AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-18)

Report of Reference Committee on Amendments to Constitution and Bylaws

Todd M. Hertzberg, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 15 – Specialty Society Representation in the House of Delegates – Five-Year Review
2. Council on Ethical and Judicial Affairs Report 1 – Competence, Self-Assessment and Self-Awareness
3. Council on Ethical and Judicial Affairs Report 3 – Amendment to E-2.2.1, "Pediatric Decision Making"
4. Council on Ethical and Judicial Affairs Report 5 – Physicians' Freedom of Speech
5. Resolution 002 – Protecting the Integrity of Public Health Data Collection

RECOMMENDED FOR ADOPTION AS AMENDED

6. Board of Trustees Report 14 – Protection of Physician Freedom of Speech
7. Resolution 001 – Support of a National Registry for Advance Directives
8. Resolution 003 – Mental Health Issues and Use of Psychotropic Drugs for Undocumented Immigrant Children
9. Resolution 004 – Opposing the Detention of Migrant Children
10. Resolution 005 (Late Resolution 1001) – Affirming the Medical Spectrum of Gender

RECOMMENDED FOR REFERRAL

11. Council on Ethical and Judicial Affairs Report 2 – Study Aid-in-Dying as End-of-Life Option / The Need to Distinguish "Physician-Assisted Suicide" and "Aid-in-Dying"

RECOMMENDED FOR NOT ADOPTION

12. Council on Ethical and Judicial Affairs Report 4 – CEJA Role in Implementing H-140.837, "Anti-Harassment Policy"

(1) BOARD OF TRUSTEES REPORT 15 – SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES – FIVE-YEAR REVIEW

RECOMMENDATION:

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

Board of Trustees Report 15 presents the completed review of the specialty organizations seated in the House of Delegates (HOD) that were scheduled to submit information and materials for the 2018 American Medical Association (AMA) Interim Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020, "Summary of Guidelines for Admission to the House of Delegates for Specialty Societies," and AMA Bylaw 8.5, "Periodic Review Process." The Board of Trustees recommends that the following be adopted and the remainder of this report be filed: That the American Academy of Allergy, Asthma & Immunology, American Academy of Ophthalmology, Inc., American Academy of Orthopaedic Surgeons, American Academy of Otolaryngology-Head and Neck Surgery, American Academy of Pain Medicine, American Academy of Pediatrics, American Academy of Physical Medicine & Rehabilitation, American Association of Neurological Surgeons, and the Society of Nuclear Medicine and Molecular Imaging retain representation in the American Medical Association House of Delegates.

Board of Trustees Report 15 was introduced by the Board of Trustees, and no further testimony was offered. Your Reference Committee recommends that Board of Trustees Report 15 be adopted.

(2) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 1 – COMPETENCE, SELF-ASSESSMENT AND SELF-AWARENESS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 1 be adopted and the remainder of the report be filed.

Council on Ethical and Judicial Affairs Report 1 examines physicians' ethical responsibility of commitment to competence and is concerned with a broader notion of competence that deals with a physician's wisdom and judgment about their own ability to provide safe, high-quality care "in the moment." The report notes certain influences on clinical reasoning such as heuristics, habits of perception and overconfidence can lead to problems in effective reasoning. Hence, it is important for physicians to develop an informed self-assessment that leads to self-awareness of a physician's own ability to practice safely in the moment and develop a "mindful practice" over the course of their lifetime to ethically maintain competence. The report proposes guidance to this end.

Your Reference Committee heard testimony that was largely supportive of Council on Ethical and Judicial Affairs Report 1. Hesitations were raised regarding circumstances in which physicians no longer possess the self-awareness to accurately assess their own competence, such as in the case of impairment. Testimony argued that impaired physicians should not be considered to be acting unethically. While your Reference Committee is sensitive to these concerns, its judgment is that these issues are duly addressed both by section (f) in the recommendations of this report as well as Opinion E-9.3.2 "Physician Responsibilities to Impaired Colleagues". Therefore, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 1 be adopted as written.

(3) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 3 – AMENDMENT TO E-2.2., "PEDIATRIC DECISION MAKING"

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 3 be adopted and the remainder of the report be filed.

This report provides ethics guidance for physicians in relation to the concerns expressed in Resolution 3-A-16, "Supporting Autonomy for Patients with Differences in Sex Development (DSD)," responding to Board of Trustees Report 7-I-16 of the same title, and Resolution 13-A-18, "Opposing Surgical Sex Assignment of Infants with Differences of Sex Development. Council on Ethical and Judicial Affairs Report 3 recommends that Opinion E-2.2.1, "Pediatric Decision Making," be amended in lieu of Resolution 3-A-16 and 13-A-18, and provides guidance to physicians on providing compassionate, humane care to all pediatric patients, while negotiating with parents/guardians to develop a shared understanding of the patient's medical and psychosocial needs and interests in the context of family relationships and resources. The report considers the continuum of pediatric decision-making between interventions about which there is consensus in the professional community, whose benefits are significant and significantly outweigh the risks they pose, and decisions that carry significant risks of harm or about which currently available evidence suggests offer little prospect of clinical benefit or cannot be reasonably expected to achieve the intended goal. The report also considers whether decisions about DSD should be different from other decisions, and advises seeking a shared understanding of goals for care in creating treatment plans that respect the unique needs, values and preferences of pediatric patients and their families.

Testimony on Council on Ethical and Judicial Affairs Report 3 was largely supportive. Critical testimony noted that much of the language of the report was satisfactory, but felt that it lacked adequate language addressing the care of intersex patients. Testimony suggested that the bulleted points on pages 5 and 6 of the report on the topic of decision-making in these circumstances would assuage concerns if it was adopted in the recommendation. All other groups and individuals who testified were satisfied with this report. Additionally, there were several personal testimonies of individuals and families directly affected by congenital adrenal hyperplasia (CAH). These individuals felt that their experiences with shared decision-making were the right choice for them and that surgical

treatment decisions were created together with their medical team in contrast to considering such surgeries to be "medically sanctioned violence." Your Reference Committee noted the majority of testimony was in support of this report and that the report created a very balanced and appropriately broad view of pediatric decision making, one that is applicable beyond those issues related only to intersex and DSD. Therefore, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 3 be adopted and the remainder of the report be filed.

(4) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 5 – PHYSICIANS' FREEDOM OF SPEECH

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 5 be adopted and the remainder of the report be filed.

Council on Ethical and Judicial Affairs Report 5 responds to referred Resolution 6-I-17, "Physician's Freedom of Speech," which asks the AMA to amend Opinion E-1.2.10, "Political Action by Physicians." This report references Opinions within the *Code of Medical Ethics* that provide guidance with respect to physicians' rights to express themselves on matters of social and political importance and underscores physicians' rights to due process when their conduct is subjected to disciplinary review. The report also notes that constitutional protection for "freedom of speech" does not apply to private places of employment, and that private employers generally have the power to terminate an employee because of the employee's speech. The Council views the situation of physicians who express personal views on political and social issues online like that of physicians who participate professionally in the media; physicians should recognize that even when they speak personally, they are likely to be viewed by the public through the lens of their professional status and relationships with health care institutions. The report recommends that Resolution 6-I-17 not be adopted.

The only testimony heard on Council on Ethical and Judicial Affairs Report 5 was given by the authors of the original resolution, who suggested referral. Your Reference Committee concluded that resolution 6-I-17 is calling for an amendment to ethics policy by making an argument grounded on concerns of First Amendment constitutional rights, which your Reference Committee believes to be a constitutional issue rather than an ethical issue. Further, the resolution's recommendation is one framed as a constitutional issue of "Freedom of Speech," but more accurately reflects employment law as the grievance described is one between physicians and their employers and not one of government restrictions of physician speech. Therefore, your Reference Committee recommends that CEJA Report 3 be adopted, but if the authors of Resolution 6-I-17 wish to create House policy, they may submit a new resolution.

(5) RESOLUTION 002 – PROTECTING THE INTEGRITY OF PUBLIC HEALTH DATA COLLECTION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 002 be adopted.

Resolution 002 asks that our AMA advocate for the inclusion of demographic data inclusive of sexual orientation and gender identity in national and state surveys, surveillance systems and health registries. The resolution also asks that our AMA advocate against the removal of such demographic data from these registries without plans for updating measures of these data.

Your Reference Committee heard testimony that unanimously supported Resolution 002. Speakers noted that such data collection is essential to providing high-quality care according to evidence-based medicine, and that efforts to develop guidelines and determine best practices depend on the availability of data about the populations being treated. Your Reference Committee recommends that Resolution 002 be adopted.

(6) BOARD OF TRUSTEES REPORT 14 – PROTECTION OF PHYSICIAN FREEDOM OF SPEECH

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that recommendation 1 in Board of Trustees Report 14 be amended by addition and deletion to read as follows:

1. That our American Medical Association ~~strongly oppose~~ support ~~litigation challenging the exercise of~~ a physician's First Amendment right to express opinions ~~regarding~~ relating to medical issues (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 14 be adopted as amended and the remainder of the report be filed.

Board of Trustees Report 14 responds to Resolution 5-I-17, "Protection of Physician Freedom of Speech," which asks that our AMA strongly oppose litigation challenging the exercise of a physician's First Amendment right to express opinions regarding medical issues. The report recommends that AMA policy H-460.895, "Free Speech Applies to Scientific Knowledge," be reaffirmed. The report recommends against the use of the term "good faith" in AMA policy regarding physician opinions on medical issues, as there is no simple test as to whether an opinion has been made in good faith or bad faith. Additionally, the report notes that the AMA Litigation Center is already aware of the possibility that physician members of medical societies may be sued for expressing opinions on medical

issues and is committed to taking appropriate steps to assist these societies and their members in the event of litigation.

