Your Reference Committee recommends the following consent calendar for acceptance:

1. Resolution 717 – Impact of the High Capital Cost of Hospital EHRs on the Medical Staff

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

2. Board of Trustees Report 37 – Eliminate the Requirement of H&P Update
5. Council on Medical Service Report 5 – Financing of Long-Term Services and Supports
6. Council on Medical Service Report 6 – Integrating Precision Medicine into Alternative Payment Models
7. Resolution 706 – Ensuring Medicare Coverage for Long Term Care
8. Resolution 710 – Code Status Through the Continuum of Care
9. Resolution 713 – Private Equity Firms
10. Resolution 714 – Laboratory Benefit Managers
11. Resolution 715 – The Obligatory Nature and Enduring Purpose of the Self-Governed Organized Medical Staff

RECOMMENDED FOR REFERRAL

13. Resolution 701 – Employed Physicians Bill of Rights
15. Resolution 704 – Non-Payment and Audit Takebacks by CMS
16. Resolution 707 – Health Plan Payment of Patient Cost-Sharing
17. Resolution 712 – Alternative Payment Models and Vulnerable Populations
RECOMMENDED FOR REFERRAL FOR DECISION

18. Resolution 705 – Modify the Clinical Laboratory Improvement Amendment of 1988
19. Resolution 716 – Hospital Closures and Physician Credentialing

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

20. Resolution 703 – Economic Credentialing
21. Resolution 711 – Compensation for Pre-Authorization Requests

Existing policy was reaffirmed in lieu of the following resolutions via the Reaffirmation Consent Calendar:

- Resolution 708 – Arbitrary Paperwork and Signature Deadlines for Hospital and Rehabilitation Unit Admission
- Resolution 709 – Prior Authorization for Durable Medical Equipment
(1) RESOLUTION 717 - IMPACT OF THE HIGH CAPITAL COST OF HOSPITAL EHRS ON THE MEDICAL STAFF

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 717 be adopted.

HOD ACTION: Resolution 717 adopted.

Resolution 717 asks that our AMA study the long-term economic impact for physicians and hospitals of EHR system procurement, including but not limited to their impact on downsizing of medical staffs and its effect on physician recruitment and retention.

Testimony on Resolution 717 was minimal and supportive. An amendment was offered to expand the requested study to include not only the effect on physician recruitment and retention but also the effect on patient safety and patient care. However, your Reference Committee believes this amendment expands the scope of the requested study well beyond its original intent and constitutes a separate study. Accordingly, your Reference Committee recommends that Resolution 717 be adopted.

(2) BOARD OF TRUSTEES REPORT 37 – ELIMINATE THE REQUIREMENT OF H&P UPDATE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 37 be amended by addition of a new Recommendation to read as follows:

That our AMA work with the Centers for Medicare and Medicaid Services to redefine the requirement that an update to a history and physical within twenty-four hours of a surgery/procedure to mean that the physician and/or non-physician provider has reviewed pertinent data and the original documented history and physical is sufficient information to determine that it is safe to proceed with the planned surgery or procedure. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 37 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 37 adopted as amended and the remainder of the report filed.
Board of Trustees Report 37 recommends that Resolution 710-A-16 not be adopted and the remainder of the report be filed.

A member of the Board of Trustees introduced the report noting that the Board has deliberated on this issue numerous times. Testimony on the report was mixed. Some speakers noted that the issue of the H&P update is a patient safety issue while others noted that the requirement is onerous and misinterpreted. Additional testimony highlighted that interpretation of preoperative clinical evaluation requirements vary. Your Reference Committee recognizes the complex nature of this issue and offers an amendment to address concerns raised in testimony. Accordingly, your Reference Committee recommends that Board of Trustees Report 37 be adopted as amended and the remainder of the report be filed.

(3) BOARD OF TRUSTEES REPORT 39 – EXPANDING ACCESS TO SCREENING TOOLS FOR SOCIAL DETERMINANTS OF HEALTH/SOCIAL DETERMINANTS OF HEALTH IN PAYMENT MODELS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 2 in Board of Trustees Report 39 be amended by addition and deletion to read as follows:

**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 continued 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, with physician input, 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.

9. Our AMA will urge EHR vendors to adopt social determinants of health SDH templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 39 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 39 adopted as amended with addition of a third Recommendation and the remainder of the report filed.
3. That our AMA support payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems.

Board of Trustees Report 39 recommends amending Policy D-478.995 by addition to state that our AMA urge EHR vendors to adopt SDH templates without adding further cost for physicians.

A member of the Board of Trustees introduced the report. Testimony was largely supportive of the report. In particular, testimony asked to modify Policy D-478.995 part 2(D) to delete the word “more” and replace it with “continued” to accurately reflect the past and current research that has occurred and the need to continue to update that research. Moreover, testimony noted physician input should be garnered in the CMS development of any minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs, and recommends an amendment to that end. Additionally, testimony requested that not only should EHR vendors adopt social determinants of health (SDH) templates, but also, they should be created with input from our AMA and other stakeholders and should do so without adding documentation burden for physicians. Your Reference Committee agrees and accepts these amendments.

