

APPENDIX - REPORTS OF REFERENCE COMMITTEES

2012 INTERIM MEETING OF THE HOUSE OF DELEGATES

Reference Committee on Amendments to Constitution and Bylaws

(1) BOARD OF TRUSTEES REPORT 3 - PHYSICIAN EDUCATION TO SUPPORT PATIENT ADHERENCE TO TREATMENT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 3 be adopted and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 3 adopted and remainder of the report filed.

Board of Trustees Report 3 recommends that Policy D-450.965 Patients' Responsibilities for Health Care Outcomes be amended by addition and deletion. The amendment proposed in this report substitutes the existing last two recommendations with a statement that the AMA will examine issues of patient adherence as part of its strategic initiative on Improving Health Outcomes and, if appropriate, will develop with others targeted education and resources to support patient adherence, as well as continuing to support and publicize existing resources.

Testimony in reference committee largely favored the adoption of this report and praised it for taking on the challenge of physician roles in improving patient adherence to treatment and, ultimately, patient outcomes. Some testimony recommended an amendment in the report to specify that the adherence is to treatment and preventive measures, because the report in some instances refers to adherence generally and in other instances to adherence to treatment specifically. However, your Reference Committee feels that the current language of the report is clear given its context and that, moreover, broad language allows the policy to address wider contexts related to patient health and adherence that may be identified as different from treatment or prevention, for example physician recommendations or advice. Therefore, your Reference Committee recommends that Board of Trustees Report 3 be adopted.

(2) RESOLUTION 2 - THE CORPORATE PRACTICE OF MEDICINE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 2 be adopted

HOD ACTION: Resolution 2 adopted.

Resolution 2 asks our AMA to study the evolving "corporate practice of medicine" in relation to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care, and other relevant issues.

Testimony strongly supported adoption of this resolution which tackles the challenging and timely issue of the corporate practice of medicine and its implications for physicians and patients. While some testimony sought to have the AMA study legal and financial considerations of corporate medicine and your Reference Committee agrees these areas of study will be important to address, the study can best define itself and all key areas of focus as it proceeds. Your Reference Committee acknowledges the time and resources necessary to thoroughly study this matter and believes that many of the questions raised by corporate medicine resemble nicely the questions being addressed by our AMA's strategic focus on

"Enhancing Physician Satisfaction and Practice Sustainability by Shaping Delivery and Payment Models." Therefore, your Reference Committee recommends that Resolution 2 be adopted.

(3) **BOARD OF TRUSTEES REPORT 1 - SPECIALTY SOCIETY
REPRESENTATION REQUIREMENTS**

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 1 be amended by addition and deletion on lines 31-40 to read as follows:

That American Medical Association Policy G-600.022 [1c] be amended by addition and deletion to read as follows:

(i) the organization must demonstrate that it has 1,000 or more members; or (ii) the organization must demonstrate that it has a minimum of ~~250-100~~ AMA members and that ~~thirty-five percent (35%) twenty-five percent (25%) twenty percent (20%)~~ of its physician members who are eligible for AMA membership are members of our AMA; or (iii) that the organization was represented in the House of Delegates at the 1990 Annual Meeting and that ~~thirty-five percent (35%) twenty-five percent (25%) twenty percent (20%)~~ of its physician members who are eligible for AMA membership are members of our AMA (Modify Current HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 1 be amended by addition of a new recommendation to read as follows:

That American Medical Association Policy G-600.020 [3] be amended by insertion and deletion to read as follows:

(a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that ~~twenty-five percent (25%) twenty percent (20%)~~ of its physician members who are eligible for AMA membership are members of the AMA; or (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that ~~twenty-five percent (25%) twenty percent (20%)~~ of its physician members who are eligible for AMA membership are members of the AMA. (Modify Current HOD Policy)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 1 adopted as amended and remainder of the report filed.

Board of Trustees Report 1 recommends that the current requirements for professional interest medical associations as described in American Medical Association Policy G-600.022 [1c] be made consistent

with the current requirements for national medical specialty societies described in American Medical Association Policy G-600.020 [3]. Per the recommendations of the report, an affected organization must demonstrate that it has a minimum of 100 (decreased from 250) AMA members and that twenty-five percent (down from thirty-five percent) of its physician members who are eligible for AMA membership are members of our AMA.

Testimony strongly favored the goal of the report to address a significant challenge for AMA membership and to treat professional interest medical associations and national medical specialty societies in parity with respect to AMA membership requirements. However, testimony was mixed on what the ideal member percentage would be to balance two competing goals. On the one hand, high percent member requirements incentivize specialty and professional interests groups to encourage their members to join our AMA. It was also suggested that there could be mechanisms to allow organizations to have a voice in the AMA even if they cannot have official voting rights. Yet lower percent requirements ensure broader representation in the House (and thus diversity of view and expertise), expend fewer AMA resources in continually reviewing those organizations that fail to maintain adequate membership, and ensure that the AMA continues to represent the broadest possible number of physicians in the country. While the Board of Trustees suggested twenty-five percent as an ideal percent membership requirement for professional interest medical associations (to mirror the current requirement for specialty societies), your Reference Committee heard testimony that fifteen percent is a more realistic attempt at balancing these AMA interests. Other testimony suggested a floating percentage requirement, varying each year to reflect the percentage of physicians who are members of the AMA nationally. Your Board recognized the diversity of testimony and acknowledged that, ultimately, the House of Delegates must be the body to determine the ideal percentage rate which should be required for representation. Compelling testimony also suggested that the criteria for becoming a member society in our AMA is equally important as those criteria for retaining membership. In an attempt to strike a balance between the proposed Board of Trustees requirement and alternatives heard in testimony, your Reference Committee proposes a membership requirement of twenty percent for both specialty societies (American Medical Association Policy G-600.020 [3] and professional interests associations (American Medical Association Policy G-600.022 [1c]), the percentage which falls between proposed percentages. A twenty-percent requirement for both policies is closer to reflecting the national representation of physicians in the AMA, is inclusive of many of the current organizations who are currently failing to meet membership requirements, and strikes a balance between incentivizing recruitment and maintaining diversity and broad representation. Therefore, your Reference Committee recommends that Board of Trustees Report 1 be adopted as amended.

(4) BOARD OF TRUSTEES REPORT 6 - AMA PRINCIPLES FOR PHYSICIAN EMPLOYMENT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1. (1)(e) of Board of Trustees Report 6 be amended by addition and deletion on lines 43-44 to read as follows:

(e) Assuming a title or position which may that removes a physician from direct patient-physician relationships – such as medical director, vice president for medical affairs, etc. – does not override professional ethical obligations.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 1. (2)(a) of Board of Trustees Report 6 be amended by addition and deletion on line 5 to read as follows:

(a) Patient advocacy is a fundamental element of the patient-physician physician-patient relationship that should not be altered by the health

care system or setting in which physicians practice, or the methods by which they are compensated.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Recommendation 1. (3)(d) of Board of Trustees Report 6 be amended by addition and deletion on line 30 to read as follows:

(d) Termination of the employment or contractual relationship does not necessarily end the patient-physician physician-patient relationship.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Recommendation 1. (3)(c) of Board of Trustees Report 6 be amended by addition and deletion on line 26 to read as follows:

(c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician should be clear in his or her understanding the factors upon which compensation is based.

RECOMMENDATION E:

Mr. Speaker, your Reference Committee recommends that Recommendation 2 of Board of Trustees Report 6 be amended by addition and deletion on lines 2-3 to read as follows:

D-225.977 Physician Independence and Self-Governance

Our AMA will: (1) develop "Principles for Physician Employment" that address the relationships between and among employed physicians, hospitals, integrated delivery systems and hospital medical staffs; (2) update its Physician's Guide to Medical Staff Organization Bylaws and other relevant resources as necessary to reflect the needs and concerns of employed physicians and to ensure the continuing self-governance of the medical staff and the clinical decision-making autonomy of all physicians in the face of rising physician employment; and (3) (1) continue to assess the needs of employed physicians, especially with concerns involving ensuring autonomy in clinical decision-making and self-governance; and (2) promote physician collaboration, teamwork, and partnership, and leadership in emerging health care organizational structures, including but not limited to hospitals, health care systems, insurance company networks and accountable care organizations, in order to assure and be accountable for the delivery of quality health care. (Res. 801, I-11)

RECOMMENDATION F:

Mr. Speaker, your Reference Committee recommends that the Recommendations of Board of Trustees Report 6 be amended by addition of a new recommendation to read as follows:

Our AMA will: disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of

these Principles by organizations of physician employers such as, but not limited to the American Hospital Association and Medical Group Management Association (New HOD Policy)

RECOMMENDATION G:

Mr. Speaker, your Reference Committee recommends that Recommendation 1. (3)(d) in Board of Trustees Report 6 be amended by addition and deletion on lines 29-30 to read as follows:

Termination of an the employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the physician-patient relationship between the employed physician and persons under his/her care. Upon termination, When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information.

RECOMMENDATION H:

Mr. Speaker, your Reference Committee recommends that Recommendation 1. (4)(d) in Board of Trustees Report 6 be amended by addition and deletion on lines 31-32 to read as follows:

(d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts ~~with one or more physicians~~

RECOMMENDATION I:

Mr. Speaker, your Reference Committee recommends that Recommendation 2 in Board of Trustees Report 6 be amended by addition on line 6 to read as follows:

(2) promote physician collaboration, teamwork, and partnership and leadership in emerging health care organizational structures, including but not limited to hospitals, health care systems, medical groups, insurance company networks and accountable care organizations, in order to assure and be accountable for the delivery of quality health care. (Res. 801, I-11)

RECOMMENDATION J:

Mr. Speaker, your Reference Committee recommends that Recommendation 1. (3)(e) in Board of Trustees Report 6 be amended by addition on line 47 to read as follows:

Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges.

RECOMMENDATION K:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 6 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 6 adopted as amended and remainder of the report filed.

Board of Trustees Report 6 responds to policy adopted at the 2011 Interim Meeting of the American Medical Association House of Delegates to "develop 'Principles for Physician Employment' that address the relationships between and among employed physicians, hospitals, integrated delivery systems, and hospital medical staffs" (AMA Policy D-225.977). The Principles for Physician Employment presented in this report aim to help solidify the AMA's position as the lead association for employed physicians, and ultimately help the AMA achieve its strategic goal of improving physician satisfaction.

In testimony there was widespread agreement to adopt this report. Supporting testimony commended the timeliness of this report, particularly in addressing the issues that employed physicians may face when patient care decisions conflict with duties related to their other roles. Significant testimony suggested a variety of editorial changes to this document. Among these were changes from "should" to "must" under the hospital medical staff relations section, suggestions to retain language in the second recommendation about continuing to ensure physician self-governance, the strengthening of language related to physician autonomy under the second recommendation, and a wide variety of other minor, substantive, or editorial changes. Your Reference Committee acknowledges the extensive review of these principles by specialty societies, legal and other experts and also recognizes that none of these proposed amendments will alter the spirit of this report, while some changes may unintentionally alter the meaning or coherency of the principles or create inconsistency between the report and existing AMA policy. The principles are not intended to be binding or authoritarian; they are a framework which must allow for individual interpretation. Moreover, as principles, they cannot address every unique situation and physicians seeking further guidance or specificity may find it in the model contracts available for their review in the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement. However, your Reference Committee did feel that several minor editorial, grammatical and non-substantive changes helped to clarify the meaning and promote the consistency of this report. Some testimony recommended clarifying the language to acknowledge that physicians in leadership roles, such as medical directors, may continue to be involved in patient care. Testimony also proposed amendments to ensure that the term "patient-physician" was used consistently throughout the report and recommendations in order to highlight the primary focus of the patient in the relationship with the physician. While some testimony questioned whether certain portions of the report should require disclosure of conflicts, your Reference Committee felt such language was inappropriate in the context of this report where broad-sweeping professional conflicts pertaining to employed physicians and questions of loyalty to the patient versus the employer are being addressed, as opposed to specific, discrete conflicts of an individual physician. Therefore, your Reference Committee recommends that Board of Trustees Report 6 be adopted as amended.

(5) BOARD OF TRUSTEES REPORT 10 - SPECIALTY SOCIETY
REPRESENTATION IN THE HOUSE OF DELEGATES - FIVE-YEAR
REVIEW

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 of Board of Trustees Report 10 be amended by addition and deletion on lines 19-24 to read as follows:

1. That the American Association of Neuromuscular and Electrodiagnostic Medicine, American College of Rheumatology,

American Society for Dermatologic Surgery, American Society for Radiation Oncology, American Society for Surgery of the Hand, American Society of Clinical Oncology, American Society of Cytopathology, Radiological Society of North America, and Society of Thoracic Surgeons, and the Society for Vascular Surgery retain representation in the American Medical Association House of Delegates. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 3 of Board of Trustees Report 10 be amended by deletion on lines 31-33 to read as follows:

~~3. That the American Society for Radiation Oncology, American Society of Cytopathology and the Society for Vascular Surgery representation in the House of Delegates be terminated at the conclusion of the 2012 Interim Meeting. (Directive to Take Action)~~

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 10 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 10 adopted as amended and remainder of the report filed.

Board of Trustees Report 10 presents the review of the specialty organizations seated in the House of Delegates scheduled to submit information and materials for the 2012 American Medical Association Interim Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020 and Bylaw 8.50. The report includes a recommendation that the American Society for Radiation Oncology, American Society of Cytopathology and the Society for Vascular Surgery representation in the House of Delegates be terminated at the conclusion of the 2012 Interim Meeting.

Testimony overwhelmingly supported efforts to retain representation for the American Society for Radiation Oncology and the Society for Vascular Surgery. Both organizations provided extensive testimony and/or written evidence of their continued efforts and success in increasing AMA membership in their organizations, despite not increasing their membership to twenty-five percent. Testimony reflected on the significant scientific expertise and diverse representation that both organizations bring to AMA policy, as well as their dedication to our AMA. The American Society of Cytopathology did not submit any materials demonstrating their compliance with membership requirements and did not testify, nor did any societies testify on this society's behalf. Testimony reflected, like BOT 1 Specialty Society Representation Requirements, on the continued importance of maintaining diverse representation and expertise in the House of Delegates, even for specialties who retain smaller membership numbers overall. Your Reference Committee recommends adoption of Board of Trustees Report 10 as amended.

(6) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 1 - AMENDMENT TO OPINION E-9.011, "CONTINUING MEDICAL EDUCATION"

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendations of Council of Ethical and Judicial Affairs Report 1 be amended by insertion and deletion on line 27 to read as follows:

Participating in certified formal continuing medical education (CME) activities is critical to fulfilling this professional commitment to lifelong learning.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Ethical and Judicial Affairs Report 1 adopted as amended and remainder of the report filed.

Council on Ethical and Judicial Affairs Report 1 amends current Opinion E-9.011 "Continuing Medical Education". Continuing medical education has evolved substantially since this Opinion was last updated in 1996, as have the standards for the conduct of CME providers, as reflected by Accreditation Council on Continuing Medical Education changes. In light of these developments, the amendments to E-9.011 speak directly to attendees of CME activities. Guidelines for faculty and sponsors of CME activities, originally covered in this opinion, are now covered by E-9.0115 "Financial Relationships with Industry in Continuing Medical Education", adopted at the 2011 American Medical Association Annual Meeting of the House of Delegates.

Testimony supported CEJA's efforts to clarify ethical guidance about the role of industry in physician attendance at continuing medical education events. Some testimony asked CEJA to clarify the term "formal" continuing medical education. In response, CEJA proposed a written editorial amendment in the virtual reference committee to change "formal continuing medical education" to "certified continuing medical education" and your Reference Committee agrees that this new language addresses the former ambiguity. While other testimony preferred the term "accredited," the language of "certified" is preferable because "accredited" could be interpreted as a narrowing term-of-art which only allows activities certified by the Accreditation Council for Continuing Medical Education (ACCME) but not activities certified by AMA or other nationally-recognized certification organizations. Some testimony raised concerns about the implications of this report for educational activities which train physicians to use certain equipment or to perform certain techniques. Many of these training sessions are often necessarily sponsored by industry because they involve the use of industry equipment, yet are important for physician education and patient care. Your Reference Committee acknowledges these concerns but differentiates these types of educational activities (e.g. training to use a robotic tool) which necessarily involve industry, from other types of continuing medical education, and suggests that the Council on Ethical and Judicial Affairs consider studying separately the ethical implications of industry-sponsored training and whether it creates ethically distinct challenges. Moreover, your Reference Committee believes that, as currently framed, this report may appropriately disincentivize industry from sponsoring events which are both for CME credit and also subsidized for physicians, allowing industry to favor subsidy where appropriate but not providing credit. Testimony raised questions about the implications of this report for CME faculty, but your Reference Committee notes that the intent of this report is for Opinion E-9.011 "Continuing Medical Education" to address physicians in the role of CME attendees only. CME faculty and sponsorship issues are now addressed in Opinion E-9.0115 "Financial Relationships with Industry in Continuing Medical Education." Therefore, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 1 be adopted as amended.

(7) RESOLUTION 1 - EMPLOYMENT STATUS AND ELIGIBILITY FOR
ELECTION OR APPOINTMENT TO MEDICAL STAFF LEADERSHIP
POSITIONS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 1
be referred.

HOD ACTION: Resolution 1 referred.

Resolution 1 asks our AMA to respond to the issue of increasing number of physicians who enter into contractual or employment arrangements with the hospitals or health care delivery systems in which they practice. The resolution posits that these arrangements have produced distrust between independent and employed physicians and provoked some organized medical staffs to exclude one class of members from holding medical staff leadership positions, voting on medical staff matters, or otherwise participating in the self-governance activities of the medical staff. As such, the resolution requests that (1) our AMA adopt as policy the principle that determinations of eligibility for participating in the self-governance of medical staff be made without respect to financial relationships with a hospital or health care delivery system; (2) our AMA draft model medical staff bylaws supporting this principle; and (3) that AMA Policy H-235.970 be amended to reflect this principle.

There was significant testimony raised in reference committee that the Resolution lacked clarity despite it being an important and timely matter. Some were concerned that the first and second resolves did not adequately address conflicts of interest, and could not stand on their own in meaning apart from the third resolve. The third resolve was applauded for making key policy changes but testimony raised concerns that the current language is unclear, needs greater nuance and specificity about when conflicts of interest might require recusals, and could be used to restrict voting where inappropriate. Your Reference Committee agrees with testimony that the policy cannot address particular institutional processes, but recognizes that the importance and widespread implications of this Resolution require further study and consideration. Therefore, your Reference Committee recommends that Resolution 1 be referred.

Reference Committee B

(1) RESOLUTION 215 - SEQUESTRATION BUDGET CUTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 215 be adopted.

HOD ACTION: Resolution 215 adopted.

Resolution 215 asks that our American Medical Association urge Congress to develop a fiscally responsible alternative that would prevent the automatic budget sequestration cuts that would endanger critical programs related to medical research, public health, workforce, food and drug safety, and health care for uniformed service members, as well as trigger cuts in Medicare payments to graduate medical education programs, hospitals, and physicians that will endanger access to care and training of physicians. (Directive to Take Action)

Your Reference Committee heard unanimous support for urging Congress to develop a fiscally responsible alternative that would prevent the automatic budget sequestration cuts that would endanger critical programs related to medical research, public health, workforce, food and drug safety, and health care for uniformed service members, as well as trigger cuts in Medicare payments to graduate medical education programs, hospitals, and physicians that will endanger access to care and training of physicians, as called for by Resolution 215. Your Reference Committee agrees that a responsible alternative approach is needed to the budget sequestration cuts, and acknowledges the ongoing, joint AMA and Federation advocacy efforts that are consistent with Resolution 215. Your Reference Committee, therefore, recommends adoption of Resolution 215.

(2) RESOLUTION 222 - GENERIC MEDICATIONS AND PAY FOR DELAY PRACTICES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 222 be adopted.