Limited testimony supported the premise of the recommendations in Board of Trustees Report 14. Some concern was expressed about the inclusion of the phrase, "regarding medical issues," in Recommendation 1 as it could be seen as unnecessarily restrictive or confusing. Your Reference Committee agrees that our AMA should support physicians' right to express opinions relating to medical issues, but believes that the positive framework as amended, as opposed to opposition of litigation, more appropriately expresses the AMA's role in these matters. Therefore, your Reference Committee recommends that Board of Trustees Report 14 be adopted as amended.

(7) RESOLUTION 001 – SUPPORT OF A NATIONAL REGISTRY FOR ADVANCE DIRECTIVES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 001 be amended by addition to read as follows:

RESOLVED, that our American Medical Association advocate for the development of model legislation and the establishment and maintenance of a national, no-charge, confidential and secure method for the storage and retrieval of advance directive documents by authorized agents. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 001 be adopted as amended.

Resolution 001 asks that our AMA advocate for the establishment and maintenance of a national, no-charge, confidential and secure method for the storage and retrieval of advance directive documents by authorized agents. The resolution notes that Advanced Care Planning (ACP) improves the respect of end-of-life wishes, improves patient and family satisfaction, and is cost-effective, but also that ACP documentation varies by state and region and is often difficult to locate, as no central database for such documentation is readily available for health care providers.

Your Reference Committee heard testimony that largely supported Resolution 001. Speakers emphasized the importance of honoring patients' preferences for end of life care, and the difficulty often faced when attempting to access this documentation across state lines or even between systems in the same geographic area. It was noted that while a number of states currently have advance directive registries, electronic health record interoperability would be essential for an effective national directory. Some concerns were raised concerning financial and legal challenges involved in creating such a directory, safeguarding the security and integrity of information within it, and ensuring that patients would be given the opportunity, if at all possible, to confirm or change advance directives

at the point of care. Your Reference Committee agreed that the development of model legislation would aid in accomplishing the goal of the resolution. Thus, your Reference Committee recommends that Resolution 001 be adopted as amended.

(8) RESOLUTION 003 – MENTAL HEALTH ISSUES AND USE OF PSYCHOTROPIC DRUGS FOR UNDOCUMENTED IMMIGRANT CHILDREN

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve in Resolution 003 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association officially object to policies separating undocumented immigrant parents ~~and/~~or guardians from children, as well as ~~allowing~~ policies that prohibit unaccompanied undocumented minors access to the U.S. (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve in Resolution 003 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~condemn~~ only support the practice of administering psychotropic drugs to immigrant children ~~without~~ when there has been evaluation by appropriate medical personnel, and with parental or guardian consent or court order except in the case of imminent danger to self or others (New HOD Policy); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve in Resolution 003 be amended by addition and deletion to read as follows:

~~RESOLVED, That our AMA support a position whereby federal immigration officials would become more aware of the emotional decompensation in this immigrant population, with the establishment of policies designed to decrease stress and emotional trauma. (New HOD Policy)~~

RESOLVED, That our AMA (1) support education for immigration officials regarding increased risk of sexual assault and sexual trauma amongst unaccompanied minor

immigrant children, as well as the emotional decompensation in this immigrant population due to these abuses and other traumas, and (2) encourage policies designed to decrease incidence of sexual assault, increase reporting and timely access to treatment services, and decrease stress and emotional trauma.

RECOMMENDATION D:

Madam Speaker, you Reference Committee recommends that Resolution 003 be adopted as amended.

Resolution 003 asks that our AMA officially object to policies separating undocumented immigrant parents/guardians from their children, as well as allowing unaccompanied minors access to the United States. The resolution also urges our AMA to condemn the practice of administering psychotropic drugs to immigrant children without parental or guardian consent or court order, except in cases of imminent danger to self or others. In addition, the resolution asks our AMA to support a position whereby federal immigration officials become more aware of emotional decompensation in this immigrant population with the establishment of policies designed to decrease stress and emotional trauma.

Testimony reflected almost unanimous support of the spirit of Resolution 003, with speakers emphasizing the trauma experienced by both parents and children when the family is separated. Amendments were offered to clarify the intent of the first and second Resolve clauses, particularly regarding the necessity of medical evaluation in cases when immigrant children are administered psychotropic drugs. Your Reference Committee also heard significant testimony regarding sexual trauma and felt that combining this into the third Resolve clause effectively addressed

the intent of the original third Resolve as well as these additional concerns. Your Reference Committee recommends that Resolution 003 be adopted as amended.

(9) RESOLUTION 004 – OPPOSING THE DETENTION OF MIGRANT CHILDREN

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the third Resolve in Resolution 004 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA urge ~~that~~ continuity of care for ~~all~~ migrant children released from ~~such~~ detention facilities. ~~be provided with indicated follow-up health care to ensure their welfare following these experiences.~~ (New HOD Policy)

Resolution 004 asks that our AMA oppose the separation of migrant children from their families and any effort to end or weaken the Flores Settlement, which requires the U.S. government to release undocumented children “without unnecessary delay” when

detention is not required for the protection and safety of that child, and that those children that remain in custody must be placed in the "least restrictive setting" possible. The resolution also asks our AMA to support the humane treatment of all undocumented children by advocating for regular, unannounced auditing of the medical conditions and services at all detention facilities by a non-governmental third party with medical expertise in the care of vulnerable children. Additionally, the resolution requests that our AMA urge that all children released from such detention be provided with indicated follow-up health care to ensure their welfare following these experiences.

Your Reference Committee heard widespread support for Resolution 004, focusing on the goal of ensuring quality health care for all patients in confined settings and the scrutiny of detention centers in general. A suggestion for referral was made in light of the complexity of the treatment of migrant children. However, due to the urgent nature of the Flores Settlement currently being threatened, your Reference Committee developed amended language in lieu of referral. Therefore, your Reference Committee recommends that Resolution 004 be adopted as amended.

(10) RESOLUTION 005 (LATE RESOLUTION 1001) – AFFIRMING THE MEDICAL SPECTRUM OF GENDER

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second resolve in Resolution 005 be amended by addition and deletion to read as follows:

~~RESOLVED, That our AMA oppose any effort to prohibit the reassignment of an individual's sex. (New HOD Policy)~~

RESOLVED, That our AMA oppose any efforts to deny an individual's right to determine their stated sex marker or gender identity. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 005 be adopted as amended.

Resolution 005 asks that AMA Policy D-295.312, "Medical Spectrum of Gender," be amended. The resolution asks our AMA to educate state and federal policymakers and legislators on and advocate for policies addressing the medical spectrum of gender identity to ensure access to quality health care. The resolution also asks that our AMA affirm that an individual's genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth.

Testimony for Resolution 005 offered nearly unanimous support, with speakers noting the ongoing difficulties faced by transgender individuals and how an improved social and structural support system might ameliorate some of those difficulties. Testimony suggested that any proposal to limit or narrow the definition of sex would lead to public

health consequences, and that it is essential to acknowledge that gender is fluid and that gender identity does not always match sex at birth. Some speakers noted that the original phrasing of the second resolve may have been problematic, and the above amendments were offered and supported by subsequent speakers. Your Reference Committee recommends that Resolution 005 be adopted as amended.

(11) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 2 – STUDY AID-IN-DYING AS END-OF-LIFE OPTION / THE NEED TO DISTINGUISH "PHYSICIAN-ASSISTED SUICIDE" AND "AID-IN-DYING"

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 2 be referred.

Council on Ethical and Judicial Affairs Report 2 responds to Resolution 15-A-15, "Study Aid-in-Dying as End-of-Life Option," and Resolution 14- A-17, "The Need to Distinguish between 'Physician-Assisted Suicide' and 'Aid in Dying'." Resolution 15-A-15 asks that the Council on Ethical and Judicial Affairs study medical aid-in-dying and make a recommendation regarding the AMA taking a neutral stance; Resolution 14-A-17 asks that AMA define and clearly distinguish "physician assisted suicide" and "aid in dying" for use in all AMA policy and position statements. This report holds that the terms 'aid in dying' and 'physician-assisted suicide' reflect different ethical perspectives. The Council finds "physician assisted suicide" to be the most precise term and urges that it be used by the AMA. Importantly, the report explains that there are irreducible differences in moral perspectives regarding the issue of physician-assisted suicide, such that both sides share common commitment to "compassion and respect for human dignity and rights" (see Principle I of the AMA Principles of Medical Ethics), but draw different moral conclusions from these shared commitments. The report considers the risks of unintended consequences of physician-assisted suicide, noting that there is debate about the available data. The report argues that where physician-assisted suicide is legal, safeguards can and should be improved to mitigate risk. The report further notes that too often physicians and patients do not have the conversations they should about death and dying and that physicians should be skillful in engaging in these difficult conversations and knowledgeable about the options available to terminally ill patients. The report concludes that in existing opinions on physician-assisted suicide and the exercise of conscience, the *Code of Medical Ethics* offers sufficient guidance to support physicians and the patients they serve in making well-considered, mutually respectful decisions about legally available options for care at the end of life while respecting the intimacy of a patient-physician relationship. Thus, the report recommends that the *Code* not be amended, and that Resolutions 15-A-16 and 14-A-17 not be adopted.