Moreover, testimony stated that one of the original referred resolutions requested fair compensation for use of SDH screening tools and interventions in the clinical setting. Your Reference Committee understands this concern; however, your Reference Committee notes that, in a Proposed Rule due by early July, CMS is expected to discuss potential modifications and/or a process to consider modifications to E/M guidelines, which may address the concern. Accordingly, your Reference Committee recommends that Board of Trustees Report 39 be adopted as amended and the remainder of the report be filed.
RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 5 of Council on Medical Service Report 4 be amended by addition and deletion to read as follows:

5. That our AMA policy affirm that medical advice services provided by health plans should adhere to the following guidelines:
   a) The primary goals of health plans' medical advice services should be to inform, educate and empower patients to make good health care choices and receive timely and appropriate care. These services should not be used to assess patients in order to inform diagnosis or treatment.
   b) Health plans’ medical advice services should comply with state licensure laws, state medical, nursing, or other relevant practice acts, state scope of practice laws, and other relevant requirements within the state in which enrollees receive services.
   c) Staff providing health plans’ medical advice services should have a level of knowledge and training no less than a registered nurse (e.g., nurse with a bachelor of science in nursing, advanced practice registered nurse, or physician assistant) and be appropriately licensed in the state in which enrollees receive services.
   d) Qualified physicians should be available for consultation to persons offering medical advice services at all times that the medical advice service is advertised as available.
   e) Health plans should have policies and procedures in place that allow medical advice services to quickly and effectively respond to enrollees' health concerns.
   f) Health plans should have policies and procedures in place to ensure that medical advice service providers routinely provide feedback to enrollees’ treating physicians regarding the nature of the enrollees’ contacts.
   g) Health plans should ensure that non-clinical staff who may be screening enrollee calls or emails for the medical advice service are neither providing medical advice nor making medical decisions.
   h) Health plans’ medical advice services staff should fully disclose relevant training and credentials, and not misrepresent themselves to users. (New HOD Policy)
RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 4 be adopted as amended and the remainder of the report be filed.


Council on Medical Service Report 4 recommends a series of guidelines that health plans’ medical advice services should adhere to. The report also recommends new policy stating that real-time interactions between health plans and enrollees that are utilized for patient assessments and result in the creation of treatment plans constitute the practice of medicine.

Testimony on Council on Medical Service Report 4 was supportive. A member of the Council on Medical Service introduced the report, noting that while it is not unusual for health plans to offer medical advice services, there have been concerns over the years regarding how these services are managed and whether staff are appropriately qualified. An amendment was offered to include nurses with associate degrees in nursing to the parentheses of Recommendation 5(c). An additional amendment was offered to Recommendation 5(d) to clarify that qualified physicians should be available for consultation to persons offering medical advice services at all times that the service is advertised as available. Your Reference Committee recommends deletion of the parenthetical language in Recommendation 5(c) for simplification purposes and also the addition of the clarifying language in 5(d). Accordingly, your Reference Committee recommends that the recommendations in Council on Medical Service Report 4 be adopted as amended and the remainder of the report be filed.

(5) COUNCIL ON MEDICAL SERVICE REPORT 5 - FINANCING OF LONG-TERM SERVICES AND SUPPORTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 4 in Council on Medical Service Report 5 be amended by addition to read as follows:

4. That our AMA support adding transferable and portable LTCI coverage as part of workplace automatic enrollment with an opt-out provision potentially available to both current employees and retirees. (New HOD Policy)
RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 5 be adopted as amended and the remainder of the report be filed.

HOD ACTION: The recommendations in Council on Medical Service Report 5 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 5 recommends a set of recommendations to modify the current financing structure of long-term services and supports with options that weave together financing reforms through publicly funded programs and private insurance.

A member of the Council on Medical Service introduced the report. The member highlighted the increased national spending for long-term services and supports (LTSS) and that the demand for LTSS is expected to double in the next thirty years as the baby boomer generation ages. Testimony stated that there are few affordable options in the private insurance market for LTSS coverage and limited coverage under Medicare. Consequently, Medicaid accounts for over half of national spending on LTSS and is the primary payer across the nation for LTSS. The Council member provided an overview of the report recommendations saying that the Council is proposing a multi-pronged approach to alter the financing and viability through a mix of public and private reforms. Finally, the Council noted that, while there may be no single, comprehensive solution to address the growing demand for LTSS, the Council believes that its recommendations represent a pragmatic step forward to address the needs of an aging population by shifting away from last-resort public financing to a more sustainable system of meaningful insurance.

Testimony on Council on Medical Service Report 5 was unanimously supportive. Testimony proposed that long-term care insurance (LTCI) coverage as part of workplace automatic enrollment should have an opt-in provision rather than an opt-out provision. However, a member of the Council noted that supporting an opt-out provision was carefully considered by the Council and mirrors the structure of many employer-sponsored retirement savings accounts. Additional testimony noted that employer-based long-term care insurance should be portable and transferable as employees transition to various jobs throughout their careers. Your Reference Committee agrees and proposes an amendment to that end. Accordingly, your Reference Committee recommends that Council on Medical Service Report 5 be adopted as amended and the remainder of the report be filed.
(6) COUNCIL ON MEDICAL SERVICE REPORT 6 -
INTEGRATING PRECISION MEDICINE INTO
ALTERNATIVE PAYMENT MODELS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends
that Recommendation 8 of Council on Medical Service
Report 6 be amended by addition and deletion to read as
follows:

8. That our AMA encourage APMs to consider measuring patient outcomes and quality improvements over time to allow for the use of precision medicine tests and therapeutics that have clinical value.