HOD ACTION: Resolution 222 adopted.

Resolution 222 asks that our American Medical Association support federal legislation that makes tactics delaying conversion of medications to generic status, also known as “pay for delay,” illegal in the United States. (New HOD Policy)

Your Reference Committee heard testimony largely in support of Resolution 222. Your Reference Committee agrees that incentives are needed to promote new drug treatments, but anti-competitive agreements between brand drug companies and certain generic companies to delay the entry of other generic competitors beyond the market exclusivity period envisioned by Congress is extraordinarily costly to our patients and reduces their access to important medications. These pay-for-delay agreements should be ended. Your Reference Committee, therefore recommends adoption of Resolution 222.

(3) RESOLUTION 223 - MANDATORY PHYSICIAN ENROLLMENT IN MEDICARE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 223 be adopted.

HOD ACTION: Resolution 223 adopted.

Resolution 223 asks (1) that our American Medical Association support every physician's ability to choose not to enroll in Medicare. (New HOD Policy); and (2) that our AMA seek the right of patients to collect from Medicare for covered services provided by unenrolled or disenrolled physicians. (Directive to Take Action)

Your Reference Committee heard testimony in support of a physician's ability to choose not to enroll in Medicare. Those who testified believe our AMA should seek the right of patients to collect from Medicare for covered services provided by unenrolled or disenrolled physicians. They also believe physicians should have the choice not to enroll in Medicare. Your Reference Committee agrees with those who testified, and therefore recommends adoption of Resolution 223.

(4) RESOLUTION 227 - MEDICARE PART B COVERAGE OF TDAP
(TETANUS, DIPHTHERIA, ACCELLUAR PERTUSSIS)

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 227 be adopted.

HOD ACTION: Resolution 227 adopted.

Resolution 227 asks that our American Medical Association urge Medicare to include Tdap (Tetanus, Diphtheria, Acellular Pertussis) under Medicare Part B as a national public health measure to help prevent the spread of Pertussis. (Directive To Take Action)

Your Reference Committee heard testimony largely in support of Resolution 227 calling for Medicare Part B to cover Tdap (Tetanus, Diphtheria, Acellular Pertussis). Your Reference Committee agrees that providing Medicare coverage and payment for Tdap under Medicare Part B is critical for increasing access to this important immunization. Your Reference Committee, therefore, recommends that Resolution 227 be adopted.

(5) BOARD OF TRUSTEES REPORT 2 - SURVEYING VIOLENCE IN THE
NON-HOSPITAL WORK ENVIRONMENT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first recommendation of Board of Trustees Report 2 be amended by addition on line 35 to read as follows:

That our American Medical Association modify Policy H-515.966 Violence and Abuse Prevention in the Healthcare Workplace by addition to read as follows:

Our AMA encourages all healthcare facilities to adopt policies to reduce and prevent all forms of workplace violence and abuse and to develop policies to manage reported occurrences of workplace violence and abuse and that our AMA advocate that training courses on workplace violence prevention and reduction be more widely available. (Modify Current HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the third recommendation of Board of Trustees Report 2 be amended by addition on line 46 to read as follows:

That our AMA continue to monitor state legislative efforts on increased criminal penalties for assaults against health care providers and continue to work with interested state and national medical specialty societies through all appropriate avenues, including state legislatures, when issues related to workplace violence inside and outside of the emergency department arise. (Directive to Take Action)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 2 be adopted as amended and the remainder of the report filed.

HOD ACTION: Board of Trustees Report 2 adopted as amended and remainder of the report filed.

The Board of Trustees recommends the following recommendations be adopted and the remainder of the report filed:

1. That our American Medical Association modify Policy H-515.966 Violence and Abuse Prevention in the Healthcare Workplace by addition to read as follows: Our AMA encourages all healthcare facilities to adopt policies to reduce and prevent workplace violence and abuse and to develop policies to manage reported occurrences of workplace violence and abuse and that our AMA advocate that training courses on workplace violence prevention and reduction be more widely available. (Modify Current HOD Policy)
2. That our AMA reaffirm Policy H-515.982, continuing to condemn violence against physicians. (Reaffirm HOD Policy)
3. That our AMA continue to monitor state legislative efforts on increased criminal penalties for assaults against health care providers and continue to work with interested state and national medical specialty societies through all appropriate avenues, including state legislatures, when issues related to workplace violence outside of the emergency department arise. (Directive to Take Action)

Your Reference Committee heard supportive testimony for Board of Trustees Report 2 and agrees with the need to amend the recommendations to ensure that (1) all forms of workplace violence and abuse are addressed and (2) the issues raised apply both inside and outside the emergency room setting. Your Reference Committee understands concerns raised about ensuring that "verbal abuse" be included in the types of abuse identified in this report's recommendations. Your Reference Committee, however, cautions our House of Delegates on specifically adding the words "verbal abuse" to the recommendations in the report given the vague and subjective nature of what constitutes verbal abuse. Your Reference Committee believes that amending the first recommendation of this report to include "all forms of workplace violence and abuse" sufficiently covers the concerns raised in testimony. Finally, your Reference Committee also agrees that the third recommendation of this report should be applied to workplace violence both inside and outside of the emergency department. Your Reference Committee, therefore, recommends that Board of Trustees Report 2 be adopted as amended.

(6) BOARD OF TRUSTEES REPORT 8 – PATIENT PROTECTION AND AFFORDABLE CARE ACT NONDISCRIMINATION LANGUAGE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 8 be amended by addition to recommend as follows:

- (1) That our AMA reaffirm policy H-35.968;
- (2) That our AMA create and actively pursue legislative and regulatory opportunities to repeal the so called “Non-discrimination in Health Care” clause in Public Health Service Act Section 2706, as enacted in the Patient Protection and Affordable Care Act (PPACA);
- (3) That our AMA lead a specific lobbying effort and grassroots campaign in cooperation with members of the federation of medicine and other interested components of organized medicine to repeal the provider portion of PPACA’s “Non-Discrimination in Health Care” language; and
- (4) That our AMA Board of Trustees report back at our 2013 AMA Annual Meeting.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 8 be adopted and the remainder of the report filed.

HOD ACTION: Board of Trustees Report 8 adopted and remainder of the report filed.

Your Reference Committee thanks our Board of Trustees for Board of Trustees Report 8, which reports back to our House of Delegates, pursuant to AMA Policy H-35.968, on the current state of activity related to our AMA's activities regarding the “Non-discrimination in Health Care” clause of the Patient Protection and the Affordable Care Act (PPACA). Your Reference Committee concurs with the overwhelmingly supportive testimony to amend the report and include new recommendations and therefore, recommends that Board of Trustees Report 8 be adopted as amended.

(7) RESOLUTION 203 - STUDENT LOANS AND MEDICARE/MEDICAID PARTICIPATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 203 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt ~~and replace it with system of garnishing Medicare and Medicaid reimbursement payments for the repayment of delinquent student loan payments.~~
(Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 203 be adopted as amended.

HOD ACTION: Resolution 203 adopted as amended.

Resolution 203 asks that our American Medical Association seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt and replace it with system of garnishing Medicare and Medicaid reimbursement payments for the repayment of delinquent student loan payments. (Directive to Take Action)

Your Reference Committee heard testimony largely in support of Resolution 203. Yet, many who testified were concerned about garnishing Medicare and Medicaid payments for the repayment of delinquent student loan payments, and suggested that other existing legal mechanisms can be used to secure delinquent payments. Others cautioned that garnishing these Medicare and Medicaid payments would be extremely difficult to administer. Some suggested amending the resolution to support the overall concept of stopping the practice of decertification of physicians due to unpaid student loan debt. Your Reference Committee believes that a physician's Medicare/Medicaid participation status should not be terminated solely for defaulting on a student loan, and agrees with those who expressed support for amending the resolution to remove the reference to garnishing Medicare and Medicaid payments to repay student loan payments. Your Reference Committee, therefore, recommends adoption of Resolution 203 as amended.

(8) RESOLUTION 209 - ELIMINATE ICD-10
 RESOLUTION 216 - RECOMMEND THE US MOVE DIRECTLY TO ICD-11 AND SKIP ICD-10

RECOMMENDATION A :

Mr. Speaker, your Reference Committee recommends that Resolution 209 be amended by deletion to read as follows:

RESOLVED, That in order to alleviate the increasing bureaucratic and financial burden on physicians, our American Medical Association vigorously advocate that the Centers for Medicare & Medicaid Services eliminate the implementation of ICD-10 and instead wait for the adoption of ICD-11. (Directive to Take Action)

Resolved, That our AMA immediately reiterate to the Centers for Medicare & Medicaid Services that the burdens imposed by ICD-10 will force many physicians in small practices out of business. This communication needs to be sent to all in Congress and displayed prominently on our AMA website; and be it further

RECOMMENDATION B :

Mr. Speaker, your Reference Committee recommends that Resolution 209 be adopted as amended in lieu of Resolution 216.

HOD ACTION: Resolution 209 adopted as amended in lieu of Resolution 216.

Resolution 209 asks that in order to alleviate the increasing bureaucratic and financial burden on physicians, our American Medical Association vigorously advocate that the Centers for Medicare & Medicaid Services eliminate the implementation of ICD-10 and instead wait for the adoption of ICD-11. (Directive to Take Action) Resolution 216 asks that our American Medical Association work with the

Centers for Medicare and Medicaid Services to transition directly to ICD-11 on Oct. 17, 2017. (Directive to Take Action)

Your Reference Committee heard strong testimony in support of Resolution 209. Many passionately expressed their belief that implementation of ICD-10 coding will create unnecessary and significant financial and workflow disruptions for physicians, especially at a time when physicians are in various stages of trying to implement electronic health records into their practices. While many supported Resolution 209, others testified that Resolution 216 could be interpreted as a blanket endorsement of ICD-11, without yet knowing the full details of ICD-11. Others noted that our AMA Board of Trustees is currently evaluating the feasibility of moving directly from ICD-9 to ICD-11 pursuant to policy adopted at our 2012 Annual Meeting, and that this report is due back at our 2013 Annual Meeting. Your Reference Committee agrees with those who testified in favor of Resolution 209, but believes our House of Delegates needs the opportunity to review our Board of Trustee's June 2013 report on the feasibility of moving directly to ICD-11. Therefore, your Reference Committee recommends adoption of Resolution 209, as amended, in lieu of Resolution 216.

(9) RESOLUTION 210 - MONITORING THE AFFORDABLE CARE ACT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 210 be adopted by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~develop affordable meaningful tools to assess the progress of success or lack of success implementation of the Patient Protection and Affordable Care Act based on AMA policy and prepare an annual report back to our House of Delegates of this assessment.~~ (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 210 be adopted as amended.

HOD ACTION: Resolution 210 adopted as amended.

Resolution 210 asks that our American Medical Association develop affordable meaningful tools to assess the success or lack of success of the Patient Protection and Affordable Care Act and prepare an annual report of this assessment. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 210. Some testified in support of assessing the success or lack of success of provisions in the Patient Protection and Affordable Care Act (ACA) and stated that it would be important for our AMA to report to our House of Delegates on efforts to implement the ACA. Others raised concerns that this resolution is too vague. They pointed out that the ACA is too massive to assess the entire bill, and in addition, it is unclear how to define "success." Testimony also indicated that it would not be feasible to assess the success or lack of success of key provisions of the ACA since some provisions, such as insurance exchanges, will not be implemented until 2014. Your Reference Committee understands these concerns, yet believes our AMA could conduct an affordable and very broad-based survey of implementation efforts of key ACA provisions, including using other sources that have reviewed ACA implementation efforts. The resolution also calls for an annual report without any sunset for presenting these reports, which could require extensive resources. Your Reference Committee believes it is important for our AMA to report back to our House of Delegates concerning ACA implementation efforts, but that our Board of Trustee should have the leeway to determine how often these reports should occur. Your Reference Committee, therefore, recommends that Resolution 210 be adopted as amended.

(10) RESOLUTION 211 - USE OF PREVENTION AND PUBLIC HEALTH FUND DOLLARS FOR ACTIVITIES UNRELATED TO PREVENTION AND HEALTH PROMOTION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 211 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support budget allocations for ~~from~~ the Prevention and Public Health Fund ~~at no less than the levels adopted in the Affordable Care Act of 2010~~ (New HOD Policy); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 211 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA actively oppose policies that aim to cut, divert, or use as an offset, dollars from the Prevention and Public Health Fund for purposes other than those stipulated in the Affordable Care Act of 2010. (Directive to Take Action)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 211 be adopted as amended.

HOD ACTION: Original Resolution 211 adopted.

Resolution 211 asks (1) that our American Medical Association support budget allocations from the Prevention and Public Health Fund at no less than the levels adopted in the Affordable Care Act of 2010 (New HOD Policy); and (2) that our AMA actively oppose policies that aim to cut, divert, or use as an offset, dollars from the Prevention and Public Health Fund for purposes other than those stipulated in the Affordable Care Act of 2010. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 211. Many passionately expressed support of the Prevention and Public Health Fund as an investment in prevention and public health programs that are needed to promote wellness, prevent disease, and protect against public health emergencies. Your Reference Committee also heard from a representative of our AMA Council on Legislation who testified in strong support of prevention and public health funding and advocacy of these programs, while cautioning that our AMA Board of Trustees needs flexibility to advance and negotiate our advocacy agenda, while maneuvering in a highly political environment with fluid dynamics that are changing almost daily or hourly, and therefore Resolution 211 should not be too prescriptive as to undermine these negotiations. Your Reference Committee feels as strongly about support for the Prevention and Public Health Fund as those who testified in favor of it, and acknowledges the extensive AMA policies supporting various prevention and public health programs. Your Reference Committee also understands that in this current budget cutting environment our AMA may undermine our advocacy efforts on all of our issues, including efforts to advance public health, if AMA policy becomes mired in Congressional politics by specifying the levels of funding for specific initiatives. Your Reference Committee, therefore, recommends that Resolution 211 be adopted, as amended, to reflect our AMA's strong support of the Prevention and Public Health Fund.

(11) RESOLUTION 221 - DECOUPLING SOCIAL SECURITY FROM MEDICARE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 221 be amended by addition and deletion to read as follows:

~~RESOLVED, That our American Medical Association support abrogation of any connection between Medicare and Social Security benefits, as prescribed in *Hall et al v. Sebelius* (New HOD Policy); and be it further~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 221 be amended by deletion as follows:

~~RESOLVED, That our AMA support the plaintiffs in *Hall et al v. Sebelius* (New HOD Policy); and be it further~~

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the third resolve of Resolution 221 be amended by deletion as follows:

~~RESOLVED, That our AMA support legislation that makes *Hall et al v. Sebelius* moot. (New HOD Policy)~~

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Resolution 221 be adopted as amended.

HOD ACTION: Resolution 221 adopted as amended.

Resolution 221 asks (1) that our American Medical Association support abrogation of any connection between Medicare and Social Security benefits as proscribed in *Hall et al v. Sebelius*. (New HOD Policy); (2) that our AMA supports the plaintiffs in *Hall et al v. Sebelius*. (New HOD Policy); and (3) that our AMA support legislation that makes *Hall et al v. Sebelius* moot. (New HOD Policy)

Your Reference Committee heard testimony generally in support of Resolution 221. Your Reference Committee agrees that individuals should be able to withdraw from Medicare Part A and that doing so should not jeopardize their Social Security benefits, which are tied to receiving Medicare Part A benefits. Your Reference Committee, however, understands that the issue in *Hall et al v. Sebelius* was that the plaintiffs wanted more than just the ability to decline Medicare Part A benefits. They sought a legal declaration that Medicare Part A benefits cannot be paid on their behalf; in other words, that they wanted a declaration that they are not legally entitled to Medicare Part A benefits. Your Reference Committee agrees with those who testified that individuals should be able to withdraw from Medicare Part A without jeopardizing their Social Security benefits. Yet, we understand that the issue in *Hall et al v. Sebelius* would not be fully satisfied by abrogating the connection between Medicare and Social Security benefits. This case takes the issue one step further and asks that individuals be declared not to be legally entitled to Medicare Part A benefits. This kind of declaration could be far-reaching and could have unintended consequences. Your Reference Committee, therefore, recommends adoption of Resolution 221, as amended, to support abrogating the connection between Medicare Part A benefits and Social Security, while maintaining legal entitlement to these benefits.

(12) RESOLUTION 224 - RAC AUDITS OF E&M CODES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 224 be amended by deletion to read as follows:

RESOLVED, That if our AMA is unsuccessful in reversing the audits, that our AMA urge CMS and elected Washington officials to require physician reimbursement for time and expense of ~~successful~~ appeals. (Directive to Take Action)

RECOMMENDATION B:

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

HOD ACTION: Resolution 224 adopted as amended.

Resolution 224 asks (1) that our American Medical Association oppose Recovery Audit Contractor audits of E&M codes with the Centers for Medicare & Medicaid Services (CMS) and explain to CMS and Congress why these audits as currently conducted are deleterious to the provision of care to patients with complex health needs. (Directive to Take Action); (2) that if our AMA is unsuccessful in reversing the audits, that our AMA urge CMS and elected Washington officials to require physician reimbursement for time and expense of successful appeals. (Directive to Take Action); and (3) that our AMA urge CMS and elected Washington officials to provide statistical data regarding the audits, including the specialties most affected by these audits, and the percentage of denied claims for E&M codes which, when appealed, are reversed on appeal. (Directive to Take Action).

Your Reference Committee heard testimony in support of Resolution 224. Your Reference Committee agrees that audits imposed by Recovery Audit Contractors (RACs) and the appeal process are extremely burdensome to practicing physicians and that physicians receive no reimbursement for time spent or expenses incurred, and that more needs to be done to alleviate audit and appeal burdens that physicians are facing. Your Reference Committee also agrees with a comment made during testimony that the second resolve could be made stronger and recommends that reimbursement not be contingent upon a "successful" appeal, but rather based on time and expense incurred by the physician. Your Reference Committee, therefore, recommends that Resolution 224 be adopted as amended.

(13) RESOLUTION 230 - INNOVATION TO IMPROVE USABILITY AND DECREASE COSTS OF ELECTRONIC HEALTH RECORD (EHR) SYSTEMS FOR PHYSICIANS

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 230 be adopted.

HOD ACTION: Substitute Resolution 230 adopted.

RESOLVED, That our AMA Board of Trustees submit a report at our 2013 Annual Meeting on what steps our AMA has taken to implement H-478.992, as well as on a strategic plan for further implementation of this policy.

Resolution 230 asks that our American Medical Association present its strategy at the 2013 Annual Meeting for further implementing AMA Policy H-478.992 in the context of the 3M Healthcare Data Dictionary software. (Directive To Take Action)

Your Reference Committee heard limited testimony in support of Resolution 230. The sponsor of the resolution offered a substitute resolution that asks our Board of Trustees to submit a report at our 2013 Annual Meeting regarding a plan to implement existing AMA Policy H-478.992, and to evaluate the role that the 3M Healthcare Data Dictionary could play in implementing this AMA Policy. Your Reference Committee agrees with those who testified that physicians incur significant costs and loss of productivity in upgrading, customizing, and integrating their electronic health records (EHRs) with other systems. Your Reference Committee, however, has concerns about focusing solely on one technology over others since this could stifle innovation, and acknowledges that existing AMA policy supports a competitive marketplace so that vendors will be motivated to create better and improved EHR products. Your Reference Committee believes the goals of Resolution 230 would be best accomplished through a Board of Trustees Report setting forth its plan to implement existing AMA Policy H-478.992. Your Reference Committee, therefore, recommends adoption of Substitute Resolution 230.

(14) RESOLUTION 208 - A MORE UNIFORM APPROACH TO ASSESSING PATIENTS FOR CONTROLLED SUBSTANCES FOR PAIN RELIEF

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 208 be referred.

HOD ACTION: Resolution 208 referred.