Your Reference Committee heard extensive mixed testimony regarding Council on Ethical and Judicial Affairs Report 2. There was broad agreement that the Council had written a strong report that thoroughly examines the issues under consideration, including focusing on the shared values of care, compassion, respect, and dignity. Testimony offered a great deal of support for keeping the current *Code* unchanged. However, your Reference Committee also heard a significant amount of testimony questioning whether the

conclusions of the report were supported by its body, specifically urging reexamination of opinion E-5.7, which states that, "physician-assisted suicide is fundamentally incompatible with the physician's role as healer" in order to acknowledge that physicians have other roles beyond healer that may be incongruent with each other. Your Reference Committee therefore recommends that Council on Ethical and Judicial Affairs Report 2 be referred.

(12) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 4 – CEJA ROLE IN IMPLEMENTING H-140.837, "ANTI-HARASSMENT POLICY"

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 4 not be adopted.

Council on Ethical and Judicial Affairs Report 4 recommends that provision (3) of AMA Policy H-140.837, "Anti-Harassment Policy," be rescinded and that the process for implementing the AMA's anti-harassment policy be referred to the Board of Trustees for further study. At the 2018 Annual Meeting, the House of Delegates adopted with amendment Board of Trustees Report 20-A-18, "Anti-Harassment Policy," giving the Council on Ethical and Judicial Affairs the authority and responsibility to take disciplinary action regarding allegations of harassment during meetings associated with the AMA. The report notes that the Council on Ethical and Judicial Affairs believes promoting safe engagement among all attendees during professional meetings affiliated with the AMA is an urgent organizational responsibility. However, the responsibility to adjudicate allegations of harassment is qualitatively different from the Council on Ethical and Judicial Affairs' normal judicial function and demands a different set of skills. The Council also expressed doubt that it possessed the resources or flexibility necessary to carry out this new role effectively, and is concerned that such a role could undermine confidence in the Council, to the detriment of both its judicial and policy work.

Your Reference Committee heard generally negative testimony on Council on Ethical and Judicial Affairs Report 3. Speakers suggested that the judicial function assigned to the Council on Ethical and Judicial Affairs in AMA Policy H-140.837 is not unreasonable given the Council's role as outlined in AMA Bylaws. Testimony also questioned the Council's concern about a potential investigatory role, noting that such activities would be conducted by the Human Resources of the AMA, with adjudication appropriately being handled by the Council. Your Reference Committee acknowledges the Council on Ethical and Judicial Affairs' significant concerns about their ability and resources to effectively carry out the role outlined in AMA policy as written, and strongly urges our Board of Trustees to further examine the process. However, since adoption of this report would eliminate the only current AMA process regarding adjudication of harassment claims at AMA meetings, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 4 not be adopted.

Madam Speaker, this concludes the report of Reference Committee on Amendments to Constitution and Bylaws. I would like to thank Mark Ard, MD, Jayne Courts, MD, Keith E. Davis, MD, Sean Figy, MD, Dionne Hart, MD, Spiro Spanakis, DO, and all those who testified before the Committee.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-18)

Report of Reference Committee B

Francis P. MacMillan, Jr., MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 4 – Increased Use of Body-Worn Cameras by Law Enforcement Officers (Resolution 208-I-17)
2. Board of Trustees Report 8 – 340B Drug Discount Program (Resolution 225-A-18 Resolve 3)
3. Resolution 201 – Reimbursement for Services Rendered During Pendency of Physician's Credentialing Application
4. Resolution 207 – Defense of Affirmative Action
5. Resolution 209 – Sexual Assault Education and Prevention in Public Schools
6. Resolution 217 – Opposition to Medicare Part B to Part D Changes
7. Resolution 226 – Support for Interoperability of Clinical Data
8. Resolution 229 – Addressing Surgery Performed by Optometrists

RECOMMENDED FOR ADOPTION AS AMENDED

9. Board of Trustees Report 5 – Exclusive State Control of Methadone Clinics (Resolution 211-I-17)
10. Board of Trustees Report 7 – Advocacy for Seamless Interface Between Physicians Electronic Health Records (EHRs), Pharmacies and Prescription Drug Monitoring Programs (PDMPs) (Resolution 212-A-17; BOT Report 12-A-18)
11. Board of Trustees Report 11 – Violence Prevention (Resolution 419-A-18, Resolves 1 and 3)
    Resolution 214 – A Public Health Case for Firearm Regulation
    Resolution 233 – Opposing Unregulated, Non-Commercial Firearm Manufacturing
12. Resolution 205 – Legalization of the Deferred Action for Legal Childhood Arrival (DALCA)
13. Resolution 208 – Increasing Access to Broadband Internet to Reduce Health Disparities
14. Resolution 211 – Eliminating Barriers to Automated External Defibrillator Use
15. Resolution 212 – Development and Implementation of Guidelines for Responsible Media Coverage of Mass Shootings
16. Resolution 216 – Medicare Part B Competitive Acquisition Program (CAP)
17. Resolution 220 – Supporting Mental Health Training Programs for Corrections Officers and Crisis Intervention Teams for Law Enforcement
18. Resolution 224 – Fairness in the Centers for Medicare & Medicaid Services Authorized Quality Improvement Organization’s (QIO) Medical Care Review Process
19. Resolution 232 – Opposition to Mandatory Licensing Requirements for Qualified Clinical Data Registries

20. Resolution 235 – Inappropriate Use Of CDC Guidelines For Prescribing Opioids

RECOMMENDED FOR REFERRAL

21. Resolution 202 – Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings
22. Resolution 204 – Restriction on IMG Moonlighting
23. Resolution 206 – Repealing Potential Penalties Associated with MIPS
Resolution 231 – Reducing the Regulatory Burden in Health Care

RECOMMENDED FOR REFERRAL FOR DECISION

24. Resolution 210 – Forced Organ Harvesting for Transplantation

RECOMMENDED FOR NOT ADOPTION

25. Resolution 215 – Extending the Medical Home to Meet Families Wherever They Go
26. Resolution 230 – Nonprofit Hospitals and Network Health Systems
27. Resolution 234 – Negligent Credentialing Actions Against Hospitals

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

28. Resolution 218 – Alternatives to Tort for Medical Liability
29. Resolution 225 – “Surprise” Out of Network Bills
30. Resolution 228 – Medication Assisted Treatment

Resolutions handled via the Reaffirmation Consent Calendar:

Resolution 203 – Support for the Development and Distribution of HIPAA-Compliant Communication Technologies
Resolution 213 – Increasing Firearm Safety to Prevent Accidental Child Deaths
Resolution 219 – Promotion and Education of Breastfeeding
Resolution 221 – Regulatory Relief from Burdensome CMS "HPI" EHR Requirements
Resolution 222 – Patient Privacy Invasion by the Submission of Fully Identified Quality Measure Data to CMS
Resolution 223 – Permanent Reauthorization of the State Children’s Health Insurance Program

(1) BOARD OF TRUSTEES REPORT 4 – INCREASED USE OF BODY-WORN CAMERAS BY LAW ENFORCEMENT OFFICERS (RESOLUTION 208-I-17)

RECOMMENDATION:

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

The Board of Trustees recommends that the following be adopted in lieu of Resolution 208-1-17, and that the remainder of the report be filed. That our American Medical Association work with interested state and national medical specialty societies to support state legislation and/or regulation that would encourage the use of body-worn camera programs for law enforcement officers and fund the purchase of body-worn cameras, training for officers and technical assistance for law enforcement agencies.

Your Reference Committee commends the Board of Trustees for an excellent and thorough board report. Your Reference Committee heard testimony largely in support of Board of Trustees Report 4. There was some testimony questioning whether the issues being raised were outside the expertise and scope of our AMA. The majority of the testimony, however, emphasized that the use of body-worn cameras by law enforcement was a matter of public health and directly related to existing AMA policy. The issues raised by this report are critical and very timely. Your Reference Committee agrees with testimony urging adoption, recognizing that there are nuances that will need to be addressed as our AMA works with interested state and specialty societies during any given state legislative and/or regulatory process. Your Reference Committee, therefore, recommends that Board of Trustees Report 4 be adopted.

(2) BOARD OF TRUSTEES REPORT 8 – 340B DRUG DISCOUNT PROGRAM (RESOLUTION 225-A-18 RESOLVE 3)

RECOMMENDATION:

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

The Board of Trustees recommends that the following recommendations be adopted in lieu of the third resolve Resolution 225-A-18 and the remainder of this report be filed 1. That our American Medical Association support a revised 340B drug discount program covered entity eligibility formula, which appropriately captures the level of outpatient charity care provided by hospitals, as well as standalone community practices. (New HOD Policy) 2. Our AMA will confer with national medical specialty societies on providing policymakers with specific recommended covered entity criteria for the 340B drug discount program. (Directive to Take Action)

Your Reference Committee heard overwhelmingly supportive testimony on Board of Trustees Report 8. Your Reference Committee heard testimony that there should be equity in payment between community practice providers and those affiliated with hospitals. Your Reference

Committee also heard testimony that the 340B rebate program should ultimately benefit patients who are underinsured or uninsured by providing rebates to those providers who actually provide medical care and treatment to them. Additionally, your Reference Committee heard testimony encouraging the collaboration with appropriate stakeholders when crafting and providing recommendations on covered entity criteria in the 340B discount program to policymakers. Accordingly, your Reference Committee recommends that Board of Trustees Report 8 be adopted.

(3) RESOLUTION 201 – REIMBURSEMENT FOR SERVICES RENDERED DURING PENDENCY OF PHYSICIAN'S CREDENTIALING APPLICATION

RECOMMENDATION:

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

Resolution 201 asks that our American Medical Association develop model state legislation for physicians being credentialed by a health plan to treat patients and retroactively receive payments if they are ultimately credentialed. (Directive to Take Action)

Your Reference Committee heard strong testimony in support of the issues raised related to Resolution 201 and therefore recommends adoption.