(New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends
that Council on Medical Service Report 6 be amended by
addition of a new Recommendation to read as follows:

That our AMA reaffirm Policy D-185.980, which encourages public and private payers to adopt a series of processes and methodologies for determining coverage and payment for genetic/genomic precision medicine.

(Reaffirm HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends
that the recommendations in Council on Medical Service
Report 6 be adopted as amended and the remainder of the report be filed.


Council on Medical Service Report 6 recommendations encourage APMs to consider the value of precision medicine and to integrate precision medicine approaches as appropriate and as recommended by national medical specialty societies.

Testimony was supportive of Council on Medical Service Report 6. A member of the Council on Medical Service introduced the report, noting that precision medicine innovations are occurring simultaneously with significant payment and delivery reforms, and that there is value to considering precision medicine approaches within alternative payment models. One speaker asked that Recommendation 8 be strengthened. Another requested reaffirmation of Policy D-185.980, which addresses payment and coverage for
genetic/genomic precision medicine. Your Reference Committee agrees, and recommends that Council on Medical Service 6 be adopted as amended and the remainder of the report be filed.

(7) RESOLUTION 706 - ENSURING MEDICARE COVERAGE FOR LONG TERM CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that first Resolve of Resolution 706 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association support the concept of increasing the existing 20-day limit of full Medicare coverage for a patient’s skilled nursing facility stay (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 706 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work to identify additional mechanisms by which the additional patients’ out-of-pocket costs for this skilled nursing facility care can be fairly covered. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 706 be adopted as amended.

HOD ACTION: Resolution 706 adopted as amended.

Resolution 706 asks that our AMA support the concept of increasing the existing 20-day limit of full Medicare coverage for a patient’s skilled nursing facility stay; and work to identify mechanisms by which the additional costs for this care can be fairly covered.

Testimony on Resolution 706 was supportive. A member of the Council on Medical Service offered an amendment to strike the first resolve and to amend the second resolve. In offering the amendment, the Council member stated that though the Council agrees with the goal of Resolution 706, it is important to have more information on this issue before calling for this specific action, including how many people exceed the 20 days and what percentage of those individuals are not covered by a Medicare Advantage plan or supplemental plan where co-pays and premiums may be covered for the beneficiary. Therefore, in the absence of that data, the Council thought it best to broadly support the idea of lowering out-of-pocket costs for patients in skilled nursing
facilities without being overly prescriptive. Moreover, the Council questioned why we should call for no co-payments on skilled nursing facility stays but not for other services such as hospital days and physician services. Finally, the Council testified that Medicare coverage of skilled nursing facility services is intended to be used for rehabilitation, not for long-term care. As such, the Council highlighted Council on Medical Service Report 5 on financing of long-term services and supports offering pragmatic and comprehensive steps to addressing the complex issue of long-term care coverage. Your Reference Committee finds this testimony persuasive and accepts the amendment. Accordingly, your Reference Committee recommends that Resolution 706 be adopted as amended.

(8) RESOLUTION 710 - CODE STATUS THROUGH THE CONTINUUM OF CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 710 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services to streamline revise or rescind the rules that prevent transfer of code status across the continuum of care in order to better meet the needs of our patients and our health care system in a comprehensive, cohesive, and more cost-effective manner. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 710 be adopted as amended.

HOD ACTION: Resolution 710 adopted as amended.

Resolution 710 asks that our AMA work with the Centers for Medicare and Medicaid Services to revise or rescind the rules that prevent transfer of code status across the continuum of care in order to better meet the needs of our patients and our health care system in a comprehensive, cohesive, and more cost-effective manner.

There was minimal supportive testimony on Resolution 710 stating that this resolution is a thoughtful step forward to address the issue of code status. An amendment was offered to simplify the resolution, and your Reference Committee accepts this amendment. Accordingly, your Reference Committee recommends that Resolution 710 be adopted as amended.
RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 713 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association study, with report back at the 2018 Interim 2019 Annual Meeting, the effects on the healthcare marketplace of corporate investors (e.g., public companies, venture capital/private equity (PE) firms, insurance companies and health systems) acquiring a majority and/or controlling interest in entities that manage physician practices, stake in physician private independent, small group and large group practices, including, but not limited to, such topics as:

- the degree of corporate investor venture capital/PE penetration and investment in the healthcare marketplace;
- the impact on physician practice and independence;
- patient access;
- resultant trends in the use of unsupervised, independently practicing non-physician extenders;
- long term financial viability of purchased practices;
- effects of ownership turnovers and bankruptcies on patients and practice patterns;
- effectiveness of methodologies employed by unpurchased private independent, small group and large group practices to compete for insurance contracts in consolidated marketplaces;
- and the relative impact corporate investor venture capital/PE transactions purchases have on the paths and durations of junior, mid-career and senior physicians (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 713 be adopted as amended.