Resolution 208 asks (1) that our American Medical Association support a more uniform approach to assessing patients for controlled substances for pain relief. (New HOD Policy); and (2) that our AMA work with federal and state entities to afford safe harbors to physicians who follow these steps in the event the patient has an adverse effect or outcome from opioid therapy or the patient is discovered to be diverting the substances. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 208. Some testified in favor of advocating for a uniform approach to assessing patients for controlled substances for pain relief. Others pointed out, however, that different medical conditions and practices may warrant different approaches. Additional testimony raised concern that safe harbors could create liability where the uniform approach to assessing patients is not appropriate. In light of these varied viewpoints, many recommended that Resolution 208 be referred to our Board of Trustees so that our Board has the opportunity to assess and develop an appropriate approach to assessing patients for controlled substances for pain relief. Your Reference Committee agrees and believes it is more prudent for our AMA Board of Trustees to address critical nuances in our position toward assessing patients for controlled substances that may not be encompassed by a single uniform approach. Your Reference Committee, therefore, recommends referral of Resolution 208 so that our AMA Board of Trustees can develop a comprehensive report for discussion and adoption by our House of Delegates.

(15) RESOLUTION 212 - PHARMACIST ADMINISTRATION OF VACCINES

RECOMMENDATION:

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

HOD ACTION: Resolution 212 referred.

Resolution 212 asks (1) that our American Medical Association recognize the role of the pharmacist as an essential member of the medical home model health team and the potential role that pharmacists may play in increasing immunization rates in this country (New HOD Policy); (2) that our AMA reaffirm its commitment that such endeavors are physician-led and that pharmacists administration of immunizations is only proper when any of the following criteria are satisfied:

- a) The pharmacist has an order from a physician licensed to practice medicine in the state where the immunization is to be administered.
- b) The pharmacist has a collaborative agreement with a physician licensed to practice in the state where the immunization is to be administered.
- c) The state where the immunization is to be administered has designated a state of emergency which necessitates the rapid immunization of the population in order to respond to the public health state of emergency. Administration by pharmacists should be limited to the specific vaccine required to respond to the emergency and only for the duration of the emergency declaration (New HOD Policy);

(3) that our AMA support that a state's educational requirements of pharmacists who administer immunizations be developed from input by both the state's boards of medicine and pharmacy (New HOD Policy); (4) that our AMA oppose any federal or state legislation allowing pharmacists to administer immunizations without a licensed physician's order or collaborative agreement, or during a designated state of emergency (New HOD Policy); (5) that our AMA draft model legislation which supports a medical home model and requires a physician's written or standing order, or a collaborative practice agreement between a physician and a pharmacist for the administration of immunizations, and to outline educational and safety requirements which must be satisfied in order for a pharmacist to administer immunizations (Directive to Take Action); and (6) that our AMA distribute this model legislation to state and specialty societies. (Directive to Take Action)

Your Reference Committee applauds the authors of Resolution 212 for bringing the critical issues related to the provision of vaccines to our House of Delegates. Your Reference Committee agrees with testimony that pharmacists are critical members of the health care team. Your Reference Committee also agrees that pharmacists should be part of a team-based model of care, directly linked to, for example, a physician-led patient centered medical home. We also concur with testimony that it is absolutely critical that a vital element of preventive care includes improvement in the number of adequately immunized Americans. We acknowledge testimony asking your Reference Committee to consider adopting some of the recommendations and referring others. Given the complexity of the issues raised, as well as the fact that the AMA Council on Legislation is currently studying many of the issues raised, your Reference Committee agrees with the vast majority of testimony that this resolution be referred. As a result, your Reference Committee recommends referral of Resolution 212.

(16) **RESOLUTION 213 - NON-PHYSICIAN PRACTITIONERS CERTIFYING MEDICARE PATIENTS' NEED FOR THERAPEUTIC SHOES AND INSERTS**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 213 be referred.

HOD ACTION: Resolution 213 referred.

Resolution 213 asks (1) that our American Medical Association support authorization of physician assistants and nurse practitioners under the supervision of an MD or DO to certify Medicare beneficiaries' need for therapeutic shoes and/or inserts (New HOD Policy); and (2) that our AMA advocate for the authorization of physician assistants and nurse practitioners under the supervision of an MD or DO to certify Medicare beneficiaries' need for therapeutic shoes and/or inserts to the Centers for Medicare and Medicaid Services and, if federal law must be amended, advocate to Congress. (Directive to Take Action)

Your Reference Committee heard overwhelming testimony about the unintended consequences related to the recommendations of Resolution 213. Your Reference Committee is sympathetic to the workforce-related issues in the state of Idaho and its aging population. Your Reference Committee also appreciates the resolution authors' testimony indicating that the recommendations of this resolution were not intended

to increase non-physician providers' scope of practice. Nevertheless, your Reference Committee is concerned that as worded, the recommendations of this resolution could be interpreted to mean more than intended. Your Reference Committee also agrees with those who testified to the need for guidance related to the meaning of terms such as "supervision," "under the direction," and "in collaboration with." Your Reference Committee also agrees that it would be helpful to look at existing state-level policies and statutory language that have created unintended burdens and increased administrative hassles for physicians and whether, by working with our colleagues in organized medicine, these issues could be addressed without implicating scope of practice-related consequences. Finally, your Reference Committee believes that addressing these issues is a logical extension of our AMA's Council on Medical Education-Council on Medical Service Joint Report, entitled "The Structure and Function of Interprofessional Health Care Teams," heard at this AMA meeting in Reference Committee J. Your Reference Committee, therefore, recommends that our AMA, with the assistance of the relevant councils and interested members of our AMA Scope of Practice Partnership, study the issues raised and provide, among other things, possible guidance related to terms such as "supervision," "under the direction," and "in collaboration with."

(17) RESOLUTION 201 - ANTITRUST EXEMPTION FOR HEALTH INSURANCE COMPANIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 201 be referred for decision.

HOD ACTION: Resolution 201 referred for decision.

Resolution 201 asks that our American Medical Association urge federal authorities to oppose antitrust exemption status for health insurance companies. (Directive to Take Action)

Your Reference Committee heard mixed, but mostly supportive testimony regarding Resolution 201. In addition, your Reference Committee heard testimony from a representative of the Board of Trustees that our AMA considered resolutions to support repeal of the McCarran-Ferguson Act's limited antitrust exemption for health insurers on several occasions in the past. The information received by your Reference Committee shows that, during the 2005 Interim Meeting, our AMA House of Delegates adopted the recommendation of Board of Trustees Report 10 (I-05) to reaffirm several of our AMA's extensive policies on antitrust reform in lieu of supporting repeal of the McCarran-Ferguson Act. This Board Report explained that the McCarran-Ferguson Act is the federal law authorizing state regulation of insurance. It provides a limited federal antitrust exemption for the business of insurance, subject to state regulation and oversight, for activities such as joint data collection that help foster a competitive marketplace benefiting consumers. The exemption does not insulate insurers from the enforcement of state or federal antitrust laws in the context of anti-competitive business practices such as boycott, coercion, or other intimidation in the marketplace. Your Reference Committee also received and reviewed a 2009 Congressional Budget Office Report indicating that repealing the antitrust exemption for health insurance companies would have no significant effect on the premiums that private insurers would charge for health insurance. Your Reference Committee believes that there is compelling evidence that repealing the McCarran-Ferguson Act's antitrust exemptions for health insurers will not bring about the antitrust relief necessary for physicians to effectively negotiate with health insurance companies on behalf of themselves and their patients. However, based on the testimony received in support of this resolution, it is evident that there are differing views within our House of Delegates. Therefore, your Reference Committee believes that this resolution should be referred to the Board of Trustees for decision on whether additional evidence is available to warrant modifications to the recommendations in Board of Trustees Report 10 (I-05).

(18) RESOLUTION 214 - SUPPORTING THE ABILITY OF ADVANCED PRACTICE PROVIDERS TO ORDER CARE

RECOMMENDATION:

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

HOD ACTION: Resolution 214 not adopted.

Resolution 214 asks (1) that our American Medical Association support authorization of physician assistants and nurse practitioners under the supervision of a MD or DO to order care for Medicare beneficiaries for skilled nursing facilities, assisted living facilities, and home health agencies, including the ability to issue initial orders and other orders associated with the level of care provided, such as ancillary services, medication reconciliation, and lab services, among others, provided that such orders are within physician assistant and nurse practitioner scope of practice under state law (New HOD Policy); (2) that our AMA advocate for the authorization of physician assistants and nurse practitioners under the supervision of a MD or DO to order care for Medicare beneficiaries for skilled nursing facilities, assisted living facilities, and home health agencies, provided that such orders are within physician assistant and nurse practitioner scope of practice under state law, to the Centers for Medicare and Medicaid Services and, if federal law must be amended, advocate to Congress. (Directive to Take Action)

Your Reference Committee heard the vast majority of testimony opposed to adoption of Resolution 214. Your Reference Committee appreciates the authors' testimony that the intent of this resolution was not to expand the scope of practice of non-physician providers. Your Reference Committee is also sympathetic to testimony related to the workforce-related issues in Idaho. However, your Reference Committee agrees with the majority of testimony that the recommendations in this resolution may have unintended consequences related to scope of practice. Your Reference Committee agrees with testimony that the adoption of this resolution could harm the annual efforts of state and national medical specialty societies to address scope of practice expansions sought by non-physician providers. Finally, your Reference Committee notes that Resolution 214 conflicts with existing AMA policy which requires that durable medical equipment, home health and other outpatient medical services be ordered by the physician responsible for the patient's care. Given the scope of practice issues raised in testimony and concern that this resolution conflicts with existing AMA policy that indicates that physicians should ultimately be responsible for home health care orders, your Reference Committee recommends that Resolution 214 not be adopted.

(19) RESOLUTION 202 - MEDICAL MARIJUANA RESEARCH

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-95.952 and H-95.998 be reaffirmed in lieu of Resolution 202.

HOD ACTION: Policies H-95.952 and H-95.998 reaffirmed in lieu of Resolution 202.

Resolution 202 asks that our American Medical Association seek federal legislation that would permit academic and clinical research on "medical marijuana." (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 202. Some who testified noted that our AMA already has policy supporting medical marijuana research and therefore supported reaffirming existing AMA policy. Your Reference Committee also heard that there is already an existing legal pathway for conducting research on medical marijuana, which is discussed in Report 3 of the Council on Science and Public Health (I-09) regarding the "Use of Cannabis for Medicinal Purposes." Since existing AMA policy already covers the goal of Resolution 202 and since a legal pathway currently exists for

conducting medical marijuana research, your Reference Committee recommends reaffirmation of existing AMA Policies H-95.952 and H-95.998.

H-95.952 Cannabis for Medicinal Use

(1) Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease. (2) Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product. (3) Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support. (4) Our AMA believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions. (CSA Rep. 10, I-97; Modified: CSA Rep. 6, A-01; Modified: CSAPH Rep. 3, I-09; Modified in lieu of Res. 902, I-10; Reaffirmed in lieu of Res. 523, A-11)

H-95.998 AMA Policy Statement on Cannabis (Marijuana)

Our AMA believes that (1) cannabis is a dangerous drug and as such is a public health concern; (2) sale and possession of marijuana should not be legalized; (3) handling of offenders should be individualized; and (4) additional research should be encouraged. (BOT Rep. K, I-69; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10)

(20) RESOLUTION 218 - OPPOSE MEDICARE PENALTIES FOR NON
ADOPTION OF EHR
RESOLUTION 219 - ELECTRONIC HEALTH RECORDS
RESOLUTION 226 - PENALTIES FOR NON-ADOPTION OF HEALTH
INFORMATION TECHNOLOGY
RESOLUTION 228 - MEDICARE'S PAYMENT REDUCTION FOR
MEDICARE ELIGIBLE PROFESSIONALS WHO DO NOT
DEMONSTRATE MEANINGFUL USE OF ELECTRONIC MEDICAL
RECORDS (EMR) BY 2015

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-478.991 and D-478.994 be reaffirmed in lieu of Resolutions 218, 219, 226, and 228.

HOD ACTION: Policies H-478.991 and D-478.994 reaffirmed in lieu of Resolutions 218, 219, 226, and 228.

Resolution 218 asks that our American Medical Association take immediate action to seek support for federal legislation to repeal the penalties in the Health Information Technology for Economic and Clinical

Health Act for physicians who do not adopt Electronic Health Records or do not meet criteria for meaningful use (Directive to Take Action); and (2) that AMA Policy H-478.991, Federal EMR and Electronic Prescribing Incentive Program, be amended be insertion and deletion to read as follows: (Modify Current HOD Policy) Our AMA: (1) will communicate to the federal government seek support for legislation to insure that the Electronic Medical Record (EMR) incentive program should be is made compliant with AMA principles by removing penalties for non-compliance and by providing inflation-adjusted funds to cover all costs of implementation and maintenance of EMR systems; and (2) supports the concept of electronic prescribing, as well as the offering of financial and other incentives for its adoption, but strongly discourages a seeks support for legislation to remove the current funding structure that financially penalizes physicians that have not adopted such technology. Resolution 219 asks (1) that our American Medical Association work with government and software developers asking that: (1) payments to physicians and hospitals for electronic health record implementation should be based on actual costs to the facility or practice rather than a government estimate; and (2) there should be no penalties to physician practices and hospitals that do not adopt electronic health records including no reduction in Medicare and Medicaid payments (Directive to Take Action); and (2) that our AMA support further studies into what constitutes a truly utilitarian electronic health record with a goal of decreasing complexity, increasing efficiency and decreasing the amount of data required by government and insurance companies. (Directive to Take Action) Resolution 226 asks that our American Medical Association oppose financial penalties by any payer for physicians who do not adopt health information technology, such as electronic medical records and electronic prescribing. (New HOD Policy) Resolution 228 asks that our American Medical Association urge Medicare to eliminate its punitive payment adjustment planned in 2015 for physicians who do not demonstrate meaningful use of electronic medical records (EMRs). (Directive To Take Action)

Your Reference Committee heard testimony in support of Resolutions 218, 219, 226, and 228. Many testified that EHR incentives should be based on actual EHR purchase and implementation costs, and that because of the complications and undue burden of federal EHR programs, physicians who are unable to adopt or demonstrate meaningful use should be protected from Medicare and Medicaid financial penalties. Your Reference Committee wholeheartedly agrees that EHR penalties should not be imposed on physicians, and believes that existing AMA policy strongly expresses that penalties should be removed from these programs, that positive incentives are needed, and that funds should be provided to physicians to cover all costs of implementation and maintenance of EHR systems. Given the strength of AMA policies H-478.991 and D-478.994, your Reference Committee recommends that these policies be reaffirmed in lieu of resolution 218, 219, 226, and 228.

H-478.991 Federal EMR and Electronic Prescribing Incentive Program

Our AMA: (1) will communicate to the federal government that the Electronic Medical Record (EMR) incentive program should be made compliant with AMA principles by removing penalties for non-compliance and by providing inflation-adjusted funds to cover all costs of implementation and maintenance of EMR systems; and (2) supports the concept of electronic prescribing, as well as the offering of financial and other incentives for its adoption, but strongly discourages a funding structure that financially penalizes physicians that have not adopted such technology. (Sub. Res. 202, A-09; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed in lieu of Res. 237, A-12)

D-478.994 Health Information Technology

Our AMA will: (1) support legislation and other appropriate initiatives that provide positive incentives for physicians to acquire health information technology (HIT); (2) pursue legislative and regulatory changes to obtain an exception to any and all laws that would otherwise prohibit financial assistance to physicians purchasing HIT; (3) support initiatives to ensure interoperability among all HIT systems; and (4) support the indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of Electronic Health Record (EHR) products and services, and will advocate for federal regulatory reform that will allow for indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of EHR products and services. (Res. 723, A-05; Reaffirmation A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed: Res. 726, A-08; Reaffirmation I-08; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed: Res. 205, A-11; Appended: Res. 220, A-12)

(21) RESOLUTION 225 - INCOME ELIGIBILITY/TAX DEDUCTIBILITY OF STUDENT LOAN INTEREST

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy D-305.962 be reaffirmed in lieu of Resolution 225.

HOD ACTION: Policy D-305.962 reaffirmed in lieu of Resolution 225.

Resolution 225 asks that our American Medical Association cause legislation to be introduced to allow 100% tax deductibility of student loan interest for physicians who choose a career in public service, or who practice in a designated Health Professionals Shortage Area regardless of their income. (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 225. Some, however, raised concerns that the resolution only supports a tax deduction for student loan interest under the specific circumstances set forth in Resolution 225, that is, for physicians who choose a career in public service or practice in a designated Health Professionals Shortage Area, and not for all physicians, as called for in existing AMA policy. Your Reference Committee agrees with these concerns and believes existing AMA policy is much broader and supports tax deductibility for student loan interest for all physicians. Your Reference Committee, therefore, recommends reaffirmation of AMA Policy D-305.962, in lieu of Resolution 225.

D-305.962 Tax Deductibility of Student Loan Payments

Our AMA will draft legislation allowing 100% tax deductibility of student loan interest. (Res. 232, A-09)

Reference Committee F

(1) REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON
COMPENSATION OF THE OFFICERS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in the Report of the House of Delegates Committee on Compensation of the Officers be adopted and the remainder of the Report be filed.

HOD ACTION: Report of the House of Delegates Committee on Compensation of the Officers adopted and remainder of the Report filed.

The Report of the House of Delegates Committee on Compensation of the Officers highlights Board of Trustees compensation for the period July 1, 2011 through June 30, 2012 and documents the taxable value of benefits, perquisites, services, and in-kind payments for all Officers. Finally, the report recommends there be no changes to the Officers' compensation for the period ending June 30, 2013.

Your Reference Committee received no testimony in response to the Report of the House of Delegates Committee on Compensation of the Officers.

(2) COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT
REPORT 1 - PROPOSAL FOR A SENIOR PHYSICIANS SECTION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Long Range Planning and Development Report 1 be adopted and the remainder of the Report be filed.

HOD ACTION: Council on Long Range Planning and Development Report 1 adopted and the remainder of the Report filed.

Council on Long Range Planning and Development Report 1 comes in response to a letter of application from the Senior Physicians Group for a change in status from a Board of Trustees advisory committee to a section with representation in our AMA House of Delegates.

The Council on Long Range Planning and Development recommends that our AMA transition the Senior Physicians Group to the Senior Physicians Section, as a delineated section, and that appropriate bylaws language be developed to recognize the Senior Physicians Section.

Your Reference Committee extends its appreciation to the Council on Long Range Planning and Development for its thorough and thoughtful work in reviewing the senior physician group's application for section status. Your Committee received predominantly positive testimony in favor of the Council's recommendation.

(3) BOARD OF TRUSTEES REPORT 7 - POTENTIAL COMBINED HOD /
NAC MEETING

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 7 be amended by substitution to read as follows:

1. Our AMA will organize and implement the pilot as specified in AMA Policy G-600.125.
2. A study and report on the feasibility and logistics of reorganized future meeting dates and schedules shall be developed and presented to the House of Delegates.
3. State and specialty societies shall be queried on the potential number of members who would attend a new, revised interim/NAC meeting.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 7 be adopted as substituted and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 7 adopted as substituted and the remainder of the Report filed.

Board of Trustees Report 7 comes in response to AMA Policy G-600.125, AMA Meeting Schedule, which reads:

1. Our AMA will convene as a pilot a combined interim policy making meeting and National Advocacy Conference.
2. The combined meetings will be held at a location in the Washington, DC metropolitan area and at an appropriate time to avoid incurring contractual penalties.
3. The pilot will take place within a reasonable time frame, and with adequate notice to members of the House of Delegates.
4. Our AMA sections will be afforded the opportunity to meet immediately prior to and in close proximity to the meetings of the House of Delegates.