(4) RESOLUTION 207 – DEFENSE OF AFFIRMATIVE ACTION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 207 be adopted.

Resolution 207 asks that our American Medical Association oppose legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population. (New HOD Policy)

Your Reference Committee heard supportive testimony for Resolution 207. Your Reference Committee heard testimony that our AMA does have existing policy in support of creating a diverse student population. Your Reference Committee heard testimony that our AMA filed amicus briefs in *Fisher v. University of Texas at Austin*, and argued that racial diversity is a vital component of a successful medical education and that medical school admission officers should be allowed to consider applicants' race in order to achieve the schools' educational goals. Your Reference Committee also heard testimony that existing AMA policy falls short in addressing the necessity of affirmative action as mechanism for equality at the undergraduate level, which is necessary to bolster the pool of minority students able to apply to a medical program. Your Reference Committee agrees with this testimony and recommends adoption.

(5) RESOLUTION 209 – SEXUAL ASSAULT EDUCATION AND PREVENTION IN PUBLIC SCHOOLS

RECOMMENDATION:

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

Resolution 209 asks that our American Medical Association support state legislation mandating that public middle and high school health education programs include age appropriate information on sexual assault education and prevention, including but not limited to topics of consent and sexual bullying. (Directive to Take Action)

Your Reference Committee heard overwhelming testimony in support of Resolution 209. The issues raised by Resolution 209 are both urgent and timely. Your Reference Committee, therefore, recommends adoption.

(6) RESOLUTION 217 – OPPOSITION TO MEDICARE PART B TO PART D CHANGES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 217 be adopted.

Resolution 217 asks that our American Medical Association advocate against Medicare changes which would recategorize Medicare Part B drugs into Part D. (New HOD Policy)

Your Reference Committee heard overwhelmingly supportive testimony on Resolution 217. Your Reference Committee heard testimony that Congress and the Administration must do more to address the high cost of physician administered drugs and access challenges. Your Reference Committee also heard testimony that the Administration's proposal to move some drugs from the Medicare Part B benefit to the Part D benefit will not result in lower costs to Medicare beneficiaries and may disrupt the chain of custody needed to ensure that physician administered drugs have not been adultered or subjected to conditions that degrade the efficacy or undermine the safety of the treatment. Accordingly, your Reference Committee recommends adoption of Resolution 217.

(7) RESOLUTION 226 – SUPPORT FOR INTEROPERABILITY OF CLINICAL DATA

RECOMMENDATION:

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

Resolution 226 asks that our American Medical Association review and advocate for the implementation of appropriate recommendations from the "Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care," a physician-directed set of recommendations, to EHR vendors and

relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 226. Your Reference Committee heard testimony that our AMA has strong policy regarding the development and adoption of universal Electronic Health Records interoperability standards. Your Reference Committee also heard testimony that our AMA is working to eliminate unjustified information blocking and excessive costs which prevent data exchange. Your Reference Committee further heard testimony that Resolution 226 would complement this existing AMA policy. You Reference Committee also heard testimony in support of referral because Resolution 226 references a document outside our AMA's control. Your Reference Committee understands these concerns but would note that the Resolution 226 explicitly state that our AMA only advocate for appropriate recommendations in the document. Your Reference Committee believes that it is a better use of our AMA resources to have our AMA advocate directly to Office of the National Coordinator to promote interoperability on the appropriate recommendations rather than drafting a report on interoperability. Accordingly, your Reference Committee recommends that Resolution 226 be adopted.

(8) RESOLUTION 229 – ADDRESSING SURGERY PERFORMED BY OPTOMETRISTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 229 be adopted.

Resolution 229 asks that our American Medical Association support legislation prohibiting optometrists from performing surgical procedures as defined by AMA policies H-475.983, "Definition of Surgery," and H-475.988, "Laser Surgery" (New HOD Policy); and be it further that our AMA encourage state medical associations to support state legislation and rulemaking prohibiting optometrists from performing surgical procedures as defined by AMA policies H-475.983, "Definition of Surgery," and H-475.988, "Laser Surgery". (New HOD Policy).

Your Reference Committee heard overwhelming supportive testimony on Resolution 229 and therefore recommends adoption.

(9) BOARD OF TRUSTEES REPORT 5 – EXCLUSIVE STATE CONTROL OF METHADONE CLINICS (RESOLUTION 211-I-17)

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Recommendation 1 of Board of Trustees Report 5 be amended by deletion to read as follows:

1. That our American Medical Association (AMA) support the right of federally certified Opioid Treatment Programs (OTPs) to be located ~~within residential, commercial and any other areas~~ where there is a demonstrated medical need; (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Recommendation in Board of Trustee Report 5 be adopted as amended and the remainder of the report be filed.

The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 211-1-17, and that the remainder of the report be filed. 1. That our American Medical Association (AMA) support the right of federally certified Opioid Treatment Programs (OTPs) to be located within residential, commercial and any other areas where there is a demonstrated medical need; (New HOD Policy) 2. That our AMA encourage state governments to collaborate with health insurance companies and other payers, state medical societies, national medical specialty societies, OTPs and other health care organizations to develop and disseminate resources that identify where OTP providers operate in a state and take part in surveillance efforts to obtain timely and comprehensive data to inform treatment opportunities; and (New HOD Policy) 3. That our AMA advocate for the federal agencies responsible for approving opioid treatment programs to consider the views of state and local stakeholders when making decisions about OTP locations and policies. (New HOD Policy)

Your Reference Committee heard supportive testimony on Board of Trustees Report 5. While there was some testimony suggesting that states should be the sole arbiter of how Opioid Treatment Programs (OTPs) should operate, your Reference Committee heard testimony that strong data exists suggesting that OTPs are providing high-quality, evidence-based care to hundreds of thousands of patients under a federal structure. Your Reference Committee heard additional testimony that this federal structure appears to provide consistency while also leaving many areas governing medical practice to state control. This information in the Board Report and the testimony provided by proponents of the recommendations strongly suggests that OTPs are one area where state and federal efforts are working well together. Your Reference Committee heard further testimony that improvements to this structure can be made. Your Reference Committee agrees with the Board that all stakeholders must work together to an even greater extent to ensure that OTPs can prosper to an even greater extent so that patients with an opioid use disorder have greater access to care. Your Reference Committee heard testimony concerning retaining local control over placement of OTPs in residential and commercial areas.

Your Reference Committee heard testimony that an additional Recommendation should be added to the Board of Trustees Report 5 that our AMA support aligning 42 CFR Part 2 privacy protections with current HIPAA regulations in an effort to promote improved coordination of care for patients being treated for substance use disorder (SUD). Others testifying against alignment stated that our AMA has strong policy protecting the confidentiality of patient records and privacy rights of patients with SUD and that our AMA shares the goal of ensuring that physicians have a patient's entire medical record to review and care for their patients. Furthermore, your Reference Committee heard that 113 patient and provider groups oppose alignment stating that federal SUD confidentiality rules must be maintained to protect patient privacy and to encourage those with opioid and other substance use disorders to enter treatment.

Testimony stated that our AMA encourages patients to consent to share SUD information to help clinicians provide coordinated and holistic care. Your Reference Committee heard testimony that our AMA believes that to balance privacy with access to information, and to have truly coordinated care, patients must be willing and active participants. Testimony further indicated that patients who refuse to sign a consent are the very patients who would be deterred from seeking treatment if the laws were aligned, and, consequently, those patients would be kept out of the treatment system without even providing them a chance to better understand the benefits of providing consent.

Your Reference Committee heard further testimony that harmonization could negatively impact privacy of a vulnerable population. SUDs are widely stigmatized and disclosure of SUD-related information can have serious consequences for the patient. Testimony noted that there exists significant confusion and misunderstanding of how Part 2 allows information to be shared among clinicians and other parties, including payers, Accountable Care Organizations, and Health Information Exchanges. Clarifying guidance and regulations would be a meaningful step to help providers, payers, and patients understand rights and obligations under the current law as well as existing opportunities for information sharing. Your Reference Committee heard testimony that while Part 2 will not give SUD information to a hospital in emergency, HIPAA is also permissive, so alignment of Part 2 and HIPAA will not compel a Part 2 program to give SUD information to an emergency room physician. Your Reference Committee also heard testimony that there are workable solutions to electronically track patient consent through EHRs that would be more effective in providing physicians with access to sensitive medical records while maintaining robust patient privacy protections.

Your Reference Committee heard testimony raising concerns that alignment of the two laws may not actually accomplish the goals of a professional being fully informed including:

- The current state of interoperability doesn't allow a physician to electronically access all of a patient's information, often requiring physicians to resort to fax or paper records. Many Part 2 facilities do not have EHRs. In most cases, alignment would not change the availability of SUD information.
- Many states have adopted their own laws restricting disclosure of sensitive medical information. Alignment will not preempt these more restrictive laws, which will further confuse patients and clinicians about how SUD information can be shared.
- If a patient's medical record needs to be shared for any reason other than for treatment, payment, or health care operations, a physician must remove all mentions of SUD information, which will be highly burdensome and time-consuming for a physician, likely needing to be done by hand.

Therefore, given the complexity and the differing views, your Reference Committee believes that adding an additional Recommendation about aligning Part 2 with HIPAA to a Board of Trustees Report regarding the exclusive state control of methadone clinics would not allow our AMA and other interested physician groups the opportunity to fully consider this important issue that directly implicates the access to appropriate treatment as well as strong patient privacy protections. Accordingly, your Reference Committee recommends that Board of Trustees Report 7 be adopted as amended.