HOD ACTION: Resolution 713 adopted as amended with change in title to read as follows:

CORPORATE INVESTORS

Resolution 713 asks that our AMA study, with report back at the 2018 Interim Meeting, the effects on the healthcare marketplace of venture capital/PE firms acquiring majority and/or controlling stake in physician private independent, small group and large group practices; and that, in order to address the particular concerns of physicians entering
into management service organization contracts, our AMA amend the AMA Annotated Model Physician-Group Practice Employment Agreement (H-215.981).

Testimony was supportive of Resolution 713. Your Reference Committee discussed broadening the requested study to include corporate ownership of physician practices beyond venture capital/private equity firms, which was proposed by some speakers. However, your Reference Committee heard substantial testimony regarding the need to specifically study venture capital/private equity firm acquisitions of physician practices and the impact of these acquisitions on practices and patients. Your Reference Committee believes that a separate report on corporate control of physician practices may benefit physicians, but your Reference Committee does not wish to broaden the purview of the study requested by Resolution 713. Your Reference Committee concurs with amendments offered to the first Resolve, including an amendment asking for a report back at the 2019 Annual Meeting instead of the 2018 Interim Meeting. Your Reference Committee believes that additional time is needed to address the numerous topics outlined in resolution. Additional amendments to the first Resolve are suggested based on your Reference Committee’s consultation with our AMA’s Office of General Counsel. Accordingly, your Reference Committee recommends that Resolution 713 be adopted as amended.

(10) RESOLUTION 714 - LABORATORY BENEFIT MANAGERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following be adopted in lieu of Resolution 714:

HOD ACTION: The following resolution adopted in lieu of Resolution 714:

RESOLVED, That our American Medical Association support efforts to reduce laboratory benefit management policies that result in delays in patient care, reduced patient access, or increased patient costs without clinical justification; (New HOD Policy) and be it further

RESOLVED, That our AMA support that any policies regarding laboratory benefit management arrangements preclude any potential conflict of interest in programs adopted by health insurance payors to provide laboratory benefit management, including prohibition on the use of any laboratory benefit management entity financially affiliated with a clinical laboratory. (New HOD Policy)

Resolution 714 asks that our AMA adopt policy that supports the adoption of laws, regulations and public or private sector policies regarding laboratory benefit management arrangements to preclude: (1) Any potential financial conflict of interest in programs adopted by health insurance payors to provide laboratory benefit management, including prohibition on the use of any laboratory benefit management
theory financially affiliated with a clinical laboratory; (2) Health insurance payer constraints on ordering physician discretion for referrals made to any in-network laboratory or pathology providers when such referrals are medically and ethically appropriate; (3) Any adverse claims impact on the laboratory or pathology provider who receives a lawful order from a health care provider for medically necessary services, based upon a compliance failure in the laboratory benefit management ordering process; and (4) The implementation by a health insurance payer of prior authorization or prior notification imposed on ordering physicians for any pathology or laboratory test ordered on a patient specimen obtained in a hospital or ambulatory surgical center.

Overall, testimony on Resolution 714 was supportive. An amendment was offered to remove the phrase “in network” because all laboratory tests are affected by these potential conflicts of interest, whether in-network or not. Testimony by other parties supported the removal of this language. A member of the Council on Medical Service testified that Resolution 714 may be overly prescriptive at this juncture and instead proposed an alternate resolution recognizing that our AMA currently does not have policy specific to laboratory benefit managers and believes that our AMA should adopt broad foundational policy to begin supporting advocacy in this area. Your Reference Committee agrees and believes that this language not only touches on most of the concerns in Resolution 714 but also addresses concerns raised in testimony over the phrase “in network,” the issue of laboratory prior authorization, as well as testing location. However, your Reference Committee believes that the inclusion of a resolve addressing any potential conflict of interest is warranted. As such, your Reference Committee recommends that an alternate resolution be adopted in lieu of Resolution 714.
RESOLUTION 715 - THE OBLIGATORY NATURE AND ENDURING PURPOSE OF THE SELF-GOVERNED ORGANIZED MEDICAL STAFF

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 715 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association amend Policy H-225.942 Physician and Medical Staff Bill of Rights by addition to read as follows:

Our AMA adopts and will distribute the following Medical Staff Rights and Responsibilities:

Preamble

The organized medical staff, hospital governing body and administration are all integral to the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated.

The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. These personal interactions between medical staff physicians and their patients give rise to a heightened and incomparable accountability to patients that is not shared by hospital administrators or members of the governing body. This unparalleled accountability requires that physicians remain answerable first and foremost to their patients.

Medical staff self-governance is vital in protecting the ability of physicians to act in their patients’ best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.
From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:

I. Our AMA recognizes the following fundamental responsibilities of the medical staff:
   a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization’s governing body.
   b. The responsibility to provide leadership and work collaboratively with the health care organization’s administration and governing body to continuously improve patient care and outcomes.
   c. The responsibility to participate in the health care organization’s operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.
   d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.
   e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.
   f. The responsibility to make appropriate recommendations to the health care organization’s governing body regarding membership, privileging, patient care, and peer review.

II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff’s ability to fulfill its responsibilities:
   a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.
   b. The right to advocate for its members and their patients without fear of retaliation by the health care organization’s administration or governing body.
   c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.
d. The right to be well informed and share in the decision-
making of the health care organization's operational and 
strategic planning, including involvement in decisions to 
grant exclusive contracts or close medical staff 
departments.
e. The right to be represented and heard, with or without 
vote, at all meetings of the health care organization's 
governing body.
f. The right to engage the health care organization’s 
administration and governing body on professional matters 
involving their own interests.