The report summarizes the findings of the Board of Trustees' efforts to implement the policy and concludes that combining the National Advocacy Conference (NAC) with the Interim Meeting would be difficult to accomplish without adversely affecting the NAC in particular. No financial benefits or time savings for participating individuals and physician organizations would be realized. For these reasons, the Board of Trustees recommends that implementation of AMA Policy G-600.125, AMA Meeting Schedule, be delayed until such time that changes in Washington, DC meeting infrastructure, capacity, and availability afford the prospect of a more viable combined, advocacy-focused meeting in that city, and that the Board of Trustees report back to the House of Delegates at such time.

Your Reference Committee recognizes the complexity of this issue. Your Reference Committee heard testimony that recognized the difficulties associated with convening a combined meeting, but still heard a clear call for implementation of the pilot specified in AMA Policy G-600.125. Based on testimony provided by the Texas Delegation and its supporters, your Reference Committee recommends the substitute language presented, which accomplishes the pilot implementation without being overly prescriptive. Testimony also reflected that our House of Delegates wants to increase and improve our AMA's advocacy efforts. Furthermore, testimony supported the desire to evaluate the potential impact, effectiveness, and efficiency of a combined interim/NAC meeting.

(4) RESOLUTION 601 - ABUSE OF CPT DESCRIPTORS RELATED TO SURGERY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 601 be referred.

HOD ACTION: Resolution 601 referred.

Resolution 601 calls upon our American Medical Association to urge the CPT Editorial Panel to retitle the section "Surgery" to read "Surgery and Procedures" and add the description of surgery in AMA Policy H-475.983 to the section preamble.

Your Reference Committee received testimony that the established CPT Editorial Panel process is the proper mechanism for addressing issues of this nature. As has been previously stated by your Reference Committee, the CPT editorial process is subject to oversight by the Board of Trustees. Perceived or actual involvement of the House of Delegates in the CPT editorial process could jeopardize the independence of the CPT Editorial Panel. It is vitally important that physicians maintain their leadership role in defining medical and surgical services and procedures.

Your Reference Committee recommends referral so that our AMA House of Delegates will be informed of the outcome of this particular issue. However, in the future, your Reference Committee strongly recommends that the CPT Editorial Panel process be utilized in lieu of bringing such resolutions to the House of Delegates.

(5) BOARD OF TRUSTEES REPORT 9 - 2013 STRATEGIC PLAN

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 9 be filed.

HOD ACTION: Board of Trustees Report 9 filed.

Board of Trustees Report 9 introduces a new five-year strategic plan that at its core includes three focus areas: improving health outcomes, accelerating change in medical education, and shaping delivery and payment models that promote practice sustainability and professional satisfaction. The rolling five-year plan is dynamic in that it will be refined and shaped by new information, insight, and changes in the health arena. Additionally, it will channel our AMA's attention toward outcomes, collaboration, and action.

Your Reference Committee received evenly divided testimony in response to the 2013 Strategic Plan. Negative testimony focused on concern that the plan does not go far enough and does not include delineated elements of public health and advocacy. The Board of Trustees indicated they will actively take this testimony into account in implementing and developing this and future strategic plans. However, our House of Delegates received reassurance that elements not specifically mentioned in the plan are still important areas of engagement for our AMA. Board of Trustees Report 9 is an informational report.

Your Reference Committee heard frustration about the process surrounding the development of our AMA's Strategic Plan and would therefore encourage our Board of Trustees to expand the House of Delegates' ability to contribute to the plan earlier in the process.

Reference Committee J

(1) BOARD OF TRUSTEES REPORT 4 – SINGLE- SIGNATURE CONTRACTS AND THE RIGHT TO "OPT OUT"

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 4 be adopted and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 4 adopted and remainder of the report filed.

Board of Trustees Report 4 reviews the implications of allowing individual physicians to opt out of contracts signed on behalf of physician organizations, and concludes that more data is needed before our AMA can make a determination of whether it should support physicians' opt out rights in settings where the physician has granted single-signature authority to the organization. The report recommends reaffirmation of Policies H-225.964 and H-383.997, which address the contracting rights and responsibilities of hospital-based physicians.

A member of the Board of Trustees introduced Board of Trustees Report 4, highlighting that the report outlines the pros and cons of an opt out choice under a single-signature contract, considers antitrust compliance issues and acknowledges a lack of data on whether having a choice to opt out of contracts negotiated by an employer benefits or harms physicians as a whole. The report concludes that more data is needed before our AMA can make a determination of whether it should support physicians' opt out rights in settings where the physician has granted single-signature authority to the organization. With this conclusion, the report recommends reaffirmation of Policies H-225.964 and H-383.997, which address the contracting rights and responsibilities of hospital-based physicians. Given that additional testimony was limited, yet supportive, your Reference Committee recommends that Board of Trustees Report 4 be adopted.

(2) COUNCIL ON MEDICAL SERVICE REPORT 1 - COST-SHARING FOR SPECIALTY DRUGS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 1 adopted and remainder of the report filed.

Council on Medical Service Report 1 provides background on the use and insurance treatment of specialty drugs, and recommends reaffirming policies that support cost sharing arrangements that promote value in health care spending, rather than shifting costs to patients.

Testimony on this report expressed concern that the recommendations did not go far enough in identifying ways to ensure that high cost specialty drugs remain affordable for those who need them, and suggested that the report be referred for further study. A member of the Council on Medical Service testified that the AMA policies recommended for reaffirmation in the Council's report support benefit designs that promote the efficient and effective use of health care services, and oppose cost sharing arrangements that simply shift costs to patients. The Council's report emphasized that a key goal of pharmacy benefit designs should be to improve patient treatment and adherence. In particular, the Council noted that value-based insurance design is emerging as a potentially effective way to ensure that

patients have access to critical drugs by reducing cost sharing requirements for medications used to treat chronic medical conditions, and that specialty medications in particular are well suited to a targeted benefit design. Your Reference Committee notes that page 6 of the report indicates that the Council on Medical Service will be reviewing the subject of value-based insurance design for a report that will be presented to the House at the 2013 Annual Meeting. In lieu of referring this report back to the Council, your Reference Committee encourages the Council to specifically address how specialty medications would be treated in a value-based insurance design to ensure that these drugs are affordable for patients who need them.

(3) COUNCIL ON MEDICAL SERVICE REPORT 3 - FACE-TO-FACE ENCOUNTER RULE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 3 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 3 adopted and remainder of the report filed.

Council on Medical Service Report 3 provides background on the face-to-face encounter requirement for Medicare home health services, outlines options for completing face-to-face encounter documentation, highlights billing and payment issues associated with the face-to-face encounter requirement, and makes recommendations to help facilitate the face-to-face encounter documentation process.

There was generally supportive testimony on this report. Speakers commended the Council for a thorough job of describing the options physicians have for fulfilling the face-to-face encounter requirement for Medicare home health services. Some speakers expressed concern that the report did not go far enough in identifying new solutions for minimizing the administrative burden of the documentation requirements, particularly for primary care physicians who often bear the responsibility for the documentation regardless of whether they have ordered the service. A member of the Council on Medical Service testified that the Council considered proposing language that would require the physician who orders the home care services to complete the documentation requirements, but was concerned that such a requirement would limit the flexibility physicians currently have for meeting the requirement. The Council noted that some primary care physicians would prefer to complete the documentation requirements, even if discharge was handled by another physician. To the extent that primary care physicians bear an undue burden for completing the face-to-face documentation requirements, your Reference Committee believes this is related to care transition and care coordination processes, rather than the requirements associated with the face-to-face encounter rule, *per se*. Your Reference Committee agrees with testimony that Recommendations 3 and 4 of the report, which emphasize better education regarding the documentation requirements and the options for completing them, are critical to minimizing the burden of this rule. Your Reference Committee notes that Recommendation 5 calls on our AMA to monitor proposals to modify the face-to-face encounter rule, and work to prevent any new unfunded administrative burdens for practicing physicians. Your Reference Committee recommends that the recommendations in Council on Medical Service Report 3 be adopted.

(4) RESOLUTION 801 - PRESCRIPTION REFILL SCHEDULES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 801 be adopted.

HOD ACTION: Resolution 801 adopted.

Resolution 801 asks that our AMA encourage insurers and pharmacy organizations to develop and implement prescription refill schedule strategies so that travel barriers are reduced for patients requiring multiple medications.

There was supportive testimony on this resolution. Your Reference Committee concurs with testimony that streamlining the prescription refill process for patients who take multiple prescriptions could help improve patient compliance and result in better health outcomes for our patients. Your Reference Committee accordingly recommends adoption of Resolution 801.

(5) RESOLUTION 803 - BILLING CODES FOR FILLING OUT FORMS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 803 be adopted.

HOD ACTION: Resolution 803 adopted.

Resolution 803 asks that our AMA lobby CMS and other payers to reimburse physicians who use billing code 99080 for filling out forms requested by patients.

There was supportive testimony on this item, and your Reference Committee agrees that physicians should be paid for the time they spend completing medical forms for patients. Accordingly, your Reference Committee recommends adoption of Resolution 803.

(6) RESOLUTION 804 - SECURITY OF TELEMEDICINE
COMMUNICATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 804 be adopted.

HOD ACTION: Resolution 804 adopted.

Resolution 804 asks that our AMA develop warnings and guidance for physicians and patients about the use and security of telemedicine technologies.

A note on Resolution 804 states that the topic of this resolution is currently under study by the Board of Trustees. Your Reference Committee is aware that this report is scheduled to be presented to the House at the 2013 Annual Meeting, and agrees with testimony that it would be appropriate for the Board to consider the issues raised in this resolution as part of their upcoming report. Accordingly, your Reference Committee recommends that Resolution 804 be adopted.

(7) RESOLUTION 815 - EVIDENCE-BASED UTILIZATION OF SERVICES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 815 be adopted.

HOD ACTION: Resolution 815 adopted.

Resolution 815 asks that our AMA support physician-led, evidence based efforts to improve appropriate utilization of medical services, and educate members, physicians, hospitals, health care leaders and patients about the need for such efforts.

There was generally supportive testimony on this resolution. Your Reference Committee notes that the "Choosing Wisely" initiative referenced in the whereas clauses serves as an excellent model of a physician-led initiative in which physicians take the lead in identifying and making recommendations regarding the appropriate utilization of services. Your Reference Committee appreciates testimony regarding the need to be cautious about the relationship between professional liability issues and utilization of certain health care services, but believes that those issues are beyond the scope of this resolution. Your Reference Committee notes that Policy H-435.947, "supports that best clinical practice guidelines represent a medical guideline not a legal one and recognize and encourage that such guidelines do not supplant clinical judgment and that failure to follow each and every clinical guideline should not be used to create a presumption of negligence." Your Reference Committee recommends that Resolution 815 be adopted.

(8) COUNCIL ON MEDICAL EDUCATION - COUNCIL ON MEDICAL SERVICE JOINT REPORT - THE STRUCTURE AND FUNCTION OF INTERPROFESSIONAL HEALTH CARE TEAMS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 in the Joint Report of the Council on Medical Education and the Council on Medical Service be amended by addition and deletion on page 10, line 1 to read as follows:

That our American Medical Association (AMA) define "team-based health care" as the provision of health care services by a physician-led team of at least two health care practitioners professionals who work collaboratively with each other and the patient and family to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 2 in the Joint Report of the Council on Medical Education and the Council on Medical Service be amended by deletion on page 10, line 7 to read as follows:

That our AMA advocate that the physician leader of a physician-led interprofessional health care team be empowered to perform the full range of medical interventions that she or he is trained and licensed to perform. (New HOD Policy)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Recommendations 4a - d in the Joint Report of the Council on Medical Education and the Council on Medical Service be amended by addition and deletion on page 10, lines 16-23, so that the principles are reordered, to read as follows:

That our AMA adopt the following principles to guide physician leaders of health care teams:

- a b.** Make clear the team's mission, vision and values.
- b c.** Direct and/or engage in collaboration with team members on patient care.

e d. Be accountable for clinical care, quality improvement, efficiency of care, and continuing education.

e a. Focus the team on patient and family-centered care.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Recommendation 5 in the Joint Report of the Council on Medical Education and the Council on Medical Service be amended by addition and deletion on page 10, lines 47-48 to read as follows:

That our AMA encourage independent physician practices and small group practices to seek consider opportunities to form health care teams with other practices, such as through independent practice associations, virtual networks or other networks of independent providers. (New HOD Policy)

RECOMMENDATION E:

Mr. Speaker, your Reference Committee recommends that Recommendation 6 in the Joint Report of the Council on Medical Education and the Council on Medical Service be amended by addition and deletion on page 11, lines 1-2 to read as follows:

That our AMA encourage study innovative payment mechanisms that appropriately compensate the physician and/or team and all team members for team-based health care with a report back to the HOD. (New HOD Policy)

RECOMMENDATION F:

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

HOD ACTION: Joint Report of the Council on Medical Education and the Council on Medical Service adopted as amended and remainder of the report filed.

The Joint Report of the Council on Medical Education and the Council on Medical Service provides background on the growing need for interprofessional team-based care, outlines the health professionals shortage and increasing demand for health care services, highlights key aspects of an interprofessional collaborative medical practice, and recommends principles to guide physician leaders of health care teams.

Your Reference Committee heard extensive testimony on the Joint Report of the Council on Medical Education (CME) and the Council on Medical Service (CMS). A member of CMS introduced the report stating that the impetus came largely from the anticipated health care professional shortage in conjunction with a projected increase in insured individuals due to the Patient Protection and Affordable Care Act (ACA). The Councils offered minor amendments addressing independent and small group practices as well as striking a reference to licensure.

The general consensus was supportive of the intent and complimentary of the Councils work. However, several amendments were suggested. Testimony suggested that "health care practitioners" in

Recommendation 1 was too narrow and did not include all individuals who could possibly work in a medical practice. One speaker suggested prioritizing the focus of the team on patient and family-centered care in the principles to guide physician team leaders. Another amendment suggested that the AMA study and report back on innovative payment mechanisms that appropriately compensate the team and all team members for team-based care. It was also suggested that "physician" be directly referred to in Recommendation 6 regarding compensation to the physician and team members. Your Reference Committee concurs with all of these suggestions and has outlined them in the recommendations.

The American Medical Group Association requested that the body of the report be amended in the paragraph that summarizes the AMA Integrated Physician Practice Section (IPPS) on page 7, lines 50 and 51, by replacing "physician representatives from" with "physicians who are in" on both lines. Since this request does not involve a recommendation, the report will be changed editorially, if appropriate.

Several issues, such as who may incur liability when practicing in a team-based environment, the credentialing of different team members and providing ethical care were brought up, all of which are beyond the scope of this report. However, the focus on team-based care is a new emphasis for the AMA and these issues could be addressed in a forthcoming report.

Given the positive testimony and suggested amendments, your Reference Committee recommends that the report of the Council on Medical Education and the Council on Medical Service be adopted as amended.

(9) COUNCIL ON MEDICAL SERVICE REPORT 2 - MEDICAL RECORD AND REPORTING STANDARDS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 in Council on Medical Service Report 2 be amended by addition and deletion on line 33 to read as follows:

That our American Medical Association encourage the College of American Pathologists, Health Level 7, the National Institute for Standards and Technology, and the Agency for Healthcare Research and Quality to urgently continue their ongoing efforts to address usability and standardization of laboratory report results for physicians and non-physician practitioners to ensure patient safety. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 2 in Council on Medical Service Report 2 be amended by addition and deletion on lines 37-39 to read as follows:

That our AMA encourage support the continued efforts of relevant national medical specialty societies, such as the American College of Radiology, the American Osteopathic College of Radiology and other appropriate entities like organizations whose members generate reports electronically to clarify terminology and work in consultation with physicians likely to be end users toward producing a standardized format with appropriate standard setting bodies for the presentation of radiology results, including clearly identifiable diagnoses and test results. (New HOD Policy)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Recommendation 3 in Council on Medical Service Report 2 be amended by addition and deletion on page 5, lines 47-49 to read as follows:

That our AMA modify Policy D-260.995 by insertion and deletion to read as follows:

Our AMA will: (1) continue make its involvement with the Office of the National Coordinator for Health Information Technology and its Health Information Technology Policy and Standards Committees a high priority Standards Panel's Electronic Health Record Technical Committee that is developing a process through which laboratory results can be communicated electronically; and (2) become involved in and/or provide input into policies involving electronic transmission of clinical laboratory results. (Modify HOD Policy)

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Council on Medical Service Report 2 be amended by the addition of a fourth recommendation to read as follows:

That our AMA report back to the HOD on progress with regard to medical record and reporting standardization. (New HOD Policy)

RECOMMENDATION E:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 2 adopted as amended and remainder of the report filed.

Council on Medical Service Report 2 outlines physician concerns with inconsistent formats for presenting laboratory results, and presents recommendations to help facilitate the reporting and use of laboratory results.

Your Reference Committee heard testimony on Council on Medical Service Report 2 expressing great interest in standardizing laboratory and radiology reports. Several amendments were proposed to add language stressing the urgency in addressing usability and standardization of laboratory report results, making the AMA's involvement with the Office of the National Coordinator for Health Information Technology a high priority, and supporting the continued efforts of relevant national medical specialty societies to clarify terminology and work in consultation with physicians likely to be end users. Your Reference Committee concurs with these amendments.

In addition, an amendment was proposed to add a fourth recommendation requesting that the Council on Medical Service (CMS) produce a follow-up report in 2 years to the House of Delegates due to this issue's impact on patient safety, quality of care, and physician efficiency. While your Reference Committee understands the intent of a follow-up report, the House of Delegates cannot direct Council work, but rather can request that the AMA report back on an issue, which would provide the Board of Trustees the opportunity to assign the forthcoming report to the appropriate Council. In addition, testimony from CMS requested that a specific time for the report back not be given so that the Council can issue a report when there is updated information to report. Your Reference Committee therefore

made the appropriate edits to this amendment and recommends that Council on Medical Service Report 2 be adopted as amended.

(10) COUNCIL ON MEDICAL SERVICE REPORT 5 - STRENGTHENING MEDICARE FOR CURRENT AND FUTURE GENERATIONS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the preamble of Recommendation 1 of Council on Medical Service Report 5 be amended by substitution on lines 45 – 46 to read as follows:

1. That it be the policy of our American Medical Association that a Medicare defined contribution program should include the following:

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendations 1a - d of Council on Medical Service Report 5 be amended by addition and deletion on page 8, lines 48 – 51, and page 9, lines 1 - 11 to read as follows:

- a. Enable beneficiaries to purchase coverage of their choice ~~through a Medicare exchange or from among~~ competing health insurance plans, which would be subject to appropriate regulation and oversight to ensure strong patient and physician protections.
- b. Preserve traditional Medicare as an option ~~within the Medicare exchange~~.
- c. Offer a wide range of plans (e.g., HMOs, PPOs, high-deductible plans paired with health savings accounts), as well as traditional Medicare, ~~through the Medicare exchange~~.
- d. Require that ~~competing~~ private health insurance plans ~~participating in the Medicare exchange~~ meet guaranteed issue and guaranteed renewability requirements, be prohibited from rescinding coverage except in cases of intentional fraudulent representation, follow uniform marketing standards, meet plan solvency requirements, and cover at least the actuarial equivalent of the benefit package provided by traditional Medicare

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Recommendation 1g of Council on Medical Service Report 5 be amended by addition and deletion on line 23 to read as follows:

- g. Ensure that health insurance coverage is affordable for all beneficiaries by allowing for adjustments to the baseline defined contribution amount. In particular, individual defined contribution amounts should vary based on beneficiary age, income and health status. ~~Older, lower~~ income and sicker beneficiaries would receive larger defined contributions.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Recommendation 3 of Council on Medical Service Report 5 be amended by addition and deletion on line 42 to read as follows:

3. That our AMA reaffirm Policies H-330.896, "Strategies to Strengthen the Medicare Program," H-385.961, "Medicare Private Contracting," D-390.986, "Medicare Balance Billing," H-165.833, "Amend the Patient Protection and Affordable Care Act (PPACA)," and H-165.852, "Health Savings Accounts," and H-185.974, "Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs." (Reaffirm HOD Policy)

RECOMMENDATION E:

Mr. Speaker, your Reference Committee recommends that Council on Medical Service Report be amended by addition of a fifth recommendation to read as follows:

5. That our AMA continue to explore the effects of transitioning Medicare to a defined contribution program on cost and access to care. (Directive to Take Action)

RECOMMENDATION F:

Mr. 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 filed.

