes of improved quality or accessibility for patient benefit; therefore be it

RESOLVED, 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)

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

Received: 05/02/18
Whereas, Direct and indirect costs of pharmaceuticals continue to grow disproportionately (accounting for almost 60% of the cost for the most expensive chronic disease diabetes mellitus, for instance\(^1\)), even while the market approaches 90% generic; and

Whereas, The growth of pharmacy-benefit interference is a major source of complaints by both patients and physicians, and unequivocally interferes with the clinical primacy of the patient-physician relationship; and

Whereas, These manipulations are interfering daily with the efficient practice of American medicine without effectively constraining the rate of growth of pharmaceutical costs; and

Whereas, Over 30 years of pharmaceutical market evolution under the Hatch-Waxman Act has allowed for perverse price discrepancies between the newest agents and popular generics, incentivized "me-too" drug development and patent-extending alterations, and created a generic market with uneven competition (co-existence of very inexpensive markets [with possible manufacturing quality implications], intermittent shortages, and unexpected cost increases for rare drugs); and

Whereas, Any change in pharmaceutical pricing policy and regulation must seek to balance incentives for innovation in addition to rewards for value delivered; therefore be it

RESOLVED, 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)


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

Received: 05/02/18
Resolved by the House of Delegates of the American Medical Association, meeting in its 239th Annual Session, the Illinois delegation, at Chicago, Illinois, 2018:

Resolved, That a resolution be introduced, referred to Committee B, and passed on for consideration:

Subject: Treating Opioid Use Disorder in Hospitals

Whereas, The opioid epidemic has become a critical threat to public health in the U.S.1; and

Whereas, Hospitalizations have been rapidly increasing for opioid overdose and for infectious complications of injection drug use such as hepatitis C, HIV, and deep tissue bacterial infections, reaching 1.27 million emergency room and inpatient stays in 20142; and

Whereas, Inpatient costs among those with opioid use disorder almost quadrupled to $15 billion between 2002 and 20123; and

Whereas, There is a high risk of repeated hospitalization4 and overdose death following hospitalization due to loss of opioid tolerance5, but hospitals rarely address the underlying chronic disease of opioid use disorder6,7; and

Whereas, FDA-approved medications for treating opioid use disorder (buprenorphine, methadone and naltrexone) reduce illicit opioid use1; opioid agonist therapy (buprenorphine or methadone) reduces opioid overdose death by 50% in part by preventing loss of opioid tolerance; and buprenorphine provides further protection because of its high receptor affinity and ceiling effect on respiratory depression8; and

Whereas, Initiation of buprenorphine in the emergency department9 and inpatient setting10 and linkage to ongoing comprehensive treatment as an outpatient is an effective means for engaging patients and reducing illicit opioid use11-13; therefore be it

Resolved that the following bill be introduced, referred to Committee B, and passed on:

Respectfully Submitted, R. Dale Blasier, MD, Chair, Reference Committee B

RESOLVED, 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

RESOLVED, 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

RESOLVED, 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)

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

Received: 05/02/18
Whereas, The opioid epidemic has become a critical threat to public health in the U.S.; and

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

Whereas, Less than half of facilities that provide inpatient treatment for opioid use disorder offer an FDA-approved medication for opioid use disorder; and

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

Whereas, Opioid overdose death is reduced by 50% by treatment with opioid replacement therapy (buprenorphine or methadone), which prevents loss of opioid tolerance; and

Whereas, The U.S. Food and Drug Administration is pursuing strategies to eliminate barriers and promote access to all effective medications known to address opioid use disorder at state-certified opioid treatment programs; and

Whereas, The President’s Commission on Combating Drug Addiction and the Opioid Crisis recommended a requirement that all three FDA-approved medications (buprenorphine, methadone and naltrexone) be available at every facility licensed to treat opioid use disorder, and clinical guidelines indicate that the choice of treatment options should be a shared decision between the clinician and the patient; therefore be it

References:

RESOLVED, 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

RESOLVED, 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

RESOLVED, 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)

Fiscal Note: Not yet determined

Received: 05/02/18
Introduction by: Illinois

Subject: Accuracy and Accountability of Physician Compensation Reporting by Drug and Device Companies

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

Whereas, U.S. federal law requires drug and device companies to report compensation to physicians as part of the Physician Payments Sunshine Act; and

Whereas, These compensations are listed on a public website named OpenPaymentsData.CMS.gov and can be searched by an individual physician’s name; and

Whereas, Companies that report physician compensation do not have to provide proof of delivery and receipt of reportable compensation; and

Whereas, Companies’ representatives may leave food, beverages, or other gifts at a physician’s office (or at the door of the office) without physician consent and report this “gift” under the Sunshine Act; and

Whereas, Disputing a payment that has been inaccurately reported by a company is cumbersome and requires the reporting company to submit paperwork redacting the payment; and