III. Our AMA recognizes the following fundamental 
responsibilities of individual medical staff members, 
regardless of employment or contractual status:
a. The responsibility to work collaboratively with other 
members and with the health care organization’s 
administration to improve quality and safety.
b. The responsibility to provide patient care that meets the 
professional standards established by the medical staff.
c. The responsibility to conduct all professional activities in 
accordance with the bylaws, rules, and regulations of the 
medical staff.
d. The responsibility to advocate for the best interest of 
patients, even when such interest may conflict with the 
interests of other members, the medical staff, or the health 
care organization.
e. The responsibility to participate and encourage others to 
play an active role in the governance and other activities of 
the medical staff.
f. The responsibility to participate in peer review activities, 
including submitting to review, contributing as a reviewer, 
and supporting member improvement.

IV. Our AMA recognizes that the following fundamental 
rights apply to individual medical staff members, 
regardless of employment, contractual, or independent 
status, and are essential to each member’s ability to fulfill 
the responsibilities owed to his or her patients, the medical 
staff, and the health care organization:
a. The right to exercise fully the prerogatives of medical 
staff membership afforded by the medical staff bylaws.
b. The right to make treatment decisions, including 
referrals, based on the best interest of the patient, subject 
to review only by peers.
c. The right to exercise personal and professional 
judgment in voting, speaking, and advocating on any 
matter regarding patient care or medical staff matters, 
without fear of retaliation by the medical staff or the health 
care organization’s administration or governing body.
d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.
e. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.
f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 715 be adopted as amended.

HOD ACTION: Resolution 715 adopted as amended.

Resolution 715 asks that Policy H-225.942 be amended by addition of a Preamble.

Testimony was supportive of Resolution 715, which adds a preamble developed by the Organized Medical Staff Section to Policy H-225.942. Your Reference Committee agrees with concerns regarding a statement in the preamble’s second paragraph that could alienate hospital administrator colleagues and physician leaders who are involved in governance, and recommends deletion of that language. Your Reference Committee recommends that Resolution 715 be adopted as amended.

(12) BOARD OF TRUSTEES REPORT 31 – PHYSICIAN BURNOUT AND WELLNESS CHALLENGES, PHYSICIAN AND PHYSICIAN ASSISTANT SAFETY NET, IDENTIFICATION AND REDUCTION OF PHYSICIAN DEMORALIZATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 31 be referred.

HOD ACTION: Board of Trustees Report 31 referred.

Board of Trustees Report 31 recommends amending Policy D-310.968 by addition to encourage hospitals to confidentially survey physicians to identify factors that may lead to physician demoralization; continue to develop guidance to help hospitals and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being; address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and develop and promote
mechanisms by which organizations and physicians can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being at the system level.

Testimony on Board of Trustees Report 31 was mixed, with several speakers strongly supporting the report and others asking for a range of amendments and more information about solutions to physician wellness challenges and demoralization. A member of the Board of Trustees introduced the report, noting that it addresses three resolutions introduced at the 2017 Interim Meeting that were referred for report back at this meeting. Several speakers testified in support of an amendment to create an AMA caucus or task force on physician health and wellness. Some speakers were concerned with the ramifications of physicians self-reporting burnout, and also the appropriateness of encouraging hospitals to confidentially survey physicians to identify factors that may lead to physician demoralization. Speakers also expressed various opinions regarding definitions and use of the terms burnout and demoralization. Because of the depth and breadth of the numerous amendments offered in testimony, your Reference Committee believes that additional study is needed. Accordingly, your Reference Committee recommends that Board of Trustees 31 be referred.

(13) RESOLUTION 701 - EMPLOYED PHYSICIANS BILL OF RIGHTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 701 be referred.

HOD ACTION: Resolution 701 referred.

Resolution 701 asks that our AMA adopt an “Employed Physicians Bill of Rights.”

Testimony strongly supported referral of Resolution 701. Several speakers acknowledged the complexities associated with the eleven Resolve clauses and the need for each to be examined individually and reviewed for consistency with AMA policy. Your Reference Committee agrees, and recommends that Resolution 701 be referred.

(14) RESOLUTION 702 - BASIC PRACTICE PROFESSIONAL STANDARDS OF PHYSICIAN EMPLOYMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 702 be referred.

HOD ACTION: Resolution 702 referred.

Resolution 702 asks that our AMA support best practice for physician employment that will promote improved work-life balance and maximal employment adaptability and professional treatment to maintain physicians in productive medical practice and
minimize physician burnout. To achieve these goals, best practice efforts in physician employment contracts would include, among other options: (1) Establishing the degree of physician medical staff support as well as specifying how different medical staff costs will be covered; (2) Establishing a specific degree of clerical and administrative support. This would include access to an EMR (electronic medical record) scribe, as well as specifying how different clerical or administrative support costs will be shared/covered; (3) Providing information regarding current EMR systems and their national ranking, including user ratings and plans to improve these systems; (4) Providing work flexibility with pay and benefit implications for reduced work hours, reduced call coverage, job sharing, child care support, use of locum tenens coverage, leave of absence for personal reasons or extended duty in the military, medical service organizations or other “greater societal good” organizations; and (5) Establishing an expected workload that does not exceed the mean RVU production of the specialty in that state/county/region.