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

Council on Medical Service Report 5 expands on longstanding AMA policy that supports providing Medicare beneficiaries with defined contributions and a choice of health care plans from which to purchase coverage. The report also recommends a set of principles that should be included in a defined contribution system to ensure that Medicare remains a viable program that provides affordable and accessible health insurance coverage for the poorest and sickest beneficiaries.

There was extensive, mixed, and passionate testimony on this issue. Those testifying on Council on Medical Service Report 5 consistently praised the Council for its efforts to identify ways to strengthen the Medicare program and address the complex issue of reforming Medicare. There was strong support for Recommendation 2 related to GME financing. Similarly there was support for Recommendations 3, which reaffirms several policies that are critical to our AMA's ongoing advocacy efforts related to Medicare reform, and Recommendation 4, which rescinds outdated policy which supports replacing Medicare with a system of prefunded, private savings accounts, and rescinds two directives related to the development of this report.

The majority of the debate was on Recommendation 1. Testimony from the Council and others noted that Medicare is not financially stable, and some action must be taken to change the program. The Council emphasized the fact that the current Medicare program does not effectively protect patients against high out-of-pocket costs, and, as a result, 90% of beneficiaries have some form of supplemental coverage. Speakers who supported the Council's recommendations praised the Council's efforts to identify safeguards that would protect patients, particularly by preserving traditional Medicare as an option for patients, and specifying regulations that would govern private insurers offering coverage to Medicare beneficiaries. Several speakers noted that the Council effectively responded to concerns raised at the

2012 Annual Meeting regarding the need for more explicit principles that would ensure that a defined contribution design did not expose patients to excessive financial burdens. Recommendations that specifically call for defined contribution amounts to be greater for lower income and sicker beneficiaries, and for annual adjustments based on changes in health care costs reinforce our AMA's commitment to ensuring patients have access to affordable care.

Several speakers called for Recommendation 1 to be referred back to the Council for further study. Testimony indicated significant concerns about the lack of concrete data and economic modeling that would assess the impact of a defined contribution program on cost and patient access. Significant concerns were raised about the potential for private insurers to cherry pick healthy patients, and otherwise take advantage of the opportunity to secure Medicare defined contribution dollars without providing adequate coverage for beneficiaries. Several speakers testified that a defined contribution program would lead to a "death spiral" for the traditional Medicare program, because only sicker and poorer beneficiaries would stay in the traditional program. Speakers opposing this report testified that rather than lowering the costs of the Medicare program, a defined contribution program would cause them to increase exponentially, and further accelerate the program's collapse.

Speakers were also divided on whether the recommendations in the Council's report are relevant in the current political and economic environment. Some speakers advocated strongly for adoption of the recommendations in the report so that our AMA could be an active player in entitlement reform discussions which are likely to take place in the next several months. However, other speakers suggested that it is unlikely that a defined contribution program will gain political traction in the current environment, and therefore there is no urgency to act on the report at this time.

Your Reference Committee thoroughly considered all of the issues raised in testimony, and evaluated each of the recommendations in the Council's report separately. The proposed amendments reflect our consideration of the excellent work by the Council, and the extensive, passionate testimony we heard from all participants in the Reference Committee hearing.

Your Reference Committee is aware that longstanding AMA policy supports allowing Medicare beneficiaries to use defined contributions to purchase private health insurance coverage or coverage under traditional Medicare, and that this report seeks to define elements that should be included in a defined contribution program. Your Reference Committee recommends modifying the preamble of Recommendation 1 to emphasize the principles that should be included as part of a defined contribution system.

Your Reference Committee agrees with testimony that references to a "Medicare exchange" as the vehicle through which beneficiaries may purchase health insurance coverage may be premature. Accordingly, your Reference Committee recommends that references to a Medicare exchange be stricken from the recommendations.

Your Reference Committee concurs with testimony that Recommendations 1d, which addresses health plan regulation, and 1e. which addresses risk adjustment, are sufficient at this time to address concerns about cherry picking and other unfair practices by private insurance companies. With these general principles the Council has acknowledged that specific safeguards will need to be developed and put in place to ensure that private health insurance plans provide high quality, appropriate coverage for Medicare beneficiaries.

Your Reference Committee also believes that Recommendations 1 f – h suggest a strong commitment to ensure that all beneficiaries are able to afford health insurance coverage, and that the value of the defined contribution does not erode over time. Your Reference Committee knows there are significant concerns that a defined contribution program will result in coverage being unaffordable for some beneficiaries, and believes that this set of recommendations helps mitigate that risk.

Your Reference Committee also heard testimony about the importance of ensuring that coverage for mental illness and substance abuse disorders be included as part of any Medicare reform proposal. Your

Reference Committee concurs with testimony that Recommendation 3 should be amended to include support for reaffirmation of Policy H-185.974, "Parity for Mental Illness, Alcoholism and Related Disorders in Medical Benefits Programs."

Your Reference Committee believes that the Council has presented a thoughtful report that continues to lay the groundwork for Medicare reforms that will benefit patients and strengthen the program. While your Reference Committee recommends that the recommendations in the Council's report be adopted as amended, the Committee recognizes that additional work is needed to more thoroughly develop the concepts presented in this report. Your Reference Committee is aware that the Council is committed to pursuing further studies and refinements on this issue, and believes that the addition of Recommendation 5 will help focus the Council's future work.

(11) RESOLUTION 807 - TRANSPARENT DEVELOPMENT OF CLINICAL COVERAGE POLICIES-PROTOCOLS BY PRIVATE CARRIERS AND BENEFIT MANAGEMENT PLANS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 807 be adopted.

HOD ACTION: Substitute Resolution 807 adopted as amended.

RESOLVED, That our American Medical Association work with specialty and service organizations to advocate that private insurance plans and benefit management companies develop transparent clinical protocols as well as formal processes to write / revise them; that those processes should seek input from the relevant national physician organizations; and that such clinical coverage policies protocols should be easily and publicly accessible on their websites, just as Medicare national and local coverage determinations are publically available (Directive to Take Action), and be it further

RESOLVED, That our AMA advocate that when private insurance plans and benefit management companies make changes to or revise clinical coverage policies-protocols, said companies must inform all insured individuals and participating providers in writing no less than 90 days prior to said change(s) going into effect. (New HOD Policy)

Resolution 807 asks that our AMA work with specialty societies to advocate that private insurers and benefit management companies develop public, formal processes to write coverage policies, engage relevant physician organizations, and make these policies accessible on their web sites.

A member of the Council on Medical Service testified that existing AMA policy is consistent with the requests in this resolution. Your Reference Committee notes that Policy D-185.986 requested the AMA to work with interested state medical and national specialty societies to develop model legislation or regulations requiring third party payers to utilize transparent and accountable processes for developing and implementing coverage decisions and policies. In response to Policy D-185.986, the AMA communicated its willingness to work with all states and medical specialty societies seeking implementation of laws that require third party payers to utilize transparent and accountable processes for coverage decisions.

Even with existing policy, your Reference Committee heard mostly supportive testimony on Resolution 807. However, one speaker offered minor amendments on the online testimony to clarify the Resolution's request. Your Reference Committee concurred with this amendment, which is the new first resolve. Your Reference Committee also felt that specific language was needed in order to ensure that when changes

or revisions are made to clinical policies, that insured individuals and participating providers should be notified in a timely manner. The second resolve addresses this concern for communication. Accordingly, your Reference Committee recommends that Substitute Resolution 807 be adopted.

(12) RESOLUTION 809 - MEDICAID EXPANSION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve Resolution 809 be amended by addition to read as follows:

RESOLVED, That our American Medical Association, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133% (138% FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 809 be adopted as amended.

HOD ACTION: Resolution 809 adopted as amended.

Resolution 809 asks that our AMA work with the Federation to advocate at the state level for Medicaid expansion to 133% FPL, and advocate for an increase in Medicaid payments to physicians and improvements in Medicaid that will reduce administrative burdens and increase the efficiency of health care delivery.

Your Reference Committee heard extensive, impassioned testimony, which was highly divided on Resolution 809. Testimony in support of adoption stressed the importance of covering the neediest patients with an expansion of Medicaid and expressed concern for individuals living below 100% of the federal poverty level being left with no health insurance if Medicaid expansion doesn't occur.

Testimony in opposition urged our AMA to allow states to consider expanding their Medicaid programs without such expansion being imposed as a requirement. Concern for state budgeting was highlighted repeatedly, and testimony urged the AMA to follow the Supreme Court's decision to leave Medicaid expansion in the hands of states.

In order to reach a consensus, an amendment was offered to include language that our AMA would work with state and specialty medical societies in advocating for Medicaid expansion only at the invitation of the state medical societies. Your Reference Committee concurs with this amendment as it supports the intent of the resolution while allowing states autonomy with their Medicaid programs. Your Reference Committee also recognizes the importance of advocating for increased Medicaid payment rates and reduced administrative burdens, as called for in the second resolve. Accordingly, your Reference Committee recommends that Resolution 809 be adopted as amended.

(13) RESOLUTION 810 - MEDICARE QUALITY AND RESOURCE USE REPORTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 810 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association continue to work with CMS ~~on a more appropriate to improve the~~ design, content, and performance indicators included in the Quality and Resource Use Reports (QRURs) for ~~pathologists and other applicable specialty~~ physicians, so that the reports reflect the quality and cost data associated with these physicians in calculating Value-Based Payment Modifiers (VBM) (Directive to Take Action); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 810 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA continue to advocate, educate and seek to delay ~~this implementation of the VBM program which is set to take effect in 2013.~~ (Directive to Take Action)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 810 be adopted as amended.

HOD ACTION: Resolution 810 adopted as amended.

Resolution 810 asks that our AMA continue to work with CMS on including elements in the QRURs that are applicable to pathologists and other specialty physicians, and advocate for a delay in QRUR implementation.

There was supportive testimony on this resolution. A member of the Board of Trustees testified that an AMA-led work group of specialty and state medical society representatives has been working with CMS to help improve the distribution, format and content of the QRURs, and CMS has welcomed the group's suggestions. Your Reference Committee understands that this work is ongoing, and agrees with the intent of Resolution 810 to support our AMA's continued efforts. Your Reference Committee agrees with testimony suggesting that the scope of the resolution be expanded to support improvements in the QRURs for the benefit of all physicians, and accordingly proposes the amended language.

The second resolve of Resolution 810 references an implementation date of 2013. Your Reference Committee notes that the value based modifier will be applied to some physicians beginning in 2015, using 2013 data. Your Reference Committee suggests streamlining the second resolve by removing the reference to specific implementation dates.

(14) RESOLUTION 811 - ADMINISTRATIVE SIMPLIFICATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the fourth resolve of Resolution 811 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA continue to use its strong leadership role to support state and specialty society initiatives to simplify administrative functions, ~~such as The Colorado Clean Claims Taskforce.~~ (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 811 be adopted as amended.

HOD ACTION: Resolution 811 adopted as amended.

Resolution 811 asks that our AMA continue working on administrative simplification efforts and prioritize efforts to increase transparency regarding cost and coverage at the point of service. Resolution 811 also asks that our AMA support state initiatives to promote administrative simplification, and expand the Heal the Claims Process initiative.

Your Reference Committee heard supportive testimony on Resolution 811 in addition to several proposed amendments. One speaker suggested adding a reference to specialty societies to encompass both state and specialty society initiatives to simplify administrative functions. Striking the language referring to the Colorado Clean Claims Taskforce was also suggested. Your Reference Committee concurs with including language highlighting specialty society initiatives and striking the specific Colorado state example in the event that it becomes obsolete.

Testimony also suggested the addition of three resolved clauses that address billing for unlisted codes, the timely return of requests for additional information from the claims processor to the physician practice and a requirement that appeals must be settled within 30 days of submission by the physician practice. While your Reference Committee considered the addition of these resolves, the relevancy of the suggested language does not appear to be compatible with the intent or content of Resolution 811. Accordingly, your Reference Committee recommends that Resolution 811 be adopted as amended.

(15) RESOLUTION 812 - SHARED DECISION MAKING RESOURCE CENTERS**RECOMMENDATION A:**

Mr. Speaker, your Reference Committee recommends that Resolution 812 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~support legislation to fund advocate for full funding for~~ section 3506 of the Affordable Care Act. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 812 be adopted as amended.

HOD ACTION: Resolution 812 adopted as amended.

Resolution 812 asks that our AMA support legislation to fund the shared decision-making related sections of the Affordable Care Act.

There was generally supportive testimony on this resolution. Several speakers expressed support for the concept of shared decision making, and agreed that securing funding for the initiatives outlined in the ACA could help advance knowledge of the field. Testimony on the virtual reference committee expressed concern that pursuing federal funding for shared decision making initiatives could result in unintended consequences related to physician autonomy and health care costs, and recommended that the report be referred. However, a member of the Council on Medical Service testified that Council on Medical Service Report 4, also before the House at this meeting, is an informational report that provides an overview of current activities related to shared decision making. The report notes that, despite the lack of funding

under the ACA, states and private entities are pursuing the development of pilot projects and other efforts to strengthen the knowledge base associated with shared decision making. In light of the Council's report, your Reference Committee does not believe that referral is necessary, and concurs with testimony that the profession could benefit from increased practical knowledge about effective ways to use shared decision making. Your Reference Committee proposes amended language to clarify that our AMA should advocate for full funding for the shared decision making provisions that were authorized by the ACA.

(16) RESOLUTION 814 - DESIGNATION OF ELECTRODIAGNOSIS/OTHER SERVICES AS SEPARATE CATEGORY IN PROVIDER NETWORKS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 814 be amended by deletion as follows:

~~RESOLVED, That our AMA proactively oppose the designation of electrodiagnosis as a separate category in insurers' provider networks (Directive to Take Action)~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the third resolve of Resolution 814 be amended by addition to read as follows:

RESOLVED, That our AMA support the ability for all appropriately trained neurologists and physiatrists to perform electrodiagnosis on patients within their provider network. (Directive to Take Action)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 814 be adopted as amended.

HOD ACTION: Resolution 814 adopted as amended.

Resolution 814 asks that our AMA oppose the re-designation of services traditionally provided by broader medical specialties as a separate specialty category for inclusion into a payor's provider network unless compelling evidence shows that such a redesignation will improve patient care; proactively oppose the designation of electrodiagnosis as a separate category in insurers' provider networks; and support the ability for all neurologists and physiatrists to perform electrodiagnosis on patients within their provider network.

Your Reference Committee heard limited, yet mostly supportive testimony on Resolution 814. The sponsors offered amendments to strike the second resolve and to add language in the third resolve to specify that all neurologists and physiatrists be "appropriately trained". The first resolve remained unchanged. Given testimony in support of the sponsors' amendments and the limited, yet supportive testimony, your Reference Committee recommends that Resolution 814 be adopted as amended.

(17) RESOLUTION 819 - RESPONSIBILITY FOR TRANSPARENCY

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 819 be amended by deletion as follows:

~~RESOLVED~~, That our American Medical Association take the position that any transparency initiative(s) intending to inform patients of their anticipated health care costs indicate that the party(ies) assigned that responsibility is/are the one(s) who set the value and/or monetary rates of insurance and/or other reimbursement rates, and associated procedures (New HOD Policy); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 819 be amended by deletion to read as follows:

~~RESOLVED~~, That our AMA actively oppose ~~wording of~~ any legislation and/or regulation that deems the physician the responsible party to inform patients of their anticipated health care costs where the practitioner does not set reimbursement rates, and/or have that information, and where being required to provide to, or assist in obtaining for, the patient such fiscal information poses an undue administrative burden. (Directive to Take Action)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 819 be adopted as amended.

HOD ACTION: Resolution 819 adopted as amended.

Resolution 819 asks that our AMA take the position that transparency initiatives to inform patients of their anticipated health care costs indicate that the party(ies) assigned that responsibility is/are the one(s) who set the value and/or monetary rates of insurance and/or other reimbursement rates, and associated procedures, and that our AMA oppose wording of any legislation and/or regulation that deems the physician the responsible party to inform patients of their anticipated health care costs where the practitioner does not set reimbursement rates, and/or have that information, and where being required to provide to, or assist in obtaining for, the patient such fiscal information poses an undue administrative burden.

There was limited but supportive testimony on this resolution. Your Reference Committee agrees with testimony that the amended language succinctly expresses the AMA's opposition to efforts to compel physicians to provide cost related information to patients when that information is determined and controlled by insurance companies or other third parties. Accordingly, your Reference Committee recommends that Resolution 819 be adopted as amended.

(18) RESOLUTION 820 - OPPOSING ASSIGNING DUAL-ELIGIBLE PATIENTS INTO MANDATORY MANAGED CARE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 820 be adopted.

HOD ACTION: Substitute Resolution 820 adopted.

~~RESOLVED~~, That our American Medical Association demand that the Centers for Medicare and Medicaid Services require all states to develop forms and related processes to facilitate opting out of managed care programs by Medicare-Medicaid dual-eligible individuals, and related

processes and that those forms and directives be available no less than 120 days before the effective date of a state's dual eligible managed care program implementation (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate to continue to revise, limit the size, and limit the expansion of the dual-eligible managed care pilot process until it demonstrates improved accessibility, quality and cost efficiencies (New HOD Policy).

Resolution 820 asks that our AMA reaffirm Policy D-290.980, and redouble its efforts to carry out advocacy related to Policy D-290.980, including, but not limited to, (1) developing resources for physicians and patients to deal with opting out of passive enrollment in managed care plans where applicable, and (2) providing timely updates and communications to all stakeholders in order to coordinate advocacy at the state and local levels.

Your Reference Committee heard supportive testimony on Resolution 820 urging the AMA to oppose the assignment of dual-eligible individuals into mandatory managed care plans. Testimony expressed concern that the AMA has not been active enough on this urgent issue. Your Reference Committee notes that the AMA Advocacy Resource Center has developed an issue brief entitled "State Demonstration Projects for Dual-Eligible Individuals," which outlines guiding principles that states should address when reviewing their state's dual eligible demonstration project.

In addition, testimony highlighted relevant Policy D-290.980, which was adopted at A-12, and states that our AMA will advocate that the Centers for Medicare & Medicaid Services (CMS) and the states delay implementation of the Medicare-Medicaid dual-eligible demonstration program for at least one year to allow beneficiaries and provider stakeholders to better understand, evaluate and comment on the "State Demonstrations to Integrate Care for Dual-Eligible Individuals" initiative. In response to D-290.980, the AMA sent a letter to CMS outlining concerns with the dual-eligible demonstration projects, including advocating that beneficiaries' freedom to choose their provider should be preserved and protected. Furthermore, your Reference Committee notes that Policies H-290.984 and H-415.988 strongly oppose mandatory enrollment of Medicare and/or Medicaid patients in managed care plans and support choice of provider.

Given AMA policy and recent advocacy efforts addressing the requests in Resolution 820, your Reference Committee recommends that the original resolves be stricken and that two resolves from an amendment submitted during testimony be substituted in their place since the proposed language provides new policy for the AMA.

(19) RESOLUTION 822 - MEDICARE CUTS TO PATHOLOGY SERVICES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 822 be adopted in lieu of Resolution 822:

HOD ACTION: Substitute Resolution 822 adopted as amended.