(10) BOARD OF TRUSTEES REPORT 7 – ADVOCACY FOR SEAMLESS INTERFACE BETWEEN PHYSICIANS ELECTRONIC HEALTH RECORDS (EHRs), PHARMACIES AND PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPs) (RESOLUTION 212-A-17; BOT REPORT 12-A-18)

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Recommendation of Board of Trustees Report 7 be amended by addition to read as follows:

2. That our AMA urge EHR vendors and Health Information Exchanges (HIEs) to increase transparency of custom connections and costs for physicians to integrate their products in their practices. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Recommendation of Board of Trustees Report 7 be amended by addition to read as follows

3. That our AMA support state-based pilot studies of best practices to integrate EHRs, HIEs, EPCS, and PDMPs as well as efforts to identify burdensome state and federal regulations that prevent such integration from occurring. (New HOD policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 7 be amended by addition of a new Recommendation to read as follows:

That our AMA support initiatives to improve the functionality of state PDMPs, including; (1) lessening the time delay between when a prescription is dispensed and when the prescription would be available to physicians through a PDMP; and (2) directing state-based PDMP's to support improved integrated EHR interfaces. (Directive to Take Action)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustee Report 7 be adopted as amended and the remainder of the report be filed.

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 212-A-17, and the remainder of the report be filed 1. That our American Medical Association (AMA) advocate for a federal study to evaluate the use of PDMPs to improve pain care as well as treatment for substance use disorders. This would include identifying whether PDMPs can distinguish team-based care from uncoordinated care, misuse, or "doctor shopping," as well as help coordinate care for a patient with a substance use disorder or other condition requiring specialty care. (Directive to Take Action) 2. That our AMA urge EHR vendors to increase transparency of custom connections and costs for physicians to integrate their products in their practice. (Directive to Take Action) 3. That our AMA support state-based pilot studies of best practices to integrate EHRs, EPCS and PDMPs as well as efforts to identify burdensome state and federal regulations that prevent such integration from occurring. (New HOD Policy)

Your Reference Committee heard supportive testimony on Board of Trustees Report 7. Concern was raised, however, that the report did not go far enough. Several testified that the issues raised are time sensitive and that our AMA needs to take a vocal and public stance on the issues raised in the report. Your Reference Committee acknowledges the aggressive advocacy our AMA is engaged in on the issues raised in this report as well as the extensive work done by nearly all state medical societies in negotiating the political pressures associated with rising mortality and the limited evidence showing PDMPs can help improve pain care. Your Reference Committee agrees that physicians need to be aware of the importance of checking PDMPs and that PDMP data needs to be incorporated into the EHR to truly improve clinical decision making at the point of care. Despite progress being made in data integration, your Reference Committee is concerned that each state is only in the initial stages of such integration and reaching agreements with PDMP vendors may not take into account how those agreements may ultimately pass costs along to physicians. While state PDMPs do not charge physicians to access the PDMP, health systems and others do incur costs for integrating HIE and PDMP data into EHRs. Each state does this differently. Further complicating this is that there are some state laws that may limit PDMP funding. Your Reference Committee received information that physicians have contacted our AMA and reported that access to a PDMP via an EHR has resulted in compounding fees where the EHR vendor, PDMP vendor, and additional third-party intermediaries separately charge physicians, health systems or hospitals. Furthermore, your Reference Committee heard that some states prohibit the use of certain sources of funding, or they rely predominantly on federal grants, thus limiting the potential range of funding mechanisms. For instance, Florida law specifically prohibits the use of state funds to support the PDMP—further tying PDMP financing to physician-bound fees. Because of the need to be very careful and cognizant of unintended consequences arising out of incredibly well intentioned proffered amendments, your Reference Committee recommends that Board of Trustees Report 7 be adopted as amended.

(11) BOARD OF TRUSTEES REPORT 11 – VIOLENCE PREVENTION (RESOLUTION 419-A-18, RESOLVES 1 AND 3)
RESOLUTION 213 – INCREASING FIREARM SAFETY TO PREVENT ACCIDENTAL CHILD DEATHS

RESOLUTION 233 – OPPOSING UNREGULATED, NON-COMMERCIAL FIREARM MANUFACTURING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendation of Board of Trustees Report 11 **be Recommendation 1 be** amended by addition and deletion to read as follows:

1. That Policy H-145.996, "Firearm Availability" be amended by addition and deletion to read as follows:

H-145.996 Firearm Availability

1. Our AMA: (a) Advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

2. Our AMA ~~policy is to~~ supports requiring ~~require~~ the licensing/permitting of ~~owners of~~ firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.

~~3. Our AMA supports granting local law enforcement discretion over whether to issue concealed carry permits, in the permitting process in such that local police chiefs are empowered to make permitting decisions regarding "concealed carry", by supporting "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and by supporting "red-flag" laws for individuals who have demonstrated significant signs of potential violence. In supporting local law enforcement, we also support as well the importance of "due process" so that decisions could be reversible by individuals can petition petitioning in court for their rights to be restored. (Modify Current HOD Policy)~~

3. Our AMA supports "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as "red-flag" laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and "red-flag" laws, we also support the importance of due process so that individuals can petition for their rights to be restored. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that recommendations of Board of Trustees Report 11 be amended by addition of new Recommendations 4 and 5 to read as follows.

4. That Policy H-145.990, "Prevention of Firearm Accidents in Children" be amended by addition and deletion to read as follows:
H-145.990, "Prevention of Firearm Accidents in Children"

Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms;(2) encourages state medical societies to work with other organizations to increase public education about firearm safety; ~~and~~ (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children; and (4) support enactment of Child Access Prevention laws that are consistent with AMA policy.

5. That Policy H-145.994, "Control of Non-Detectable Firearms" be amended by addition to read as follows:

H-145.994, "Control of Non-Detectable Firearms"
The AMA supports a ban on the (1) manufacture, importation, and sale of any firearm which cannot be detected by ordinary airport screening devices, including 3D printed firearms and (2) production and distribution of 3D firearm digital blueprints.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 11 be adopted as amended in lieu of Resolutions 213 and 233 and the remainder of the report be filed.

The Board of Trustees recommends that the following recommendations be adopted in lieu of the first and third resolves of Resolution 419-A-18 and the remainder of the report be filed. 1. That Policy H-145.996, "Firearm Availability" be amended by addition and deletion to read as follows: H-145.996 Firearm Availability - 1. Our AMA: (a) Advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic,

ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices. 2. Our AMA ~~policy is to~~ supports requiring ~~require~~ the licensing/permitting of ~~owners of~~ firearms~~ owners~~ and purchasers, including the completion of a required safety course, and registration of all firearms. 3. Our AMA supports granting local law enforcement discretion over whether to issue concealed carry permits. ~~in the permitting process in such that local police chiefs are empowered to make permitting decisions regarding "concealed carry",~~ ~~by supporting "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and by supporting "red-flag" laws for individuals who have demonstrated significant signs of potential violence.~~ In supporting local law enforcement, we also support ~~as well~~ the importance of ~~"~~due process~~"~~ so that ~~decisions could be reversible by~~ individuals can petition ~~petitioning in court~~ for their rights to be restored. (Modify Current HOD Policy) 2. That Policy H-145.972, "Firearms and High-Risk Individuals" be reaffirmed. Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals. (Reaffirm HOD Policy) 3. That our American Medical Association: (1) encourages the enactment of state laws requiring the reporting of relevant mental health records, as defined by state and federal law, to the National Instant Criminal Background Check System (NICS); (2) supports federal funding to provide grants to states to improve NICS reporting; and (3) encourages states to automate the reporting of mental health records to NICS to improve the quality and timeliness of the data. (New HOD Policy). Resolution 213 asks that our American Medical Association advocate for enactment of Child Access Prevention laws in all 50 states or as federal law. (New HOD Policy). Resolution 233 asks that our AMA support legislation that opposes: a) unregulated, non-commercial firearm manufacturing, such as via 3-D printing, regardless of the material composition or detectability of such weapons; b) production and distribution of 3-D firearm blueprints; and be it further that our AMA issue a statement of concern to Congress and the Bureau of Alcohol, Tobacco, Firearms and Explosives regarding the manufacturing of firearms using 3-D printers and the online dissemination of 3-D firearm blueprints as a public health issue.

Your Reference Committee heard mixed testimony on Board of Trustees Report 11. Your Reference Committee heard that our AMA has extensive policy on firearm safety and violence prevention including policy that supports requiring the licensing of firearm owners, including completion of a required safety course and registration of all firearms. Your Reference Committee heard testimony expressing concerns surrounding granting local law enforcement discretion over whether to issue concealed carry permits and that these decisions may be made arbitrarily and without just cause. However, testimony also indicated that our AMA should support gun violence restraining orders and extreme risk protection orders, commonly known as "red flag" laws, as currently stated in AMA policy H-145.996. Accordingly, your Reference Committee recommends that Board of Trustees 11 be adopted with amendment.

Your Reference Committee heard generally supportive testimony on Resolution 213. Your Reference Committee heard testimony that our AMA already has strong policy regarding the prevention of unintentional shooting deaths among children and firearm accidents in children

including supporting efforts to reduce pediatric firearm morbidity and mortality. Your Reference Committee also heard testimony in support of the intent behind Resolution 213 in supporting Child Access Prevention (CAP) laws; however, the testimony raised concerns that supporting all Child Access Prevention laws could be problematic because an individual state's CAP law may be contrary to existing AMA policy. Accordingly, given the strong existing AMA policy, your Reference Committee recommends adding a fourth recommendation to Board of Trustees Report 11 to amend existing policy by incorporating the intent of Resolution 213 where the CAP law is consistent with AMA policy.