Testimony was generally supportive of the intent of Resolution 702. While acknowledging the importance of the topics addressed by the resolution, speakers also testified that the suggested best practices need further study and refinement. It was further noted that some of the best practices are addressed by existing AMA policy. There was strong negative testimony regarding option 5 on establishing an expected workload that does not exceed the mean RVU production of the specialty in that state/county region. Several speakers asked that the item be referred. Accordingly, your Reference Committee recommends Resolution 702 be referred.

(15) RESOLUTION 704 - NON-PAYMENT AND AUDIT TAKEBACKS BY CMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 704 be referred.

HOD ACTION: Resolution 704 referred.

Resolution 704 asks that our AMA seek through legislation and/or regulation policies opposing claim nonpayment due to minor wording or clinically insignificant documentation inconsistencies; seek through legislation and/or regulation policies opposing extrapolation of overpayments based on minor inconsistencies; and seek through legislation and/or regulation policies opposing bundled payment denial based on minor wording or clinically insignificant documentation inconsistencies.

Your Reference Committee heard limited supportive testimony on Resolution 704. The sponsor of Resolution 704 testified that this resolution would complement existing fraud and abuse policy, as it specifically addresses the penalization of physicians for minor wording and clinical inconsistencies in documentation. A member of the Council on Medical Service suggested reaffirmation of several existing policies. The Council testified that this issue is addressed by policy stating that the AMA will respond vigorously to any public statements that fail to distinguish between inadvertent billing errors and fraud and abuse (H-175.985). It is equally addressed by policy stating that the AMA will seek congressional intervention to halt practices by the federal government and refocus enforcement activities on traditional definitions of fraud rather than inadvertent
billing errors (H-175.979). In addition, the member of the Council stated that policy
directs the AMA to urge CMS to create an expedited process to review minor clerical
errors on enrollment applications that result in CMS deactivating the physician’s billing
privileges (D-330.905).

Additionally testimony in support of Resolution 704 was offered stating that this addresses
a very important issue not currently addressed by AMA policy. More specifically,
testimony noted that practices have had entire patient stays denied due to minor clerical
errors, resulting in non-payment, and that these errors have no consequence on patient
care or safety, but are rather due to routine human error. Testimony further stated that
this resolution should also be considered in light of physician burnout and the pressure
to produce perfect documentation causes major pressures on physicians and is
ultimately detrimental patients.

A majority of the testimony was in support of referral stating that, while current AMA
policy does address the larger issue reflected in the resolution, reaffirmation would not
be appropriate in this case. Instead, referring this resolution would allow our AMA to
study the breadth of the issue and determine what constitutes a minor or clinically
insignificant error.

Your Reference Committee acknowledges that the issue of minor documentation
inconsistencies leading to unjustified payment denials is of great frustration to
physicians. Further, your Reference Committee believes that existing policy does not
point to the specific issue of minor errors in documentation; rather it is more concerned
with minor errors in billing and enrollment. Moreover, your Reference Committee
believes that phrases such as “minor wording” and “clinically insignificant” should be
defined before moving forward on this issue. Accordingly, your Reference Committee
recommends referral.

(16) RESOLUTION 707 - HEALTH PLAN PAYMENT OF
PATIENT COST-SHARING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends
that Resolution 707 be referred.

HOD ACTION: Resolution 707 referred.

Resolution 707 asks that our AMA urge health plans and insurers to bear the
responsibility of ensuring physicians promptly receive full payment for patient
copayments, coinsurance and deductibles.

Testimony provided by the sponsor was the only testimony on Resolution 707. The
speaker called for referral of Resolution 707 due to the complexity of this issue and
varying considerations. Your Reference Committee agrees that this issue warrants
study. However, your Reference Committee believes that, due to the potential
unintended consequences and competing interests within this issue, immediate report
back at Interim 2018 will not allow for the requisite research and consideration that this
resolution demands. Therefore, your Reference Committee does not recommend
immediate report back at Interim 2018 as requested by the sponsor. Accordingly, your Reference Committee recommends that Resolution 707 be referred.

(17) **RESOLUTION 712 - ALTERNATIVE PAYMENT MODELS AND VULNERABLE POPULATIONS**

**RECOMMENDATION:**

Madam Speaker, your Reference Committee recommends that Resolution 712 be referred.

**HOD ACTION:** Resolution 712 referred.

Resolution 712 asks that our AMA study the impact of current advanced Alternative Payment Models (APMs) and risk adjustment on providers caring for vulnerable populations; and advocate legislatively that advanced APMs examine the evaluation of quality performance (for bonus or incentive payment) of providers caring for vulnerable populations in reference to peer group (similarities in SES status, disability, percentage of dual eligible population).

Testimony on Resolution 712 was supportive. Regarding the second resolve clause, your Reference Committee notes that our AMA does not have policy stating that quality should be based on peer groups. Rather, in comment letters, our AMA has generally stated that there needs to be a risk adjuster for socioeconomic and demographic issues. Moreover, your Reference Committee highlights that the issue of peer group evaluation is a regulatory issue, not a legislative issue. Therefore, your Reference Committee believes it is premature to adopt the second resolve of Resolution 712 without first conducting the study called for in the first resolve. Accordingly, your Reference Committee recommends that Resolution 712 be referred.