AMA/SPECIALTY SOCIETY RELATIVE VALUE SCALE UPDATE COMMITTEE RECOMMENDATIONS

RESOLVED, That our American Medical Association oppose cuts changes in Relative Value Units that are in excess of those recommended by the AMA/Specialty Society Relative Value Scale Update Committee (RUC) (Directive to Take Action); and be it further

~~RESOLVED, That our AMA continue to aggressively lobby to prevent cuts to physician payments from being enacted on January 1, 2013 as a result of the sustainable growth rate (SGR) formula. (Directive to Take Action)~~

Resolution 822 asks that our AMA immediately send a letter to the Centers for Medicare and Medicaid Services requesting cuts to the technical component of surgical pathology be reevaluated and adjusted to meet the Medicare Economic Index, aggressively lobby to prevent this cut from being enacted on January 1, 2013, and oppose further cuts to physician payments.

The sponsor of Resolution 822 presented substitute language for this resolution, which was strongly supported by others testifying before the committee. The substitute language reflects additional information the sponsors received about the circumstances surrounding the cuts to pathology services, and an acknowledgement that the issues addressed in the resolution may have broader implications than just pathology. Testimony strongly supported the work of the RUC, and the important role it plays in helping advise the Centers for Medicare and Medicaid Services about code values. The substitute language also calls on our AMA to aggressively lobby to prevent the physician payment cuts that are scheduled to take place as a result of the flawed SGR formula. Your Reference Committee recommends that Substitute Resolution 822 be adopted.

(20) RESOLUTION 813 - HOSPITAL BASED PHYSICIANS AND THE VALUE BASED PAYMENT MODIFIER

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 813 be referred.

HOD ACTION: Resolution 813 referred.

Resolution 813 asks that our AMA conduct a study to identify and evaluate appropriate metrics for hospital based specialties within the VBM initiative, with the goal of accurately capturing hospital-based practice and achieving better physician-hospital alignment where appropriate. The resolution also asks the AMA to work with hospital based professional societies to construct a program that complies with the ACA VBM mandate and that will validly evaluate hospital based physicians at the individual and group practice level.

There was supportive testimony on the intent of this resolution. Speakers expressed concern about the implementation of the VBM initiative, particularly about the metrics that are being used to determine how the modifier is applied to physicians or physician groups. Testimony supported the concept of our AMA serving as a "convener" to facilitate the development of relevant metrics, and a member of the Board of Trustees testified that an AMA-led work group of specialty and state medical society representatives has been working with the Centers for Medicare and Medicaid Services to help improve the distribution, format and content of the QRURs (which will be the basis for the application of the VBM). Your Reference Committee believes that the intent of Resolution 813 goes beyond our AMA's current advocacy efforts, since it asks our AMA to identify and evaluate specific performance metrics for hospital-based specialties. Your Reference Committee agrees with testimony suggesting that this resolution be referred so that further consideration can be given to the issue, including consideration of whether our AMA has the resources and expertise to pursue the activities called for in the resolution.

(21) RESOLUTION 802 - USE OF INTEGRATED ELECTRONIC PATIENT CARE REPORTS FOR PREHOSPITAL PROVIDERS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 802 not be adopted.

HOD ACTION: Resolution 802 referred for study.

Resolution 802 asks that our AMA support legislation incentivizing the comprehensive use of electronic patient care reports by EMTs and paramedics for better cross communication and to standardize the flow of information to and from the hospital.

Your Reference Committee heard limited, yet supportive testimony on Resolution 802 in the on-site hearing. However, several speakers raised concerns about the feasibility of the resolution's requests in virtual testimony.

One online speaker questioned the financial feasibility as an EMS system may interface with potentially a dozen different hospitals in their catchment area, which would make the practical aspects very complex and expensive to implement. Another speaker expressed concern that the resolution's request is beyond the scope of AMA advocacy efforts and that a negative impact on local governments would need to be considered prior to supporting such an initiative.

Your Reference Committee notes that AMA Policy D-160.944 promotes improved and standardized flow of critical information across the spectrum of care, which addresses with the intent of Resolution 802 without imposing financially infeasible legislation or negatively impacting local governments as testimony has cautioned. While your Reference Committee acknowledges the positive goal of this resolution, it recommends that Resolution 802 not be adopted.

(22) RESOLUTION 817 - PHYSICIAN SIGNATURES ATTESTING TO CAUSE AND MANNER OF DEATH ON DEATH CERTIFICATES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 817 not be adopted.

HOD ACTION: Resolution 817 not adopted.

Resolution 817 asks that our AMA advocate that only physicians should complete, certify, and sign the cause and manner of death section on all death certificates.

There was mixed testimony on this resolution. Some speakers suggested that there are potential scope of practice issues associated with non-physicians completing death certificates. Other speakers testified that death certificates may require reporting of specific information or data that may not reflect or depend on a medical diagnosis, in which case they can effectively be completed by people who are specifically trained to complete such documentation. In addition, several speakers expressed concern that physicians are not always available to complete death certificates, especially in rural areas, which could result in an unnecessary delay in reporting cause of death information. A member of the Council on Medical Service testified that Policy H-85.960 states that physicians are the "appropriate parties to certify cause of death." Your Reference Committee believes that this language – which was reaffirmed at the 2012 Annual Meeting – emphasizes the important role of physicians in certifying the cause of death, without implying that physicians must complete the certificate in all circumstances. In light of the mixed testimony, your Reference Committee recommends that this resolution not be adopted.

(23) RESOLUTION 805 - TELEMEDICINE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-480.947, H-480.969, H-480.961, and H-390.859 be reaffirmed in lieu of Resolution 805.

HOD ACTION: Policies H-480.947, H-480.969, H-480.961, and H-390.859 reaffirmed in lieu of Resolution 805.

Resolution 805 asks that our AMA encourage state medical boards to regulate telemedicine and to work with state legislatures to seek full licensure for intrastate telemedicine practice and seek full reimbursement for physicians who provide telemedicine services.

There was generally supportive testimony on this item. Speakers noted that telemedicine is a rapidly evolving field, and it is important to work with the states to ensure appropriate regulations and licensure requirements are in place. Your Reference Committee notes that this resolution was originally placed on the Reaffirmation Consent Calendar, and believes that the issues addressed in this resolution are covered by existing policies. Accordingly, your Reference Committee recommends that the following policies be reaffirmed in lieu of Resolution 805.

H-480.974 Evolving Impact of Telemedicine

Our AMA: (1) will evaluate relevant federal legislation related to telemedicine; (2) urges CMS and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship; (3) urges medical specialty societies involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine; (Reaffirmed by CME/CMS Rep. A-96) (4) encourages the CPT Editorial Board to develop CPT codes or modifiers for telemedical services; (5) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms; (6) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine; and (7) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries. (CMS/CME Rep., A-94; Reaffirmation A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11)

H-480.969 The Promotion of Quality Telemedicine

(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles: (a) application to situations where there is a telemedical transmission of individual patient data from the patient's state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board's state; (b) exemption from such a licensure requirement for traditional informal physician-to-physician consultations ("curbside consultations") that are provided without expectation of compensation; (c) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and (d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices. (2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must

sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the interstate telemedicine approach adopted must accommodate these essential quality-related functions. (3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties). (CME/CMS Rep., A-96; Amended: CME Rep. 7, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 6, A-10; Reaffirmed: CME Rep. 6, A-12)

H-480.961 Teleconsultations and Medicare Reimbursement

Our AMA demands that CMS reimburse telemedicine services in a fashion similar to traditional payments for all other forms of consultation, which involves paying the various providers for their individual claims, and not by various "fee splitting" or "fee sharing" reimbursement schemes. (Res. 144, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07)

H-390.859 Reimbursement for Telephonic and Electronic Communications

(1) The policy of our AMA is that physicians should uniformly be compensated for their professional services, at a fair fee of their choosing, for established patients with whom the physician has had previous face-to-face professional contact, whether the current consultation service is rendered by telephone, fax, electronic mail or other forms of communication. (2) Our AMA presses CMS and other payers to separately recognize and adequately pay for non-face-to-face electronic visits. (Res. 810, A-00; Reaffirmation I-04; Reaffirmation A-05; Reaffirmation A-07; Reaffirmation A-08; Modified: CMS Rep. 1, A-10; Reaffirmed in lieu of Res. 705, A-11)

(24) RESOLUTION 806 - PAY FOR CONSULTATION VIA TELEPHONE AND ELECTRONIC COMMUNICATIONS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-390.859 and H-480.961 be reaffirmed in lieu of Resolution 806.

HOD ACTION: Policies H-390.859 and H-480.961 reaffirmed in lieu of Resolution 806.

Resolution 806 asks that our AMA petition the Centers for Medicare and Medicaid Services to provide a fee for the existing codes for reimbursement to physicians for telephone and electronic communications.

Your Reference Committee heard limited, yet supportive testimony on the intent of Resolution 806. A member of the Council on Medical Service testified that requesting the Centers for Medicare and Medicaid Services (CMS) to pay physicians for telephone and electronic communications reflects existing AMA policy. Your Reference Committee notes that AMA Policies H-390.859 and H-480.961 adequately address the requests in Resolution 806 by urging CMS and other payers to separately recognize and adequately pay for non-face-to-face electronic visits and demanding that CMS reimburse telemedicine services in a fashion similar to traditional payments for all other forms of consultation.

Furthermore, in early November 2012, The Centers for Medicare and Medicaid Services issued a final rule for 2013 Medicare physician payment. This final rule contained some of the AMA's key recommendations, including adopting the CPT codes for transitional care management, which incorporates significant non face-to-face services, such as telephone calls to the patient during the 30 day

period of time following discharge from a hospital. The AMA has also advocated that CMS pay for individual CPT codes for telephone services (CPT Codes 99441-99443 and 98966-98969).

Given existing AMA policy and advocacy efforts with CMS, which address the concerns raised in Resolution 806, your Reference Committee recommends that Policies H-390.859 and H-480.961 be reaffirmed in lieu of Resolution 806.

H-390.859 Reimbursement for Telephonic and Electronic Communications

(1) The policy of our AMA is that physicians should uniformly be compensated for their professional services, at a fair fee of their choosing, for established patients with whom the physician has had previous face-to-face professional contact, whether the current consultation service is rendered by telephone, fax, electronic mail or other forms of communication. (2) Our AMA presses CMS and other payers to separately recognize and adequately pay for non-face-to-face electronic visits. (Res. 810, A-00; Reaffirmation I-04; Reaffirmation A-05; Reaffirmation A-07; Reaffirmation A-08; Modified: CMS Rep. 1, A-10; Reaffirmed in lieu of Res. 705, A-11)

H-480.961 Teleconsultations and Medicare Reimbursement

Our AMA demands that CMS reimburse telemedicine services in a fashion similar to traditional payments for all other forms of consultation, which involves paying the various providers for their individual claims, and not by various "fee splitting" or "fee sharing" reimbursement schemes. (Res. 144, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07)

(25) RESOLUTION 816 - "SWIPE CARDS" FOR INSURANCE ELIGIBILITY DETERMINATION AND PAYMENT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy D-185.999 be reaffirmed in lieu of Resolution 816.

HOD ACTION: Policy D-185.999 reaffirmed in lieu of Resolution 816.

Resolution 816 asks that our AMA support requiring that insurers implement "swipe card" technology to verify insurance eligibility and enable faster payment for medical services at the point of delivery.

Positive testimony was heard supporting the implementation of patient identification cards that could be "swiped" at the point of care in order to efficiently determine benefit eligibility and electronically transmit payment. The Council on Medical Service identified Policy D-185.999, which advocates that the AMA continue to work with payers, the federal and state governments, and standards organizations to adopt and implement appropriate policies, technologies (e.g., smart cards, telephone hot lines, electronic data interchange, and website access), and national technology standards to provide physicians with accurate and real time verification of patient eligibility, co-payment due, deductible payable information, and claims processing. In addition, the AMA is active on this issue. As an official supporter of the Medical Group Management Association (MGMA) SwipeIT campaign, the AMA contributed to the content of the Workgroup on Electronic Data Interchange (WEDI) white paper regarding standardized ID cards. Given policy addressing Resolution 816 and AMA advocacy efforts, your Reference Committee recommends that the following Policy D-185.999 be adopted in lieu of Resolution 816.

D-185.999 Information Included On Health Insurance Identification Cards

Our AMA will continue to work with payers, the federal and state governments, and standards organizations to adopt and implement appropriate policies, technologies (e.g., smart cards, telephone hot lines, electronic data interchange, and website access), and national technology standards to provide physicians with accurate and real time verification of patient eligibility, co-payment due, deductible payable information, and claims processing. (Sub. Res. 828, A-99; Modified: Sub. Res. 713, A-08; Reaffirmation A-09)

(26) RESOLUTION 818 - MEDICAL STAFF BYLAWS AS BINDING
CONTRACTS
RESOLUTION 821 – MEDICAL STAFF AUTONOMY TO ASSURE
QUALITY CARE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-235.976 be reaffirmed in lieu of Resolutions 818 and 821.

HOD ACTION: Substitute Resolution 818 adopted.

RESOLVED, That our American Medical Association actively pursue the enactment of federal legislation and/or regulation that will recognize medical staff bylaws as a binding contract, not subject to unilateral amendment, between the organized medical staff and the governing board of a hospital or health care delivery system.

Resolution 818 asks that our AMA take action to recommend and support federal regulation and legislation to recognize medical staff bylaws as binding contracts between organized medical staffs and the governing bodies of their hospitals.

Resolution 821 asks that our AMA take action to recommend and support federal legislation to recognize Medical Staff Bylaws as binding contracts between Organized Medical Staffs and the Governing Boards of their Hospitals.

Your Reference Committee heard positive testimony urging the AMA to support federal regulation and/or legislation recognizing medical staff bylaws as binding contracts between organized medical staffs and the governing boards of hospitals. The sponsors of the two resolutions expressed strong concerns that legislation is needed on a federal level, especially because a Minnesota state court recently ruled that medical staff bylaws do not constitute a contract between the medical staff and the hospital governing body. Concern was raised that this issue could appear in other states. Testimony explained that the medical staff in the Minnesota case is appealing the court ruling. Your Reference Committee notes that the AMA Litigation Center is aware of the case, is actively involved, and will be filing an amicus brief.

Your Reference Committee notes that the AMA Advocacy Resource Center (ARC) has developed model legislation entitled an “Act to Ensure the Autonomy of Hospital Medical Staffs,” which requires that medical staff bylaws approved by the medical staff and adopted by the governing body of a hospital constitute a mutually binding and enforceable contract between the medical staff, its individual members and the hospital, notwithstanding any bylaw provision subjecting medical staff decisions to the final authority of the hospital. The ARC serves as a resource for any state facing these types of issues. Given AMA model legislation, legal resources and Policy H-235.976, which states that medical staff bylaws are a contract between the organized medical staff and the hospital, your Reference Committee recommends that the following Policy H-235.976 be reaffirmed in lieu of Resolutions 818 and 821.

H-235.976 Medical Staff Bylaws and Medical Staff Autonomy

Our AMA reaffirms that (1) medical staff bylaws are a contract between the organized medical staff and the hospital; and (2) application for medical staff appointment and clinical privileges should provide that each member of the medical staff, as well as the hospital, is bound by the terms of the medical staff bylaws, and the terms of the medical staff bylaws should be incorporated by reference into the application. (Res. 8, A-91; Modified: Sunset Report, I-01; Reaffirmed: BOT Rep. 9, I-04)

Reference Committee K

(1) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 1 - USE OF ATYPICAL ANTIPSYCHOTICS IN PEDIATRIC PATIENTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Science and Public Health Report 1 adopted and the remainder of the report filed.

Council on Science and Public Health Report 1 addresses safety and appropriate use of atypical antipsychotics and briefly discusses the complex issues surrounding the clinical use of these drugs in pediatric patients, evaluating new data, and referencing clinical recommendations that are intended to improve outcomes when atypical antipsychotics are used in pediatric patients. It recommends that our American Medical Association (AMA) (1) urge the National Institute of Mental Health to assist in developing guidance for physicians on the use of atypical antipsychotic drugs in pediatric patients; (2) encourage and support ongoing federally funded research, with a focus on long term efficacy and safety studies, on the use of antipsychotic medication in the pediatric population; and (3) rescind Policy D-120.955 as it has been accomplished by preparation of this report.

Limited but supportive virtual testimony was offered on this report, which summarizes recently developed guidance on the use of atypical antipsychotics in pediatric patients and recommends further attention be devoted to this issue at a national level. Similar support was offered during live testimony, although a complaint was registered about the Council's delay in responding to the original resolution. Your Reference Committee urges adoption.

(2) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 3 - RISK EVALUATION AND MITIGATION STRATEGIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 3 be adopted and the remainder of the report filed.

HOD ACTION: Council on Science and Public Health Report 3 adopted and remainder of the report filed.

Council on Science and Public Health Report 3 provides an update of REMS programs in the U.S. and serves as a contemporary resource for helping to increase physician awareness of this issue. It recommends that Policy H-100.961—The Evolving Culture of Drug Safety in the United States: Risk Evaluation and Mitigation Strategies (REMS) be amended by insertion and deletion to read as follows and the remainder of the report be filed:

(1) The Food and Drug Administration (FDA) issue a final industry guidance on Risk Evaluation and Mitigation Strategies (REMS) with provisions that: (a) urge ~~require~~ sponsors to consult with impacted physician groups and other key stakeholders early in the process when developing REMS with elements to assure safe use (ETASU); (b) establish a process to allow for physician feedback regarding emerging issues with REMS requirements; and (c) recommend ~~clearly specify~~ that sponsors ~~must~~ assess the impact of ETASU on patient access and clinical practice, particularly in underserved areas or for patients with serious and life threatening conditions, and to make such

~~assessments publicly available; and (d) conduct a long term assessment of the prescribing patterns of drugs with REMS requirements.~~

(2) The FDA, in concert with the pharmaceutical industry, evaluate the evidence for the overall effectiveness of REMS with ETASU in promoting the safe use of medications and appropriate prescribing behavior.

(23) FDA ensure appropriate Advisory Committee review of proposed REMS with ETASU before they are finalized as part of the premarket review of New Drug Applications, and that the Drug Safety and Risk Management Advisory Committee fulfills this obligation for drugs that are already on the market and subject to REMS because of new safety information.

(34) To the extent practicable, a process is established whereby the FDA and sponsors work toward standardizing procedures for certification and enrollment in REMS programs, and the common definitions and procedures for centralizing and standardizing REMS that rely on ETASU are developed.

(45) REMS-related documents intended for patients (e.g., Medication Guides, acknowledgment/consent forms) be tested for comprehension and be provided at the appropriate patient literacy level in a culturally competent manner.

(6) The FDA solicit input from the physician community before establishing any REMS programs that require prescriber training in order to ensure that such training is necessary and meaningful, requirements are streamlined and administrative burdens are reduced.

Limited but fully supportive virtual testimony was offered on this report. FDA-mandated REMS programs containing elements to assure safe use (restricted distribution) continue to be developed which can serve as barriers to physician use and patient access. This report updates a previous Council report on the subject, further developing AMA policy in a way that fosters better program design. Live testimony supported the Council's recommendations to modify current policy, although some questions were raised about the change in verbiage in Recommendation 1 to "urge" rather than "require." These changes were made to accommodate the fact that a "guidance" offered by the FDA does not obligate pharmaceutical manufacturers to engage in a specific activity or process.

(3) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 5 - AMA POLICY CONSOLIDATION: INFLUENZA AND INFLUENZA VACCINE

RESOLUTION 916 - MANDATORY IMMUNIZATION FOR LONG-TERM CARE WORKERS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 5 be adopted in lieu of Resolution 916 and the remainder of the report filed.