Whereas, Payment posted in error may imply a conflict of interest or relationship between the physician and the company to the public, including the physician’s patients; therefore be it

RESOLVED, 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

RESOLVED, 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

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)

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

Received: 05/02/18
Whereas, Compounding pharmacies tailor and customize prescriptions to meet patients’ needs for medications that are not commercially available; and

Whereas, Many of these patients have problems with mass-produced medications including allergic reactions, inability to swallow pills, or a need for a different dosage or formulation than is available on the commercial market; and

Whereas, Compounding pharmacies must have federal certification as a result of the Drug Quality and Security Act enacted in 2013; and

Whereas, Compliance with this Act by compounding pharmacies requires acceptable manufacturing practices, proper labeling including directions for use, inspections of these pharmacies by the U.S. Food and Drug Administration (FDA) on a regular basis, and FDA approval prior to marketing compounding medications; and

Whereas, Pharmacy benefit managers (PBMs) are hired by employers to manage their employee prescription drug coverage; and

Whereas, PBMs control the drug benefits of 210 million Americans of which 28 million are Medicare Part D patients; and

Whereas, The largest PBMs in the U.S. include Express Scripts, CVS Caremark, Optum Rx, Argus, EnvisionRx, ProCareRX, and Prime Therapeutics; and

Whereas, At the heart of the conflict between PBMs and compounding pharmacies is the fact that PBMs have used their position and power as health plan administrators to boycott compounding pharmacies by eliminating coverage for compounding ingredients, cutting off health network access, and devising various “gate keeper tactics” using unreasonable administrative mandates designed to deny prescriptions from being filled; and

Whereas, Their intent is to cause a significant decline and potential elimination of independent compounding pharmacies from the health plan market; and

Whereas, PBMs have a conflict of interest in their gatekeeper role as they own a financial stake in a mail order business that competes with compounding pharmacies that use the U.S. Postal Service, UPS, and other delivery systems; and

Whereas, PBMs maintain that spending on compound medications has increased exponentially; and
Whereas, Their solution to address these rising costs is to target and block thousands of ingredients used by compounding pharmacies that they claim are greatly inflated but provide no added clinical benefit; and

Whereas, One needs to question whether PBMs are qualified to evaluate clinical benefit or is it just part of their financial agenda in the $270 billion drug market; and

Whereas, PBMs have sent letters to patients and pharmacies containing inaccurate and misleading information about the safety and efficacy of compound medications. These letters to patients inform them there has been an unspecified change in their compound medication benefit plan although PBMs lack the authority to alter the terms of patient health care plans. These documents serve to cover up the financially driven scheme of PBMs to cut their compound spending by 95 percent; and

Whereas, This scheme has resulted in denial of care to thousands of patients as PBMs continue to issue unlawful blanket denials of compounded medications; and

Whereas, PBMs have engaged in retroactive audits of compounding pharmacies to claim back reimbursements for compounded scripts already filled citing the lack of FDA approval of the medications; and

Whereas, They have removed compounding pharmacies from provider networks by terminating agreements without just cause and often without knowledge of these compounding pharmacies; and

Whereas, PBMs have also threatened some physicians with accusations of fraud or abuse if they prescribe compounded medications; and

Whereas, As a result of their anti-competitive conduct, PBMs have continued to “line their pockets” financially at the expense of the most vulnerable patients in America; therefore be it

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 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)

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

Received: 05/02/18

RELEVANT AMA POLICY

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; and
(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.

Citation: BOT Rep. 9, I-97; Appended: Res. 224, I-98; Appended: Res. 529, A-02; Reaffirmed: Res. 533; A-03; Reaffirmation I-08; Reaffirmation A-10; Reaffirmed: Alt. Res. 806, I-17;
Whereas, High profile cases of health care provider sexual abuse and assault of patients have increased public awareness of this issue; and

Whereas, Public outcry is justly critical of an opaque system that protects and shields abusers from justice, allowing abuse to continue; and

Whereas, The process to report health care provider sexual abuse and assault of patients is confusing for victims and colleagues and the legal definition of criminal sexual conduct is often poorly understood; and

Whereas, Victims and reporting colleagues of the accused may not realize a crime has occurred or may assume that reports to the board of medicine will also trigger a criminal investigation; and

Whereas, Not all states permit or require their licensing boards to report suspected sex crimes to the police; and

Whereas, Eleven states (AZ, DE, FL, IA, OR, MA, MD, NY, TN, TX, WA) have such a provision in their public health codes, to not only allow reporting to law enforcement but to mandate it; and

Whereas, This loophole has allowed health care providers across the country to commit sex crimes against patients with only medical sanctions, revocation of their licenses, or “quiet retirement” without facing criminal charges for their actions; therefore be it

RESOLVED, 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)