(18) **RESOLUTION 705 - MODIFY THE CLINICAL LABORATORY IMPROVEMENT AMENDMENT OF 1988**

**RECOMMENDATION:**

Madam Speaker, your Reference Committee recommends that Resolution 705 be referred for decision.

**HOD ACTION:** Resolution 705 referred for decision.

Resolution 705 asks that our AMA adopt the position that it is proper to remove the CLIA certification mandate requirement for physicians who only use CLIA-waived tests and physician-performed microscopy.

Testimony on Resolution 705 was mixed, with substantial testimony both supportive and opposed to the item. Some speakers emphasized the need for relief from Clinical Laboratory Improvement Amendments of 1988 regulations. However, additional testimony spoke to the importance of these regulations to ensure the accuracy and reliability of all lab testing results regardless of where these tests are performed. Your Reference Committee recommends that Resolution 705 be referred for decision.
(19) RESOLUTION 716 - HOSPITAL CLOSURES AND PHYSICIAN CREDENTIALING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 716 be referred for decision.

HOD ACTION: Resolution 716 referred with report back at Interim 2018.

Resolution 716 asks that our AMA work with appropriate stakeholders, such as the AMA Organized Medical Staff Section and National Association Medical Staff Services (NAMSS), to produce an AMA credentialing repository that would allow hospitals and other organizations that credential physicians to access verified credentialing information for physicians who were on staff at a hospital, or one of its departments, at the time of closure, and report back at the 2018 Interim Meeting.

Testimony on Resolution 716 was supportive. Your Reference Committee notes that not only would the cost of implementing Resolution 716 be significant, but also, there are many unanswered questions about the demand for such a service and how it would work. Additionally, your Reference Committee is unsure if our AMA is the best organization to take up this issue and believes that that determination is best left up to the Board of Trustees. Further, testimony noted that producing a credentialing repository as called for in Resolution 716 may be considered an AMA member benefit, and again your Reference Committee believes that consideration of a potential new member benefit is best left to the Board of Trustees. Therefore, your Reference Committee recommends that Resolution 716 be referred for decision.

(20) RESOLUTION 703 - ECONOMIC CREDENTIALING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-180.963 be reaffirmed in lieu of Resolution 703.

HOD ACTION: Policy H-180.963 reaffirmed in lieu of Resolution 703.

Resolution 703 asks that our AMA vigorously oppose clinical credentialing based solely on surgical and non-surgical case volume when there is no other basis for questioning the physician’s ability to function with skill and safety.

Testimony was supportive of the intent of Resolution 703. Members of the Council on Medical Service and the Organized Medical Staff Section pointed out that existing AMA policy states that volume indicators should not be used as the sole criteria for credentialing. Your Reference Committee believes that the concerns expressed by some speakers regarding the lack of evidence linking volume to quality are sufficiently
addressed by Policy H-180.963. Accordingly, your Reference Committee recommends that Policy H-180.963 be reaffirmed in lieu of Resolution 703.

**Volume Discrimination Against Physicians H-180.963**

The AMA recommends that volume indicators should be applied only to those treatments where outcomes have been shown by valid statistical methods to be significantly influenced by frequency of performance; and affirms that volume indicators should not be used as the sole criteria for credentialing and reimbursement and that, when volume indicators are used, allowances should be made for physicians starting practice. (Sub. Res. 101, A-96 Reaffirmed: CMS Rep. 8, A-06 Reaffirmed: BOT Rep. 3, A-09)

(21) **RESOLUTION 711 - COMPENSATION FOR PRE-AUTHORIZATION REQUESTS**

**RECOMMENDATION:**

Madam Speaker, your Reference Committee recommends that Policy H-320.939 be reaffirmed in lieu of Resolution 711.

**HOD ACTION:** Policy H-320.939 reaffirmed in lieu of Resolution 711.

Resolution 711 asks that our AMA petition the Centers for Medicare and Medicaid Services that CPT code 99080 be reimbursed by Medicare.

Your Reference Committee heard limited testimony on this issue. A member of the Council on Medical Service testified that at last year’s Annual Meeting, the Council presented a report on prior authorization that considered potential funding sources and mechanisms to pay for time and expertise expended pursuing prior authorization procedures. Ultimately, the Council recommended that the AMA continue its extensive advocacy campaign based on the Prior Authorization and Utilization Management Reform Principles released in 2017 and complete ongoing research on prior authorization burdens. A member of the Council went on to outline the numerous challenges with making payment for prior authorization a priority such as insufficient payment, logistical challenges (e.g. unlikely that plans would pay for prior authorization on a service that was denied), and contractual provisions that require physicians to complete prior authorization protocols and bar practices from billing patients for prior authorization. A member of the Council further stressed that adopting policy requesting payment for prior authorization would legitimize prior authorization and directly conflict with our AMA’s efforts to reduce the overall volume of drugs and medical services requiring authorization, as well as detract from the patient impact message that highlights the care delays and negative clinical outcomes associated with prior authorization. While recognizing the associated administrative hassles and clinical burdens, a member of the Council testified it is most prudent that our AMA refrain from actively seeking physician compensation for prior authorizations due to the logistical and practical challenges just noted, as well as the risk of undermining the collaborative outreach efforts associated with the Prior Authorization and Utilization Management Reform Principles. The member of the Council on Medical Service went on to urge
reaffirmation of existing AMA policy that calls for our AMA to continue its ongoing,
extensive advocacy and outreach, including promotion and/or adoption of the Prior
Authorization and Utilization Management Reform Principles, AMA model legislation,
Prior Authorization Physician Survey and other research, and the AMA Prior
Authorization Toolkit, which is aimed at reducing administrative burdens and improving
patient access to care; and oppose health plan determinations on physician appeals
based solely on medical coding and advocate for such decisions to be based on the
direct review of a physician of the same medical specialty/subspecialty as the
prescribing/ordering physician.