RESOLVED, That our American Medical Association support a mandatory annual influenza vaccination for every long term care health care worker who has direct patient contact unless a medical contraindication or religious objection exists (New HOD Policy); and be it further

RESOLVED, That our AMA recommend that medical directors and other practitioners encourage caregivers (both professional health care workers and family caregivers) to obtain these vaccinations (New HOD Policy); and be it further

RESOLVED, That our AMA recommend vaccinations be made available and offered at no cost to staff working in long-term care settings. (New HOD Policy)

**HOD ACTION: Council on Science and Public Health Report 5 adopted.
Resolution 916 adopted.**

Council on Science and Public Health Report 5 is an initiative to consolidate several current policies of our American Medical Association (AMA) on issues related to the supply, distribution, payment, pandemic preparedness, and clinical recommendations for the use of influenza vaccine. It recommends that (1) the consolidated policy listed in Appendix A be added to the AMA Policy Database; and (2) the following policies be rescinded because they are outdated or duplicative of policies presented in Appendix A:

- H-440.896 Influenza Vaccine Availability and Distribution
- D-440.941 Preventing Spread of Novel H1N1 Flu Virus and Spreading the Word
- D-440.962 Avian Influenza Preparedness for Guam and Other Border States and Territories
- D-440.990 Influenza Vaccine Delays and the 2001-2002 Influenza Season: Update
- D-440.993 Influenza Vaccine Availability And Distribution

Resolution 916 asks that our AMA (1) support a mandatory annual influenza vaccination for every long term care health care worker who has direct patient contact unless a medical contraindication or religious objection exists; (2) recommend that medical directors and other practitioners encourage caregivers (both professional health care workers and family caregivers) to obtain these vaccinations; and (3) recommend vaccinations be made available and offered at no cost to staff working in long-term care settings.

Your Reference Committee received limited but supportive virtual and live testimony in favor of the Council's recommendations to consolidate influenza and influenza vaccine policy. Testimony noted that the Council's recommendations clearly delineate the efforts of the AMA to improve the efficient delivery and appropriate use of influenza vaccine to benefit the health of the public. With respect to Resolution 916, current AMA policy and ethical opinion supports universal, but not mandatory, vaccination of health care workers. Accordingly, your Reference Committee recommends adoption of the report's recommendations to consolidate existing policy in lieu of Resolution 916.

(4) **RESOLUTION 920 - ACGME RESIDENCY PROGRAM ENTRY
REQUIREMENTS**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 920 be adopted.

HOD ACTION: Resolution 920 adopted.

Resolution 920 asks that our AMA support entry into Accreditation Council on Graduate Medical Education (ACGME) accredited residency and fellowship programs from either ACGME-accredited programs or American Osteopathic Association (AOA) accredited programs.

Testimony was strongly supportive of the concept of entry into ACGME-accredited residency and fellowship programs from either ACGME- or AOA- accredited programs. The Council on Medical Education noted that the ACGME and AOA recently announced that they are pursuing a unified system of accrediting osteopathic graduate medical education (expected to be effective in 2015), and that therefore this resolution has already been accomplished and is not needed. However, your Reference Committee believes the AMA could benefit from having such policy in its compendium, as that would guide AMA efforts to ensure that the unified system is implemented in a suitable manner. Your Reference Committee therefore recommends adoption.

(5) BOARD OF TRUSTEES REPORT 5 - NATIONAL DATABASE FOR J-1 VISA WAIVER PROGRAM

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 3 in Board of Trustees Report 5 be amended by deletion on page 4, lines 25-31, to read as follows:

3. That AMA Policy D-255.985, "Conrad 30 - J-1 Visa Waivers" be amended by addition and deletion to read as follows:

Our AMA will: (1) lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program; (2) advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state; (3) advocate for expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages; and (4) advocate for redistribution of the unoffered Conrad 30 J-1 Visa waiver slots for those states that could use more than 30 slots to serve in their health professional shortage areas, medically underserved areas and populations. ~~advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of J-1 visa waiver positions in the US.~~ (Modify Current HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 5 be adopted as amended and the remainder of the report filed.

HOD ACTION: Board of Trustees Report 5 adopted as amended and remainder of the report filed.

Board of Trustees Report 5 explores the feasibility of having a national data repository of J-1 visa waiver statistics so that unfilled J-1 visa waiver positions could be transferred to states as needed in order to treat underserved communities and to monitor the success of this program. It recommends that (1) our American Medical Association (AMA) publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program; (2) our AMA advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage; (3) AMA Policy D-255.985, "Conrad 30 - J-1 Visa Waivers" be amended by addition and deletion to read as follows:

Our AMA will: (1) lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program; (2) advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state; (3) advocate for expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages; and (4) advocate for redistribution of the unoffered Conrad 30 J-1 Visa waiver slots for those states that could use more than 30 slots to serve in their health professional shortage areas, medically underserved areas and populations. ~~advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of J-1 visa waiver positions in the US;~~ (4) our AMA work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and (5) our AMA continue to communicate with the Conrad 30 administrators and IMGs members to share information and best practices in order to fully utilize and expand the Conrad 30 program.

Virtual testimony reflected the passion and frustration of U.S. citizen international medical graduates (IMGs) who have not been able to secure a residency position in the U.S. At the same time, this testimony was not germane to the content of the report, which addresses the Conrad 30 program and J-1 visa waivers rather than expanded availability of residency program slots. Live testimony was near unanimous in support of the report, although some concern was expressed about the shift of the program away from its original goals, as specified in the program's founding in 1994. The proposed deletion in Recommendation 3 is to remove redundant language that is already included in Recommendation 2.

(6) COUNCIL ON MEDICAL EDUCATION REPORT 1 - UPDATE ON
INTERPROFESSIONAL EDUCATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 in Council on Medical Education Report 1 be amended by addition on page 4, line 44, to read as follows:

1. That our American Medical Association (AMA) support the concept that medical education should prepare students for practice in physician-led interprofessional teams. (New HOD Policy).

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 3 in Council on Medical Education Report 1 be amended by addition and deletion on page 4, lines 49-50 and page 5, lines 1-2, to read as follows:

3. That our AMA encourage the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and the Accreditation Council for Graduate Medical Education to facilitate the incorporation of physician-led interprofessional education into the educational programs for medical students and residents in ways that support high quality medical education and patient care. (Directive to Take Action)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Recommendation 4 in Council on Medical Education Report 1 be amended by addition and deletion on page 5, line 4, to read as follows:

4. That our AMA encourage the development of competencies skills for interprofessional education that are applicable to and appropriate for each group of learners. (Directive to Take Action)

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 1 be adopted as amended and the remainder of the report filed.

HOD ACTION: Council on Medical Education Report 1 adopted as amended and remainder of the report filed.

Council on Medical Education Report 1 provides an update on the current status of interprofessional education for physicians-in-training and highlights the successes that have been achieved. It recommends that our American Medical Association (AMA) (1) support the concept that medical education should prepare students for practice in interprofessional teams; (2) encourage health care organizations that engage in a collaborative care model to provide access to an appropriate mix of role models and learners; (3) encourage the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to facilitate the incorporation of interprofessional education into the educational programs for medical students and residents in ways that support high quality medical education; and (4) encourage the development of competencies for interprofessional education that are applicable to and appropriate for each group of learners.

Your Reference Committee heard both virtual and live testimony in favor of this report and the need for a more integrated education pathway with students in nursing, public health, pharmacy and other non-physician professions. The addition of "physician-led" in the first recommendation is important, since the medical student must learn the value of being part of an interprofessional team and prepare for leading that team as a physician. Your Reference Committee also believes it is appropriate to delineate the osteopathic accrediting agencies along with their allopathic counterparts in Recommendation 3, and to note specifically that the ultimate goal of interprofessional education is high-quality patient care. In the fourth recommendation, the word "competencies" should be changed to "skills" to avoid any potential confusion that this would be seen as encouraging a seventh physician competency. A question was raised whether the term "health care organizations" in recommendation 2 was overly broad, but others believed that this was appropriate, to encompass the various types of sites where interprofessional education is practiced.

(7) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 2 -
NATIONAL DRUG SHORTAGES UPDATE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Science and Public Health Report 2 be amended by addition and deletion on lines 43-44, to read as follows:

6. The Council on Science and Public Health will continue to evaluate the drug shortage issue and report back on progress made in addressing drug shortages at the ~~2012 Interim Meeting of the House of Delegates as needed 2013 Annual Meeting~~. (Modify Current HOD Policy)

10. Our AMA will collaborate with medical specialty partners in identifying and supporting legislative remedies that urges Congress to amend the 2003 Medicare Modernization Act to allow for more reasonable and sustainable payment rates for prescription drugs. (Modify Current HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Science and Public Health Report 2 be adopted as amended and the remainder of the report filed.

HOD ACTION: Council on Science and Public Health Report 2 adopted as amended and the remainder of the report filed.

Council on Science and Public Health Report 2 provides an update on the current status of drug shortages, describes new developments, summarizes relevant AMA activities, and updates AMA policy on

this issue. It recommends that Policy H-100.956 be amended by insertion and deletion in sections 6 and 10 to read as follows:

6. The Council on Science and Public Health will continue to evaluate the drug shortage issue and report back on progress made in addressing drug shortages ~~at the 2012 Interim Meeting of the House of Delegates as needed.~~ (Modify Current HOD Policy)

10. Our AMA ~~will collaborate with medical specialty partners in identifying and supporting legislative remedies that urges Congress to amend the 2003 Medicare Modernization Act to allow for more reasonable and sustainable payment rates for prescription drugs.~~

This Council report was broadly supported by the virtual and live testimony. National drug shortages continue to affect clinical decision-making and patient care. AMA policy already lays out an extensive series of recommendations that position the AMA to be actively engaged in efforts to identify problems and issues that contribute to medication shortages, as well as the mitigation of such shortages. This report amends current policy to allow for a more expansive approach to address challenges affecting the reimbursement formula for drugs administered under Medicare Part B, which may be a factor in some shortages of injectable products. Because of the continuing nature of the drug shortage problem, your Reference Committee recommends that the Council on Science and Public Health continue to inform the House of the AMA's efforts to address drug shortages at the 2013 Annual Meeting.

(8) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 4 - CLINICAL APPLICATION OF NEXT-GENERATION GENOMIC SEQUENCING

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the Council on Science and Public Health Report 4 be amended by addition of a new second recommendation, to read as follows:

2. Our American Medical Association encourages the development of standards for appropriate clinical use of NGS-based technologies and best practices for laboratories performing such tests. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 3 in Council on Science and Public Health Report 4 be amended by addition on page 7, line 49, to read as follows:

3. Our American Medical Association will support regulatory policy that protects patient rights and confidentiality, and enables physicians to access and use diagnostic tools, such as NGS-based technologies, that they believe are clinically appropriate. (New HOD Policy)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 4 be adopted as amended and the remainder of the report filed.

HOD ACTION: Council on Science and Public Health Report 4 adopted as amended and remainder of the report filed.

Council on Science and Public Health Report 4 briefly reviews the clinical applications of next-generation sequencing, concerns surrounding its implementation, and the extent to which the increasing accessibility of genomic data has the capability to improve health outcomes. It recommends that our American Medical Association (AMA) (1) recognize the utility of next-generation sequencing (NGS)-based technologies as

tools to assist in diagnosis, prognosis, and management, and acknowledges their potential to improve health outcomes; (2) will monitor research on and implementation of NGS-based technologies in clinical care, and will work to inform and educate physicians and physicians-in-training on the clinical uses of such technologies; (3) will support regulatory policy that enables physicians to access and use diagnostic tools, such as NGS-based technologies, that they believe are clinically appropriate; and (4) will continue to enhance its process for development of CPT codes for evolving molecular diagnostic services, such as those that are based on NGS; serve as a convener of stakeholders; and maintain its transparent, independent, and evidence-based process.

Virtual testimony was fully supportive of the Council's recommendations. Testimony noted that next-generation sequencing is a game-changer for the practice of oncology, and that it has ramifications outside of oncology as well. Since next-generation sequencing-based techniques are new, your Reference Committee believes that the report could benefit from a recommendation encouraging the development of standards for appropriate clinical use and best practices for laboratories conducting such tests. Live testimony was also supportive of the report, but noted that there are several issues still to be studied, such as privacy and confidentiality, responsibility to report results, and informed consent. Your Reference Committee agrees that these are important issues that are yet to be fully explored, and encourages the Council on Science and Public Health, in collaboration with other AMA Councils and the Board of Trustees, to continue to examine these issues and keep the AMA educated and informed.

(9) RESOLUTION 902 - ELIMINATING LEGACY ADMISSIONS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 902 be amended by addition and deletion on lines 21-25, to read as follows:

RESOLVED, That our American Medical Association oppose the use of legacy status in medical school ~~applications admissions and support mechanisms to eliminate its inclusion from the application process, such as by encouraging the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and the Liaison Committee on Medical Education to encourage schools to remove any questions on secondary applications pertaining to legacy status.~~ (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 902 be adopted as amended.

HOD ACTION: Resolution 902 not adopted.

Resolution 902 asks that our AMA oppose the use of legacy status in medical school admissions and support mechanisms to eliminate its inclusion from the application process, such as by encouraging the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and the Liaison Committee on Medical Education to encourage schools to remove any questions on secondary applications pertaining to legacy status.

Your Reference Committee heard mixed but largely favorable testimony on Resolution 902. An important distinction was made between application to medical school versus admission to medical school. The concern is using legacy status in a preferential or inappropriate way during the application process. There should be no inquiry as to legacy status on the application. If a student wishes to mention it in the personal statement, that is certainly their right. The Liaison Committee on Medical Education (LCME) states that "selection of individual medical students for admission must not be influenced by any political

or financial factors." For these reasons, your Reference Committee urges adoption of Resolution 902 as amended.

(10) RESOLUTION 903 - EXPANDING CLERKSHIP SITE ACCESS TO INCLUDE US MEDICAL SCHOOLS UNDERGOING ACCREDITATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 903 be amended by addition of a new second Resolve, to read as follows:

RESOLVED, That the AMA study the issue of limiting international medical student clerkship rotations to a maximum of 12 weeks, with a report back to the House of Delegates (Directive to Take Action).

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 903 be adopted as amended.

HOD ACTION: Resolution 903 adopted as amended.

Resolution 903 asks that AMA policy D-295.320 be amended by insertion as follows:

D-295.320 Factors Affecting the Availability of Clinical Training Sites for Medical Student Education
 1. Our American Medical Association will work with the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medical Education to encourage local and state governments and the federal government, as well as private sector philanthropies, to provide additional funding to support infrastructure and faculty development for medical school expansion. 2. Our AMA will encourage medical schools and the rest of the medical community within states or geographic regions to engage in collaborative planning to create additional clinical education resources for their students. 3. Our AMA will support the expansion of medical education programs only when educational program quality, including access to appropriate clinical teaching resources, can be assured. 4. Our AMA will advocate for regulations that would ensure clinical clerkship slots be given first to students of US medical schools that are Liaison Committee on Medical Education- or Commission on Osteopathic College Accreditation-approved, or schools currently given preliminary accreditation status, provisional accreditation status, or equivalent, from either of the above bodies. 5. Our AMA will advocate for federal and state legislation or regulations to oppose any extraordinary compensation for clinical clerkship sites by medical schools or other clinical programs that would result in displacement or otherwise limit the training opportunities of United States LCME/COCA students in clinical rotations.

Virtual testimony was unanimously in favor of this resolution. A proposed insertion to AMA policy D-295.320, part 5, reflected in the virtual Reference Committee report, asked that the AMA "support the concept of limiting international medical student clerkship rotations to a maximum of 12 weeks." Your Reference Committee appreciates the intent of this addition but believes that it is not germane to the original intent of the resolution. At the same time, this is an important issue that merits further study, so your Reference Committee recommends a new second Resolve asking for a report on this issue.

(11) RESOLUTION 904 - IMPROVED AND STANDARDIZED INSTRUCTIONS FOR DRUG LABELS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 904 be adopted.

HOD ACTION: Substitute Resolution 904 adopted.**IMPROVED PRESCRIPTION CONTAINER LABELING**

RESOLVED, That our AMA encourage state Boards of Pharmacy to adopt the newly revised standards contained in the United States Pharmacopeia general chapter on prescription container labeling, which offers specific guidance on how prescription labels should be organized in a patient-centered manner. (Directive to Take Action)

Resolution 904 asks that our AMA (1) encourage the US Food and Drug Administration (FDA) and other appropriate parties to consider the implementation of a system of written medication instructions with strongly correlating standardized pictorial representations that adequately represent the instructions in order to allow individuals of low literacy to clearly comprehend directions for and significance of medication; and (2) encourage the FDA and other appropriate third parties to include on all prescribed medication labels, if the patient so desires, the reason for which the medication was prescribed.

Your Reference Committee believes that the intent of Resolution 904 is laudable. Virtual testimony on this item was sparse and conflicting. However, your Reference Committee is aware that the United States Pharmacopeia recently completed a lengthy evidence-based exercise addressing the format and content of prescription container labeling that also considered the wisdom of using pictorial displays for patients with low literacy. Current evidence does not support this general approach for such patients. With respect to the second resolve, the AMA does not support including the indication on the prescription, much less the container label; the FDA also does not have jurisdiction over this. Live testimony was fully supportive of the Virtual Reference Committee report on this item.

(12) **RESOLUTION 906 - INCREASED ADVOCACY FOR HEPATITIS C VIRUS EDUCATION, PREVENTION, SCREENING AND TREATMENT**

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolve 2 of Resolution 906 be amended by addition and deletion on lines 30 and 34-35, to read as follows:

RESOLVED, That our American Medical Association encourage the adoption of ~~age birth year~~-based screening practices for hepatitis C, in alignment with recent Centers for Disease Control and Prevention recommendations (New HOD Policy); and be it further

RESOLVED, That our AMA encourage ~~increased resources for the~~ CDC and state Departments of Public Health ~~for the development and coordination of to develop and coordinate~~ Hepatitis C Virus infection educational and prevention efforts. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 906 be adopted as amended.

HOD ACTION: Resolution 906 adopted as amended.

Resolution 906 asks that our AMA (1) encourage the adoption of age-based screening practices for hepatitis C, in alignment with recent Centers for Disease Control and Prevention recommendations; and (2) encourage increased resources for CDC and state Departments of Public Health for the development and coordination of Hepatitis C Virus infection educational and prevention efforts.

Your Reference Committee received testimony in support of the CDC's screening recommendations, noting concern for the fiscal note attached to the original resolution. However, your Reference Committee believes it is important for the CDC and state Departments of Health to educate providers and patients about the updated Hepatitis C screening recommendations, and therefore suggests a slight change in the language of the second resolve to support such education and to avoid language that may be perceived as a mandate to spend money that cash-strapped states may not have. Also, your Reference Committee changed the term "age-based" to "birth year" in order to be in accordance with CDC recommendations.

(13) RESOLUTION 907 - PSYCHIATRIC DISEASES AMONG ETHNIC-MINORITY AND IMMIGRANT POPULATIONS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 907 be amended by addition and deletion on lines 28-29 to read as follows:

RESOLVED, that our American Medical Association encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations ~~with the goal of creating psychometrically validated tools to appropriately address the needs of immigrant and minority populations in order to increase access to care and appropriate treatment.~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 907 be adopted as amended.

HOD ACTION: Resolution 907 adopted as amended.

Resolution 907 asks that our AMA encourage the National Institute for Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant and minority populations with the goal of creating psychometrically validated tools to appropriately address the needs of immigrant and minority populations.

Testimony generally supported the resolution, noting some concern for the use of the term "immigrant." Testimony also recommended inclusion of the term "refugee." Language regarding "psychometrically validated tools" was removed, given consensus by your Reference Committee that the actual need that must be addressed is access to care and appropriate treatment. It was also noted that the AMA has multiple policies addressing the health of minority populations and disparities, as well as policy addressing mental health.

(14) RESOLUTION 909 - HARM REDUCTION STRATEGIES FOR PATIENTS AT RISK OF OPIOID OVERDOSE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the Resolve 2 of Resolution 909 be amended by addition and deletion on page 1, line 27, to read as follows:

RESOLVED, That our AMA encourage the continued study of and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 909 be adopted as amended.