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

Physician Competence H-275.998
Our AMA urges: (1) The members of the profession of medicine to discover and rehabilitate if possible, or to exclude if necessary, the physicians whose practices are incompetent. (2) All physicians to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, need help, or whose practices are incompetent. (3) The appropriate committees or boards of the medical staffs of hospitals which have the responsibility to do so, to restrict or remove the privileges of physicians whose practices are known to be incompetent, or whose capabilities are impaired, and to restore such physicians to limited or full privileges as appropriate when corrective or rehabilitative measures have been successful. (4) State governments to provide to their state medical licensing boards resources adequate to the proper discharge of their responsibilities and duties in the recognition and maintenance of competent practitioners of medicine. (5) State medical licensing boards to discipline physicians whose practices have been found to be incompetent. (6) State medical licensing boards to report all disciplinary actions promptly to the Federation of State Medical Boards and to the AMA Physician Masterfile. (Failure to do so simply allows the incompetent or impaired physician to migrate to another state, even after disciplinary action has been taken against him, and to continue to practice in a different jurisdiction but with the same hazards to the public.)


E-9.4.3 Discipline & Medicine
Incompetence, corruption, dishonest, or unethical conduct on the part of members of the medical profession is reprehensible. In addition to posing a real or potential threat to patients, such conduct undermines the publics confidence in the profession. The obligation to address misconduct falls on both individual physicians and on the profession as a whole.

The goal of disciplinary review is both to protect patients and to help ensure that colleagues receive appropriate assistance from a physician health program or other service to enable them to practice safely and ethically. Disciplinary review must not be undertaken falsely or maliciously.

Individually, physicians should report colleagues whose behavior is incompetent or unethical in keeping with ethics guidance.

Collectively, medical societies have a civic and professional obligation to:
(a) Report to the appropriate governmental body or state board of medical examiners credible evidence that may come to their attention involving the alleged criminal conduct of any physician relating to the practice of medicine.
(b) Initiate disciplinary action whenever a physician is alleged to have engaged in misconduct whenever there is credible evidence tending to establish unethical conduct, regardless of the outcome of any civil or criminal proceedings relating to the alleged misconduct.
(c) Impose a penalty, up to and including expulsion from membership, on a physician who violates ethical standards.

AMA Principles of Medical Ethics: II,III,VII
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016
Whereas, Existing AMA policy states “gun violence represents a public health crisis which requires a comprehensive public health response and solution” (D-145.995); and

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

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

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

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

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

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

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

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

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

Whereas, In an unadjusted t-test analysis of gun related deaths in each state in 2016, there were statistically significantly fewer gun related deaths in states which had a law requiring an individual purchasing a gun to be 21 or older compared to states with a lower purchase age. (p=5.15e-06).1516

Whereas, In 2015, among “Crime Against Person” offenders who used a firearm, offenders ages 18-20 (our target cohort) constituted the second largest cohort (11.5%). Offenders ages 19-24 and 25-29 were the largest cohort (13.0%, tied), while offenders ages 30-34 constituted the third largest cohort (8.2%)17; and

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

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

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

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

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

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

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

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

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

It is the policy of the AMA to:

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

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

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

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

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

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

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

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

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

Received: 05/08/18


\textsuperscript{21} Shepard, Steven. Gun control support surges in polls. Politico.  

\textsuperscript{22} United States, Congress, Age 21 Act. 2018.  
RELEVANT AMA POLICY

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

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

Correlation Between State Handgun Purchase Age and Rate of Deaths from Firearms

![Box plot showing correlation between state handgun purchase age and death rate from firearms per 100,000 people](image)
Whereas, The National Conference of Insurance Legislators (NCOIL) is an organization that convenes legislators from around the United States who are involved with insurance legislation; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 Guns to Carry. Reciprocity Map. www.guntocarry.com/ccw-reciprocity-map/.

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

Received: 05/08/18

RELEVANT AMA POLICY

Gun Violence as a Public Health Crisis D-145.995
Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress to lift the gun violence research ban.
Citation: Res. 1011, A-16;

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms; (2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths; (3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns; (4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible; (6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms; (7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and (8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.
Citation: (CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appendix: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appendix: Res. 921, I-13)
Whereas, Health insurers are increasingly limiting the size of primary care and specialty networks available to plan members as a cost containment measure, without much consideration to the effect on quality and access to care; and

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

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

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

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

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

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

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

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

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

Whereas, There is no current AMA policy supporting the right of all patients, regardless of plan type and acuity of illness, to select the physician of their choice, and for those physicians to receive compensation for the care they deliver, therefore be it
RESOLVED, That our American Medical Association draft and promote model state legislation which:

1. Allows any patient covered by a specific managed care organization to choose to receive medical care from a physician (MD and DO) licensed in that state willing to agree to the terms of that managed care organization’s contract, and

2. Allows a physician (MD or DO) licensed in that state willing to agree to the terms of a specific managed care organization’s contract to participate in delivering medical services to the patients covered by that managed care organization without being mandated to accept any specific type of insurance or managed care organizations contract. (Directive to Take Action)

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

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

Received: 05/10/18