Testimony stated that Resolution 711 would add a different dimension to existing policy,
as it would require payment for the uncompensated work that providers do. Additional
testimony cautioned that prior authorization is rationing by irritation. Further, testimony
highlighted that requiring payment for prior authorization could lead insurers to decrease
the volume of prior authorizations. An amendment was offered to request that the AMA
petition the Centers for Medicare and Medicaid “every year” citing that prior authorization
is an unfunded mandate.

A member of the Board of Trustees acknowledged the extensive advocacy work that our
AMA has undertaken. This year, our AMA’s prior authorization advocacy has been highly
visible and effective. Key elements of our AMA’s current work on this issue include
research, direct insurer engagement, state legislation, grassroots efforts and practice
education. The testimony also cited that our AMA released a 2017 physician survey
which has provided valuable data detailing the significant impact of prior authorization on
both patients and physicians and has achieved substantial media attention. Further, our
AMA will be fielding a patient survey this summer to further assess how prior
authorization affects patients and their care. Additionally, our AMA and a coalition of
sixteen other provider and patient organizations released a set of 21 Prior Authorization
and Utilization Management Reform Principles in January 2017. These principles were
used to initiate a broad outreach campaign to health plans, benefit managers, and
accreditation organizations to urge reform in prior authorization programs. One initial and
noteworthy outcome of this outreach was the January 2018 release by the AMA,
American Hospital Association, American’s Health Insurance Plans, American
Pharmacists Association, Blue Cross Blue Shield Association, and Medical Group
Management Association of the Consensus Statement on Improving the Prior
Authorization Process. Notably, the consensus statement reflects an agreement to
pursue reduced overall volume in prior authorizations through both selective application
of these requirements and regular review and adjustment of the drugs and services on
authorization lists. Moreover, a member of the Board of Trustees highlighted that our
AMA continues to work with state and specialty societies to enact legislation to protect
physicians and patients from prior authorization burdens.

Furthermore, your Reference Committee notes that our AMA has built grassroots
activities into its prior authorization reform campaign. Prior authorization–related content
has been added to both the Patients Action Network and Physicians Grassroots Network
websites. Both sites include a “share your story” call to action, which is echoed in an
accompanying social media campaign. Additional enhancements of our AMA’s
grassroots web presence are underway, and an updated site will be launched this
summer. Moreover, our AMA also offers educational resources to help physicians and
their staff reduce the manual burdens associated with prior authorization and transition
to automated processes. A new, three-part educational video series demonstrates the workflow improvements and other advantages of implementing pharmacy electronic prior authorization transactions that integrate with electronic health record systems and offers tips on how practices can start using this technology. This activity has been approved for

AMAPRA Category 1 Credit™.

Your Reference Committee recognizes that few phrases draw the ire of physicians and their staff more than prior authorization and commends the sponsors for trying to address this major pain point. As a result of this time-intensive and administratively burdensome process, many physicians justifiably would like to receive payment for completing prior authorization processes. While your Reference Committee understands this position and agrees that physicians should be properly compensated for their time, several considerations potentially limit the effectiveness and practicality of such an advocacy initiative, and your Reference Committee finds that adopting Resolution 711 will not remedy the problem. As reflected during testimony, requesting payment for prior authorization would legitimize the practice, potentially leading to more treatments and services requiring prior authorization. Your Reference Committee is concerned that instead of deterring prior authorization practices if they are paid for, these costs may pass through the insurance and add on costs to premiums and employers. Moreover, your Reference Committee is concerned that, should our AMA undertake and achieve widespread compensation for prior authorization, a perverse and unintended consequence could be an overall increase in prior authorization requirements, as health plans could use payment as justification for additional utilization review. As such, your Reference Committee believes that our AMA should continue with the extensive advocacy efforts already in process on this important issue and not redirect valuable resources—or weaken the campaign that is built on reducing the overall volume of prior authorizations—by focusing on compensation for this administrative work. Accordingly, your Reference Committee recommends that Policy H-320.939 be reaffirmed in lieu of Resolution 711.

Prior Authorization and Utilization Management Reform H-320.939

1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.

2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician. (CMS Rep. 08, A-17; Reaffirmation: I-17)
Madam Speaker, this concludes the report of Reference Committee G. I would like to thank Steven Falcone, MD, Brian Gavitt, MD, Peter Rahko, MD, Joseph Adashek, MD, Kathryn Lombardo, MD, Michele Manahan, MD, and all those who testified before the Committee.

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