Your Reference Committee heard generally supportive testimony on Resolution 233. Your Reference Committee heard testimony expressing concern regarding the accessibility of 3D printers and the ability to easily fabricate 3D printed firearms. Your Reference Committee heard testimony that using digital blueprints to a 3D printed firearms will increase access to guns in an unregulated manner. Your Reference Committee also heard testimony that our AMA already has policy supporting a ban on the manufacture, importation, and sale of any firearm which cannot be detected by ordinary airport screening devices and that this policy would cover 3D printed firearms. Testimony also indicated that a ban on all unregulated or non-commercial firearms is too broad and does not take into account how states vary in interpreting what are unregulated firearms. Accordingly, given the potential unintended consequences and the focus of the Resolution 233 is on 3D firearms and digital blueprints, your Reference Committee recommends adding a Fifth recommendation to Board of Trustees Report 11 that existing policy be amended to specifically reference 3D printed firearms and 3D digital blueprints.

Therefore, your Reference Committee recommends that Board of Trustees Report 11 be adopted as amended in lieu of Resolutions 213 and 233 and the remainder of the report be filed.

(12) RESOLUTION 205 – LEGALIZATION OF THE DEFERRED ACTION FOR LEGAL CHILDHOOD ARRIVAL (DALCA)

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy D-255.979 be <u>amended by addition</u> as follows:

Our AMA will work with all relevant stakeholders to clear the backlog for conversion from H1-B visas for physicians to permanent resident status, <u>and support dependents of physicians on H-1B visas, who are admitted to the U.S. under the H-4 nonimmigrant classification to remain in the U.S. legally while their green card applications are pending.</u>

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that <u>Policy D-255.979 be adopted as amended in lieu of Resolution 205</u>.

Resolution 205 asks that our American Medical Association support legalization of the Deferred Action for Legal Childhood Arrival (DALCA) (New HOD Policy); and be it further; that our AMA work with the appropriate agencies to allow DALCA children to start and finish

medical school and/or residency training until these DALCA children have officially become legal. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 205. Your Reference Committee heard testimony that there are thousands of children who arrive in our country with their H-1B physician parents legally. Your Reference Committee heard testimony that physicians with H-1B visas may bring their immediate dependents, such as their children, to the U.S. through the H-4 visa process; however, once their children turn 21 years of age they are at risk for deportation because they have aged out and are no longer dependents admitted to the U.S. under the H-4 non-immigration classification while their families' green cards are caught in the H-1B visa backlog. Your Reference Committee heard testimony that Deferred Action for Legal Childhood Arrival (DALCA), is a newly developed term used to draw a distinction from Deferred Action for Childhood Arrivals (DACA) students and is not widely-used by either immigration attorneys or public officials at the federal level. Your Reference Committee also heard testimony that many of these H-4 visa children are in medical schools or have already graduated from U.S. medical schools, but are subject to deportation because they have reached the age of 21. Your Reference Committee further heard testimony that our AMA already has strong policy regarding permanent residence status for physicians and that Resolution 205 should be incorporated into this existing policy. Accordingly, your Reference Committee recommends that current AMA policy D-255.979 be amended and adopted in lieu of Resolution 205.

(13) RESOLUTION 208 – INCREASING ACCESS TO BROADBAND INTERNET TO REDUCE HEALTH DISPARITIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 208 <u>amended by addition</u> to read as follows:

RESOLVED, That our AMA advocate for the expansion of broadband <u>and wireless</u> connectivity to all rural <u>and underserved</u> areas of the United States. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 208 be <u>adopted as amended</u>.

Resolution 208 asks that our American Medical Association advocate for the expansion of broadband connectivity to all rural areas of the United States. (New HOD Policy)

Your Reference Committee heard overwhelmingly supportive testimony on Resolution 208. Your Reference Committee heard testimony that to address the access challenges in rural and other underserved areas that lack broadband and wireless connectivity, it is essential to advocate adequate federal support so that residents have access to digital health modalities. Your Reference Committee also heard testimony that innovations in health care delivery will increasingly rely on connectivity that is reliable, adequate, and affordable. In line with our AMA's effort to develop, support, and implement digital health technology across the United States, your Reference Committee recommends adoption of Resolution 208 with an

amendment to include wireless in addition to broadband and underserved communities as well as rural.

(14) RESOLUTION 211 – ELIMINATING BARRIERS TO AUTOMATED EXTERNAL DEFIBRILLATOR USE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that third Resolve of Resolution 211 be amended by addition and deletion to be read as follows:

RESOLVED That our AMA support consistent and uniform legislation across states for the legal protection of ~~untrained personnel~~ those who use AEDs in the course of attempting to aid a sudden cardiac arrest victim. (Directive to Take Action)

RECOMMENDATION B:

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

Resolution 211 asks that our American Medical Association update its policy on cardiopulmonary resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications (New HOD Policy); and be it further that our AMA urge AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators (Directive to Take Action); and be it further that our AMA support consistent and uniform legislation across states for the legal protection of untrained personnel who use AEDs in the course of attempting to aid a sudden cardiac arrest victim. (Directive to Take Action)

Your Reference Committee heard strong testimony in support of Resolution 211. Your Reference Committee heard testimony that Resolution 211 will help increase use of AEDs in public sudden cardiac arrest events. Your Reference Committee agrees with testimony that the term “untrained personnel” should to be deleted as it is confusing and ambiguous. Your Reference Committee heard testimony that by deleting this term, resulting policy will be unambiguous and consistent with the reasonable person standard that currently underlies Good Samaritan laws across the country. Accordingly, your Reference Committee recommends that Resolution 211 be adopted as amended.

(15) RESOLUTION 212 – DEVELOPMENT AND IMPLEMENTATION OF GUIDELINES FOR RESPONSIBLE MEDIA COVERAGE OF MASS SHOOTINGS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be adopted in lieu of Resolution 212:

DEVELOPMENT AND IMPLEMENTATION OF RECOMMENDATIONS FOR RESPONSIBLE MEDIA COVERAGE OF MASS SHOOTINGS

RESOLVED, that our AMA encourage the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations or best practices for media coverage of mass shootings. (New HOD Policy)

Resolution 212 asks that our American Medical Association encourage the Centers for Disease Control and Prevention, the National Institute of Mental Health, the Associated Press Managing Editors, the National Press Photographers Association, and other relevant organizations to develop guidelines for media coverage of mass shootings in a manner that is unlikely to provoke additional incidents. (New HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 212. Testimony was provided that research suggests that an incident of a mass shooting increases the probability of another mass shooting in the immediate future, and the contagion effect was demonstrated in the mid-1990's with suicides, which led to the development of media coverage guidelines by the Centers for Disease Control and Prevention (CDC), the World Health Organization, and media organizations. Your Reference Committee also heard testimony that recommended that the resolution be amended to encourage the development of recommendations or best practices by the CDC, in collaboration with other public and private organizations, rather than "guidelines," for media coverage of mass shootings, and that the following language in the resolved clause should be deleted since it is too vague: "in a manner that is unlikely to provoke additional incidents." Accordingly, your Reference Committee recommends that an alternate resolution be adopted in lieu of Resolution 212.

(16) RESOLUTION 216 – MEDICARE PART B COMPETITIVE ACQUISITION PROGRAM (CAP)

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 216 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate that any revised Medicare Part B Competitive Acquisition Program meet the following standards to improve the value of the program by lowering the cost of drugs without undermining quality of care:
(1) it must be genuinely voluntary and not penalize practices ~~which~~ that choose not to participate;

(2) it should provide supplemental payments to ~~support complex care coordination and management for cancer patients, including~~ reimburse~~ment for~~ costs associated with ~~the administration of anticancer drugs such as~~ special handling and storage for Part B ~~hazardous~~ drugs

(3) it must not reduce reimbursement for services related to provision/administration of Part B drugs, and reimbursement should be indexed to an appropriate healthcare inflation rate;

(~~3~~)(4) it should permit flexibility such as allowing for variation in orders that may occur on the day of treatment, and allow for the use of CAP-acquired drugs at multiple office locations;

(~~4~~)(5) it should allow practices to choose from multiple vendors to ensure competition, and should also ensure that vendors meet appropriate safety and quality standards;

(~~5~~)(6) it should include robust and comprehensive patient protections which include preventing delays in treatment, helping patients find assistance or alternative payment arrangements if they cannot meet the cost-sharing responsibility, and vendors should bear the risk of non-payment of patient copayments in a way that does not penalize the physician;

~~(6) it should not be tied to negotiated discounts~~ (7) it should not allow vendors to restrict patient access using utilization management policies such as step therapy; and

(~~7~~)(8) it should not force disruption of current systems which have evolved to ensure patient access to necessary medications.