HOD ACTION: Resolution 909 adopted as amended.

Resolution 909 asks that our AMA (1) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (2) study appropriate treatments and risk mitigation methods for patients at risk for opioid overdose.

Virtual testimony was limited but supportive of the general intent of Resolution 909. Live testimony was generally supportive of the virtual Reference Committee report on this item. Attention was directed to naloxone community-based programs as a mitigation strategy for preventing opioid overdoses. Additionally, a need exists for adequate and appropriate reimbursement for counseling, evaluation and assessment of patients at risk for substance misuse and addiction. Also, the feasibility of eliminating questions on patient satisfaction surveys that may exert undue pressure on prescribers to issue prescriptions for opioid analgesics, anti-anxiety agents, and sedative-hypnotics should be examined. While these are important related issues, your Reference Committee believes they should not be addressed in this resolution. Many different public and private entities, states, and the AMA are working intently and in a broad-based manner to address this problem, hence the recommended change in wording for the second resolve.

(15) RESOLUTION 910 - PUBLIC SERVICE ANNOUNCEMENTS TO EDUCATE CHILDREN AND ADULTS NEVER TO USE MEDICATIONS PRESCRIBED TO OTHER INDIVIDUALS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 910 be amended by addition and deletion on page 2, lines 16-27, to read as follows:

RESOLVED, That our American Medical Association ~~work with~~ ~~encourage~~ interested stakeholders, federal agencies and pharmaceutical companies ~~required by~~ ~~Risk Evaluation and Mitigation Strategy~~ legislation to educate patients in order to develop public service announcements for television and other media to educate children and adults about the dangers of taking medications that are prescribed for others. : 1. Never to use medications prescribed to other individuals, especially controlled substances such as opioid analgesics, benzodiazepines and stimulants; and 2. That the use of non-prescribed medications may result in injury or death to anyone for whom they are not prescribed; and 3. That taking other people's medications is usually illegal. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 910 be adopted as amended.

HOD ACTION: Resolution 910 adopted as amended.

Resolution 910 asks that our AMA work with interested stakeholders, federal agencies and pharmaceutical companies required by Risk Evaluation and Mitigation Strategy legislation to educate patients in order to develop Public Service Announcements, for television and other media, to educate children and adults:

1. Never to use medications prescribed to other individuals, especially controlled substances such as opioid analgesics, benzodiazepines and stimulants; and
2. That the use of non-prescribed medications may result in injury or death to anyone for whom they are not prescribed; and
3. That taking other people's medications is usually illegal.

Your Reference Committee received limited but supportive virtual testimony on this resolution. Live testimony was mostly in support of the Virtual Reference Committee report. Related comments noted continuing problems with the impact of patient satisfaction surveys on prescribing behavior for opioid analgesics. Public service announcements (PSAs) are very expensive; the fiscal note on this resolution is \$85,000. Although PSAs on this topic would be beneficial to the public, the AMA likely could not afford to undertake the project. Accordingly, your Reference Committee recommends amending the resolution to encourage others to develop PSAs, with the understanding that the AMA stands ready to assist as an academic resource for such a project. Your Reference Committee also recommends removing specific language about what should be included in PSAs, preferring to recommend that the PSAs generally cover the topic of the danger of taking medication prescribed for others.

(16) RESOLUTION 911 - SUPPORT OF THE MEDICARE DIABETES PREVENTION ACT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 911 be adopted.

HOD ACTION: Substitute Resolution 911 adopted with a title change.

Expansion of the National Diabetes Prevention Program

RESOLVED, That our American Medical Association (AMA) support evidence-based, physician-prescribed ~~led~~ diabetes prevention programs; and be it further (New HOD Policy)

~~RESOLVED, That our AMA reaffirm policy H-160.938, Disease Specific Self-Management Programs.~~

~~RESOLVED, that our AMA supports the expansion of the NDPP to more CDC-certified sites across the country; and be it further (New HOD Policy)~~

~~RESOLVED, that the NDPP should become a Medicare benefit and be covered by all private insurers. (New HOD Policy)~~

Resolution 911 asks that our AMA (1) actively support the "Medicare Diabetes Prevention Act" in the 112th Congress and all future congressional sessions in which it is introduced; and (2) support the expansion of the National Diabetes Prevention Program (NDPP) to more sites across the country, and coverage of the program by all private insurers.

Virtual testimony generally expressed concern about the AMA lending support to a proposed federal bill which may still be changed. Onsite, the resolution sponsors proposed language that did not specify a bill, and that touted the effectiveness of the National Diabetes Prevention Program. Your Reference

Committee agrees that diabetes prevention is of utmost importance, and believes that insurance coverage of evidence-based programs is warranted. To broadly support diabetes prevention programs, your Reference Committee recommends that the language of the resolution be modified to include all evidence-based physician-led programs, rather than singling out one specific program. It also notes that current Policy H-160.938 supports insurance coverage for evidence-based disease specific programs, and therefore recommends reaffirmation of that policy.

Policy recommended for reaffirmation:

H-160.938 Disease-Specific Self-Management Programs

The AMA: (1) will work with invited medical groups to promote the physician-led team approach to disease-specific patient care as providing the highest quality of patient care; (2) insists that evidence-based disease -specific (eg, diabetes and asthma) education services and self-management training be initiated and continued under the direction of a physician; (3) believes all changes of care or medications by members of the team should be supervised by a physician; (4) will seek to have physician-directed benefits of evidence-based disease-specific education and self-management training provided to the beneficiaries of Medicare, Medicaid, other publicly supported programs, and all other payers; and (5) believes that status reports and all changes made by the disease-specific self-management team be transmitted in a timely fashion to the primary care physician, if the primary care physician is not the supervisor of the management team. (Sub. Res. 515, I-96; Amended by CSA Rep. 4, A-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmation A-09)

(17) RESOLUTION 922 - SUPPORT FOR BREAST RECONSTRUCTION PUBLIC EDUCATION INITIATIVES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 922 be adopted.

HOD ACTION: Substitute Resolution 922 adopted.

SUPPORT FOR BREAST RECONSTRUCTION EDUCATION INITIATIVES

RESOLVED, That our American Medical Association support education for physicians and breast cancer patients on breast reconstruction and its availability.

Resolution 922 asks that our AMA actively support legislative initiatives calling for implementation of state or federal public education campaigns on the topic of breast reconstruction awareness.

Your Reference Committee heard extensive and impassioned testimony regarding the issue of awareness of breast reconstruction, and the importance of culturally competent education for both physicians and patients. Your Reference Committee agrees and offers substitute language which removes "legislative initiatives" in order to provide broad support for the issue in a more timely manner.

(18) RESOLUTION 923 - PHARMACEUTICAL COMPOUNDING COMPANY OVERSIGHT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 923 be adopted.

ENSURING THE SAFE AND APPROPRIATE USE OF COMPOUNDED MEDICATIONS

RESOLVED, that our AMA: (1) monitor ongoing federal and state evaluations and investigations of the practices of compounding pharmacies; (2) encourage the development of regulations that ensure safe compounding practices that meet patient and physician needs; and, (3) report back on efforts to establish the necessary and appropriate regulatory oversight of compounding pharmacy practices. (Directive to Take Action)

HOD ACTION: Substitute Resolution 923 adopted.

Resolution 923 asks that our AMA (1) engage in efforts to identify inadequacies of federal and state regulation of pharmaceutical compounding companies; (2) actively support appropriate correction of identified inadequacies of federal and state regulation of pharmaceutical compounding companies; and (3) render a report at the 2013 Annual Meeting with regard to the results of its efforts in identifying inadequacies of federal and state regulation of pharmaceutical compounding companies as well as the results of our AMA's efforts in actively supporting appropriate correction of inadequacies of federal and state regulation of pharmaceutical compounding companies.

Limited testimony strongly supported the intent of Resolution 923. Significant and intensive investigations of the practices of pharmacy compounders and the pharmacy compounding industry are ongoing, and legislative/regulatory responses are being considered or have been developed to address inadequate oversight and regulation. Our AMA has limited ability to augment these ongoing investigations. Therefore, your Reference Committee recommends a substitute resolution that creates a sensible course of action.

(19) RESOLUTION 926 - PRESERVATION OF RESIDENCY TRAINING POSITIONS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first Resolve of Resolution 926 be amended by addition and deletion on lines 23-24, to read as follows:

RESOLVED, That our American Medical Association oppose the closure of residency/fellowship programs or reductions in the number of current positions in programs ~~dismissal or reassignment of any current resident or fellow as a result of changes in GME funding (New HOD Policy); and be it further.~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second Resolve of Resolution 926 be deleted.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 926 be adopted as amended.

HOD ACTION: Resolution 926 adopted as amended.

Resolution 926 asks that our AMA (1) oppose the dismissal or reassignment of any current resident or fellow as a result of changes in GME funding, and (2) oppose any reduction in the number of residency and fellowship training positions.

Your Reference Committee heard uniform testimony in favor of this resolution, especially in light of limited (and endangered) funding of GME residency program slots, and concerns of displacement during natural disasters. The current wording, however, was seen as somewhat confusing, so the authors submitted revised language, which captures the spirit and intent of both original resolutes.

(20) RESOLUTION 905 - INCLUSION OF FOLIC ACID SUPPLEMENTS IN NUTRITIONAL ASSISTANCE PROGRAMS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 905 be referred.

HOD ACTION: Resolution 905 referred.

Resolution 905 asks that AMA (1) support the addition of folic acid supplements in the Supplemental Nutrition Assistance Program, the Special Supplemental Nutrition Program for Women, Infants, and Children, and other similarly aligned programs; and (2) work with United States Department of Agriculture and other appropriate organizations to encourage and procedurally facilitate the implementation of folic acid supplements in the Supplemental Nutrition Assistance Program, the Special Supplemental Nutrition Program for Women, Infants, and Children, and other similarly aligned programs.

Testimony noted the importance of folic acid in preventing neural tube defects, and was supportive of the addition of folic acid supplements to supplemental nutrition programs. Others noted that there are many additional vitamins and nutrients that are essential to health, and that these should also be considered for eligibility. However, your Reference Committee believes that before certain supplements could be considered for eligibility, a system must be established to sort through the thousands of supplements on the market and determine which are necessary for improved health. Your Reference Committee is also aware that supplemental nutrition programs emphasize getting required nutrients from healthy foods, and therefore the goals of the program may need to shift if supplements are added as eligible items. The current definition of eligible items is a specific part of the Food and Nutrition Act of 2003; any change to this definition would require Congressional action. Also, the supplemental nutrition programs referred to in this resolution are overseen by the U.S. Department of Agriculture, yet regulation of supplements is the responsibility of the FDA under the Dietary Supplement Health and Education Act, bringing into question whether the USDA has the jurisdiction to include supplements as eligible products. While this resolution is well-intentioned, it brings up several questions that must be answered. Your Reference Committee therefore recommends referral so that the appropriate Council can review the issue and comment on its feasibility.

(21) RESOLUTION 917 - ACCREDITATION / CERTIFICATION COST AND CONVENIENCE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 917 be referred.

HOD ACTION: Resolution 917 referred.

Resolution 917 asks that our AMA adopt the following additional principles related to certifying and accrediting entities: 1) There should be full transparency related to the costs of preparing, administering, scoring and reporting the results of board certifying exams. 2) There should be full transparency on the costs of facility documentation review, facility inspection, scoring and reporting of accreditation results. 3) There is the expectation that timely and multiple board exam sites will be available so as to minimize the need for physicians to travel long distances or wait long times for exam dates. 4) The accreditation

process should be timely and efficient. 5) Finally, there is the expectation that certification and accreditation services should not be a source of substantial profit for these entities.

Your Reference Committee heard support for the overall concept of increased transparency and reduced costs (and reduced burdens) for physicians and health care organizations as they relate to the certification, accreditation, and licensing processes. Nonetheless, testimony noted that these are very broad issues, and any attempt to incorporate all these issues into a single resolution muddies the waters. Many of these issues are being addressed by the Council on Medical Education, which issued two reports on Maintenance of Certification and Maintenance of Licensure at A-12 and will continue to monitor these concerns going forward. For these reasons, your Reference Committee believes that referral of this resolution is warranted.

(22) RESOLUTION 908 - INCREASING THE SCHOOL NURSE TO STUDENT RATIO

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-60.991 be reaffirmed in lieu of Resolution 908.

HOD ACTION: Policy H-60.991 reaffirmed in lieu of Resolution 908.

Resolution 908 asks that our AMA encourage state medical societies and organizations, such as the National Association of School Nurses and other stakeholders, to advocate at all levels for adequate funding of school nurse positions; and (2) encourage public schools, private schools, and other relevant organizations to employ school nurses in a manner that complies with Centers for Disease Control and Prevention recommended nurse-to-student ratios.

Your Reference Committee received limited testimony on this issue, which suggested that the AMA already has policy to support medical services in schools. Your Reference Committee expressed concern about this resolution going beyond the scope of the AMA, in that it asks the AMA to address how such medical services should be funded. Therefore your Reference Committee recommended that current Policy H-60.991 be reaffirmed in lieu of Resolution 908. The sponsor of the resolution testified in agreement with the reaffirmation.

Policy recommended for reaffirmation:

H-60.991 Providing Medical Services through School-Based Health Programs

(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and

evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children. (CSA Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: Res. 412, A-05)

(23) RESOLUTION 912 - COLD TURKEY SMOKING CESSATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-490.917 be reaffirmed in lieu of Resolution 912.

HOD ACTION: Policy H-490.917 reaffirmed in lieu of Resolution 912.

Resolution 912 asks that our AMA (1) encourage physicians and the public health community to offer written materials, internet links, education and counseling to enable and encourage more successful assisted "Cold Turkey" quitting; (2) encourage private, state, and federally funded tobacco control programs to conduct research and evaluation, and implement educational and counseling programming that promotes "Cold Turkey" quitting, as a smoking cessation option; and (3) petition The Joint Commission to amend their requirement relative to smokers being discharged from hospitals to recognize education and counseling to promote "Cold Turkey" quitting as an alternative to a prescription for a smoking cessation pharmaceutical product.

Your Reference Committee received virtual testimony that expressed concern over the scientific validity of the "cold turkey" method as described in the Resolution. Onsite, many pointed out that the evidence supports the efficacy of cessation aids, such as pharmaceuticals and counseling. Others noted that they believe physicians should support any and all methods for smoking cessation, and that indeed abrupt cessation may be efficacious. While referral was called for, the Council on Science and Public Health testified that the evidence has been well-reviewed already and a report would not advance the understanding further. Your Reference Committee believes that AMA policy should be evidence-based, but is aware that some patients may desire to quit smoking abruptly and without cessation aids. Your Reference Committee notes that current AMA policy strongly supports cessation initiatives, calling for physicians to identify and treat tobacco dependence recognizing that the context of care should take into account the many potential sources of treatment, and therefore recommends reaffirmation of current policy.

Policy recommended for reaffirmation:

H-490.917 Physician Responsibilities for Tobacco Cessation

Cigarette smoking is a major health hazard and a preventable factor in physicians' actions to maintain the health of the public and reduce the high cost of health care. Our AMA takes a strong stand against smoking and favors aggressively pursuing all avenues of educating the general public on the hazards of using tobacco products and the continuing high costs of this serious but preventable problem. Additionally, our AMA supports and advocates for appropriate surveillance approaches to measure changes in tobacco consumption, changes in tobacco-related morbidity and mortality, youth uptake of tobacco use, and use of alternative nicotine delivery systems. In view of the continuing and urgent need to assist individuals in smoking cessation, physicians, through their professional associations, should assume a leadership role in establishing national policy on this topic and assume the primary task of educating the public and their patients about the danger of tobacco use (especially cigarette smoking). Accordingly, our AMA: ... (7) (a) believes that collaborative approaches to tobacco treatment across all points of contact within the medical system will maximize opportunities to address tobacco use among all of our patients, and the likelihood for successful

intervention; and (b) supports efforts by any appropriately licensed health care professional to identify and treat tobacco dependence in any individual, in the various clinical contexts in which they are encountered, recognizing that care provided in one context needs to take into account other potential sources of treatment for tobacco use and dependence. (CSA Rep. 3, A-04; Appended: Res. 444, A-05; Reaffirmed: BOT Rep. 8, A-08)

(24) RESOLUTION 921 - SHORTAGE OF RESIDENCY TRAINING POSITIONS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies D-305.958 and D-305.973 be reaffirmed in lieu of Resolution 921.

HOD ACTION: Policies D-305.958 and D-305.973 reaffirmed in lieu of Resolution 921.

Resolution 921 asks that our AMA support efforts to urgently address the anticipated imbalance between the number of medical school graduates and available residency training positions.

Your Reference Committee heard unanimous support for this resolution. As the number of U.S. medical school graduates continues to grow, the importance of enhanced funding for graduate medical education and increased residency program slots grows as well. Such support is essential to teaching hospitals' ability to provide patient care as well as preventing a worsening of the physician shortages. With the passage of national health care reform legislation, as well, the number of newly insured patients seeking medical care could grow by 30 million in 2014. In addition, the nation's growing percentage of elderly, and the burden of chronic conditions such as obesity, will place stress on the physician workforce. In this regard, the AMA has continued to collaborate with other key stakeholders to advocate for GME funding and alert Congress that cuts to GME funding would jeopardize the ability of medical schools and teaching hospitals to train physicians, as well as limit critical services to patients. Not surprisingly, the AMA already has significant policy on this topic, and the Council on Medical Education, Section on Medical Schools, and related bodies are actively monitoring this issue. The proposed resolution does not appear to offer any new direction that is not already reflected in current AMA policy, so your Reference Committee believes that reaffirmation of current policy is warranted.

Policies recommended for reaffirmation:

D-305.958 Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy

1. Our AMA will ensure that actions to bolster the physician workforce must be part of any comprehensive federal health care reform. 2. Our AMA will work with the Centers for Medicare and Medicaid Services to explore ways to increase graduate medical education slots to accommodate the need for more physicians in the US. 3. Our AMA will work actively and in collaboration with the Association of American Medical Colleges and other interested stakeholders to rescind funding caps for GME imposed by the Balanced Budget Act of 1997. 4. Our AMA will actively advocate for expanded funding for entry and continued training positions in specialties and geographic regions with documented medical workforce shortages. 5. Our AMA will lobby Congress to find ways to increase graduate medical education funding to accommodate the projected need for more physicians. 6. Our AMA will work with key organizations, such as the US Health Resources and Services Administration, the Robert Graham Center, and the Cecil G. Sheps Center for Health Services Research, to: (A) support development of reports on the economic multiplier effect of each residency slot by geographic region and specialty; and (B) investigate the impact of GME funding on each state and its impact on that state's health care workforce and health outcomes. (Sub. Res. 314, A-09; Appended: Res. 316, A-12)

D-305.973 Proposed Revisions to AMA Policy on the Financing of Medical Education Programs

Our AMA will work with: (1) the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to bring about the following outcomes: (a) ensure adequate Medicaid and Medicare funding for graduate medical education; (b) ensure adequate Disproportionate Share Hospital funding; (c) make the Medicare direct medical education per-resident cost figure more equitable across teaching hospitals while assuring adequate funding of all residency positions; (d) revise the Medicare and Medicaid funding formulas for graduate medical education to recognize the resources utilized for training in non-hospital settings; (e) stabilize funding for pediatric residency training in children's hospitals; (f) explore the possibility of extending full direct medical education per-resident payment beyond the time of first board eligibility for specialties/subspecialties in shortage/defined need; (g) identify funding sources to increase the number of graduate medical education positions, especially in or adjacent to physician shortage/underserved areas and in undersupplied specialties; and (h) act on existing policy by seeking federal legislation requiring all health insurers to support graduate medical education through an all-payer trust fund created for this purpose; and (2) other interested parties to ensure adequate funding to support medical school educational programs, including creating mechanisms to fund additional medical school positions. (CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmation I-07)