RECOMMENDATION B:

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

Resolution 216 asks that our American Medical Association advocate that any revised Medicare Part B Competitive Acquisition Program meet the following standards to improve the value of the program by lowering the cost of drugs without undermining quality of care: (1) it must be genuinely voluntary and not penalize practices which choose not to participate; (2) it should provide supplemental payments to support complex care coordination and management for cancer patients, including reimbursement for costs associated with the administration of anticancer drugs such as special handling and storage for hazardous drugs; (3) it should permit flexibility such as allowing for variation in orders that may occur on the day of treatment, and allow for the use of CAP-acquired drugs at multiple office locations; (4) it should allow practices to choose from multiple vendors to ensure competition, and should also ensure that vendors meet appropriate safety and quality standards; (5) it should include robust and comprehensive patient protections which include preventing delays in treatment, helping patients find assistance or alternative payment arrangements if they cannot meet the cost-sharing responsibility, and vendors should bear the risk of non-payment of patient copayments in a way that does not penalize the physician; and (6) it should not be tied to negotiated discounts such as rebates to pharmacy benefit managers given in exchange for implementing utilization management policies like step therapy. (New HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 216. Your Reference Committee heard testimony that the physicians in community practice must have access to affordable Part B drugs and the payment should cover actual costs. Your Reference Committee also heard testimony that a new competitive acquisition program should account for all of the issues raised in the resolved of this resolution. Your Reference Committee heard testimony of an amendment that included a provision that our AMA oppose models that do not meet the criteria set out in Resolution 216. Your Reference Committee believes that this language could hamper our AMA's efforts to advocate and negotiate on this important issue because future alternatives may be offered and our AMA may not be able to support potentially beneficial options. Therefore, your Reference Committee recommends adoption of Resolution 216 as amended.

(17) RESOLUTION 220 – SUPPORTING MENTAL HEALTH TRAINING PROGRAMS FOR CORRECTIONS OFFICERS AND CRISIS INTERVENTION TEAMS FOR LAW ENFORCEMENT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 220 be amended by addition and deletion to read as follows.

RESOLVED, That our American Medical Association support legislation and federal funding for evidence-based training programs by qualified professionals aimed at educating corrections officers in effectively interacting with ~~mentally ill populations~~ people with mental health diagnoses in ~~federal prisons~~ all detention and correction facilities. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 220 be adopted as amended.

Resolution 220 asks that our American Medical Association support legislation and federal funding for evidence-based training programs aimed at educating corrections officers in effectively interacting with mentally ill populations in federal prisons. (New HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 220, which addresses the important issues of mental health training programs for corrections officers and crisis intervention teams for law enforcement. Your Reference Committee heard further testimony that corrections officers can play a vital role in the proper treatment of offenders with mental illness but generally receive very little training in mental health issues, making violence between inmates and officers commonplace.

Your Reference Committee also heard testimony that our AMA already has strong policy supporting mental health crisis interventions, H-345.972, "Mental Health Crisis Interventions", as a means for jail diversion and community-based treatment options for those with severe mental illness. Testimony further indicated that AMA policy also supports federal funding to encourage increased community and law enforcement participation training including evidence-based crisis intervention training programs, as they have been shown efficacious in

promoting jail diversion for individuals experiencing a mental-health related crisis. However, this policy does not specifically apply to educating and supporting law enforcement officials in federal or state prisons. Your Reference Committee heard testimony (1) that evidence-based training programs should be conducted by qualified professionals; (2) to change "mentally ill populations" to "people with mental health diagnoses"; and (3) to change "federal prisons" to be more expansive and cover "all detention and correction facilities." Accordingly, your Reference Committee agrees with these changes and recommends that Resolution 220 be adopted as amended.

(18) RESOLUTION 224 – FAIRNESS IN THE CENTERS FOR MEDICARE & MEDICAID SERVICES AUTHORIZED QUALITY IMPROVEMENT ORGANIZATION'S (QIO) MEDICAL CARE REVIEW PROCESS

RECOMMENDATION A:

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

RESOLVED, that our American Medical Association advocate ~~seek by regulation and/or legislation~~ to change ~~amend~~ the Centers for Medicare and Medicaid Services (CMS) quality improvement organization (QIO) process to mandate an opportunity for practitioners and/or providers to request an additional review when the QIO initial determination peer review and the QIO reconsideration peer review are in conflict (Directive to Take Action)

RESOLVED, that our AMA advocate ~~seek by regulation and/or legislation~~ to require CMS authorized QIOs to disclose to practitioners and/or providers when the QIO peer reviewer is not a peer match and is reviewing a case outside of their area of expertise (Directive to Take Action);

RESOLVED, that our AMA advocate ~~seek by regulation and/or legislation~~ to require CMS authorized QIOs to disclose in their annual report, the number of peer reviews performed by reviewers without the same expertise as the physician being reviewed. (Directive to Take Action)

RECOMMENDATION B:

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

Resolution 224 asks that our American Medical Association seek by regulation and/or legislation to amend the Centers for Medicare and Medicaid Services (CMS) quality improvement organization (QIO) process to mandate an opportunity for practitioners and/or providers to request an additional review when the QIO initial determination peer review and the QIO reconsideration peer review are in conflict (Directive to Take Action); and be it further,

that our AMA seek by regulation and/or legislation to require CMS authorized QIOs to disclose to practitioners and/or providers when the QIO peer reviewer is not a peer match and is reviewing a case outside of their area of expertise (Directive to Take Action); and be it further, that our AMA seek by regulation and/or legislation to require CMS authorized QIOs to disclose in their annual report, the number of peer reviews performed by reviewers without the same expertise as the physician being reviewed. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 224. Your Reference Committee heard testimony that our AMA has existing policy regarding Quality Improvement Organization (QIO), including offering due process and fairness for physicians, requiring physician consent before disclosure of QIO review determinations, mandating the utilization of specialty-specific physician reviewers, and to annually publish the names of physician reviewers with credentials and specialties. Your Reference Committee heard further testimony that our AMA submitted to CMS a letter in October that implements the Resolves of Resolution 224. This letter includes advocating for similar due process procedures for physicians and patients, allowing for physician-to-physician conversations at the second level of review, notifying physicians when a peer reviewer does not have similar expertise or specialty as the physician subject to the QIO process, and to disclose the number of peer reviews performed by reviewers without the same expertise. However, your Reference Committee also heard testimony that existing AMA policy does not specifically address the issues identified in Resolution 224. Your Reference Committee believes that Resolution 224 should be amended to provide flexibility to our AMA in its advocacy activities to include potentially resolving the issues with CMS through subregulatory actions or other activities that are not explicitly regulation or legislation. Accordingly, your Reference Committee recommends that Resolution 224 be adopted as amended.

(19) RESOLUTION 232 – OPPOSITION TO MANDATORY LICENSING REQUIREMENTS FOR QUALIFIED CLINICAL DATA REGISTRIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be <u>adopted in lieu of Resolution 232</u>.

RESOLVED, that our American Medical Association (AMA) oppose any Centers for Medicare and Medicaid Services (CMS) proposal that would require Qualified Clinical Data Registries (QCDR) measure owners, as a condition of measure approval for reporting in Merit-based Incentive Payment System (MIPS) and other Medicare quality payment programs, to enter into a free license agreement with CMS that would allow other QCDRs to use the owner's measures without a direct license with the measure owner; and be it further (Directive to Take Action)

RESOLVED, that our AMA oppose any CMS proposal that would require inclusion of CMS as a party in a QCDR measure

licensing agreement between the QCDR measure owner and another; and be it further (Directive to Take Action)

RESOLVED, that our AMA support in situations where QCDR measures are shared between the original measure owner and another QCDR, that the latter QCDR:

1. Must adhere to certain standards and terms set out by the QCDR measure owner on measure implementation and data capture, including data validity and reliability, plus fair remuneration for measure development and ongoing measure stewardship.
2. Must have demonstrated clinical expertise in medicine, quality measure development and improvement by providing methods to ensure data quality, routine metric reporting, and quality improvement consultation. (New HOD Policy)

Resolution 232 asks that our American Medical Association actively oppose any Centers for Medicare & Medicaid Services (CMS) proposal that would require qualified clinical data registry (QCDR) measure owners, as a condition of measure approval for reporting in the Merit-based Incentive Payment System and other Medicare quality payment programs, to enter into a license agreement with CMS that would allow other QCDRs to use the owner's measures without a fee or without a direct license with the measure owner. (Directive to Take Action)

Your Reference Committee heard generally supportive testimony for Resolution 232. Your Reference Committee heard testimony that our AMA opposed the CMS proposal to undermine QCDR measure ownership and development in the physician fee schedule. Your Reference Committee also heard testimony that CMS did not finalize the proposal. Your Reference Committee heard further testimony that even though CMS did not finalize the proposal, this issue may come up again in future rulemaking. An amendment was offered to address the concerns of Resolution 232 through adherence to and implementation of standards and terms set by a specialty's QCDR including demonstrating clinical expertise and providing methods to ensure data quality. Your Reference Committee understands that the first Resolve means that our AMA would oppose CMS requiring QCDR measure owners as a condition of measure approval to enter into a free license agreement. Your Reference Committee further understands that Resolution 232 does not prevent QCDR measure owners from providing to CMS the QCDR measures for free. Accordingly, your Reference Committee recommends that an alternate resolution that reflects these amendments be adopted in lieu of Resolution 232.

(20) RESOLUTION 235 – INAPPROPRIATE USE OF CDC GUIDELINES FOR PRESCRIBING OPIOIDS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be <u>adopted in lieu of Resolution 235</u>:

RESOLVED, that our American Medical Association (AMA) applaud the Centers for Disease Control and Prevention (CDC) for its efforts to prevent the incidence of new cases of opioid misuse, addiction, and overdose deaths (Directive To Take Action)

RESOLVED, that our AMA continue to communicate with the nation's largest pharmacy chains, pharmacy benefit managers, National Association of Insurance Commissioners, Federation of State Medical Boards, and National Association of Boards of Pharmacy opposing communications being sent to physicians that include a blanket proscription against filing prescriptions for opioids that exceed numerical thresholds without taking into account the diagnosis and previous response to treatment for a patient and any clinical nuances that would support such prescribing as falling within standards of good quality patient care. (Directive To Take Action)

RESOLVED, that Policies H-120.924, D-95.987, D-160.981, H-265.998, and H-220.951 be reaffirmed. (Reaffirm Existing HOD Policy)

Resolution 235 asks that our American Medical Association applaud the Centers for Disease Control and Prevention (CDC) for its efforts to prevent the incidence of new cases of opioid misuse, addiction, and overdose deaths; and be it further, that no entity should use MME (morphine milligram equivalents) thresholds as anything more than guidance and that MME thresholds should not be used to completely prohibit the prescribing of, or the filling of prescriptions for, medications used in oncology care, palliative medicine care, and addiction medicine care (New HOD Policy); and be it further, that our AMA communicate with the nation's largest pharmacy chains and pharmacy benefit managers to recommend that they cease and desist with writing threatening letters to physicians and cease and desist with presenting policies, procedures and directives to retail pharmacists that include a blanket proscription against filling prescriptions for opioids that exceed certain numerical thresholds without taking into account the diagnosis and previous response to treatment for a patient and any clinical nuances that would support such prescribing as falling within standards of good quality patient care (New HOD Policy); and be it further, that AMA Policy opposing the legislating of numerical limits on medication dosage, duration of therapy, numbers of pills/tablets, etc., be reaffirmed (Reaffirm HOD Policy); and be it further, that physicians should not be subject to professional discipline or loss of board certification or loss of clinical privileges simply for prescribing opioids at a quantitative level that exceeds the MME thresholds found in the CDC Guidelines (New HOD Policy); and be it further, that our AMA encourage the Federation of State Medical Boards and its member boards, medical specialty societies, and other entities (including, possibly, the CDC) to develop improved guidance on management of pain and management of potential withdrawal syndromes and other aspects of patient care for "legacy patients" who may have been treated for extended periods of time with high-dose opioid therapy for chronic non-malignant pain. (New HOD Policy)

Your Reference Committee heard supportive testimony of the intent of Resolution 235. Your Reference Committee heard testimony that the third resolve should be amended to reflect that our AMA is already working with national pharmacy chains regarding physicians who have received letters about exceeding numerical thresholds. Your Reference Committee also heard

testimony that our AMA already has strong policy regarding many of the resolves in Resolution 235, including opposing specific doses or durations limits on pharmacologic therapy not supported by medical evidence and protecting due process for medical staff, professional discipline, and board certifications that covers physicians being subject to professional actions for prescribing opioids at a quantitative level that exceeds CDC guidelines. Further testimony indicated that it would redundant to ask FSMB to develop improved guidance because our AMA's "End the Epidemic" website has more than 400 state- and specialty-specific resources. Accordingly, your Reference Committee recommends that an alternate resolution be adopted in lieu of Resolution 235, including reaffirming existing policy.

Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care H-120.924
Our AMA will: (1) urge the National Association of Boards of Pharmacy, Federation of State Medical Boards (FSMB), and National Association of Insurance Commissioners (NAIC) to support having national pharmacy chains, health insurance companies, and pharmacy benefits managers (PBMs) testify at state-level public hearings by state medical/pharmacy boards and state departments of insurance, on whether the pharmacy chains, health insurance companies, and PBMs' policies to restrict the prescribing/dispensing of opioid analgesics are in conflict with state insurance laws or state laws governing the practice of medicine and pharmacy; and (2) oppose specific dose or duration limits on pharmacologic therapy that are not supported by medical evidence and clinical practice.
BOT Rep. 17, A-18

Prevention of Opioid Overdose D-95.987
1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate. 2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose. 3. Our AMA will support the development and implementation of appropriate education programs for persons in recovery from opioid addiction and their friends/families that address how a return to opioid use after a period of abstinence can, due to reduced opioid tolerance, result in overdose and death. (Res. 526, A-06 Modified in lieu of Res. 503, A-12 Appended: Res. 909, I-12 Reaffirmed: BOT Rep. 22, A-16 Modified: Res. 511, A-18)

Promotion of Better Pain Care D-160.981
1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; and (b) encourages relevant specialties to collaborate in studying the following: (i) the scope of practice and body of knowledge encompassed by the field of pain medicine; (ii) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of

quality pain care; (iii) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (iv) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic. 2. Our AMA encourages relevant stakeholders to research the overall effects of opioid production cuts. 3. Our AMA strongly urges the US Drug Enforcement Administration to base any future reductions in aggregate production quotas for opioids on actual data from multiple sources, including prescribing data, and to proactively monitor opioid quotas and supply to prevent any shortages that might develop and to take immediate action to correct any shortages. 4. Our AMA encourages the US Drug Enforcement Administration to be more transparent when developing medication production guidelines. 5. Our AMA and the physician community reaffirm their commitment to delivering compassionate and ethical pain management, promoting safe opioid prescribing, reducing opioid-related harm and the diversion of controlled substances, improving access to treatment for substance use disorders, and fostering a public health based-approach to addressing opioid-related morbidity and mortality. (Res. 321, A-08 Appended: Res. 522, A-10 Reaffirmed in lieu of Res. 518, A-12 Reaffirmed: BOT Rep. 19, A-16 Reaffirmed in lieu of Res. 117, A-16 Appended: Res. 927, I-16 Appended: Res. 526, A-17 Modified: BOT Action in response to referred for decision Res. 927, I-16)

Guidelines for Due Process H-265.998
While it is not possible to develop universal guidelines for due process, voluntary utilization of the following general guidelines for due process, adapted in each instance to suit the circumstances and conditions of the health care organization and within the requirements of the applicable laws of the jurisdiction, should assist in providing the type of hearing which the law in each jurisdiction requires: (1) The physician should be provided with a statement, or a specific listing, of the charges made against him or her. (2) The physician is entitled to adequate notice of the right to a hearing and a reasonable opportunity of no less than 30 days to prepare for the hearing. (3) It is the duty and responsibility of the hearing officer to conduct a fair, objective, expeditious and independent hearing pursuant to established rules. (4) The rules of procedure should clearly define the extent to which attorneys may participate in the hearing. (5) The physician against whom the charges are made should have the opportunity to be present at the hearing and hear all of the evidence against him or her. (6) The physician is entitled to the opportunity to present a defense to the charges against him or her. (7) To the extent feasible, the hearing panel should evaluate the issues and evidence presented related to the proposed corrective action while blinded to the patient outcome. (8) The hearing panel should render a decision based on the evidence produced at the hearing. (9) The hearing panel should include in its decision the conclusions reached and actions recommended and, as an important focus if feasible, remedial steps for the physician and for the health care facility itself. When feasible, the hearing panel should include terms that permit measurement and validation of the completed remediation process. (10) The hearing panel should endeavor to state its findings, the clinical basis and support for its findings, its recommendations, and actions as clearly as possible. (11) Within 10 days of the receipt of the hearing panel's decision, the physician, medical executive committee or health care organization, if it brought the correction action, has the right to request an appellate review. The written request for an appellate review shall include an identification of the grounds for appeal and a clear and concise statement of the facts and/or evidence in support of the appeal. The grounds for an appeal of the decision shall be: (a) substantial non-compliance with the procedures required in the medical

staff bylaws; or (b) the decision is against the manifest weight of the evidence. If an appellate review is to be conducted, the appeal board shall schedule the appellate review and provide notice to the physician, medical executive committee and the health care organization. The MEC shall appoint an appeal board consisting of members of the medical staff who did not sit on the original hearing panel, or, at the request of the MEC, the governing body or at least three members thereof may sit as the appeal board. The appeal board shall consider the record of the hearing before the hearing panel. If the appeal board determines that significant relevant evidence, which could bear on the outcome of the proceeding, was not entertained by the hearing panel, it may refer the matter back to the hearing panel for further deliberation or, at the appeal board's discretion, it may receive and consider the new evidence. Similarly, if the appeals board determines that there was not substantial compliance with the hearing procedures in the medical staff bylaws, the appeal board may refer the matter back to the hearing body or, at the appeal board's discretion, it may convene additional hearings to correct any defect in the process. Upon completion of the appeal board's deliberations, the appeal board shall present its recommendation(s) to the governing body as to whether the recommendations(s) of the hearing body should be affirmed, modified, or reversed. (12) In any hearing, the interest of patients and the public must be protected. (BOT Rep. II, A-80 Reaffirmed: Sunset Report, I-98 Amended: BOT Action in response to referred for decision BOT Rep. 23, A-05 Reaffirmed: Res. 12, A-06 Reaffirmed: BOT Rep. 06, A-16)

Medical Staff Membership H-220.951
Our AMA (1) requests The Joint Commission to require that conditions for hospital medical staff membership be based only on the physician's professional training, experience, qualifications, and adherence to medical staff bylaws; and (2) will work toward protecting the due process rights of physicians when medical staff privileges are terminated without appropriate due process as described by the medical staff bylaws. (Res. 721, I-91 Reaffirmed by Res. 802, I-94 Reaffirmed: CLRPD 1, A-04 Reaffirmation A-05 Modified: CMS Rep. 1, A-15)

(21) RESOLUTION 202 – ENABLING METHADONE TREATMENT OF OPIOID USE DISORDER IN PRIMARY CARE SETTINGS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 202 be referred.

Resolution 202 asks that our American Medical Association study the implications of removing those administrative and/or legal barriers that hamper the ability of primary care physician practices to dispense methadone, as part of medication assisted treatment (Directive to Take Action); and be it further, that our AMA study the implications of working with other Federation stakeholders to identify the appropriate educational tools that would support primary care practices in dispensing ongoing methadone for appropriate patients as part of medication-assisted treatment. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 202. Your Reference Committee heard testimony that our AMA should study the implications of removing barriers that hamper the ability of physician practices to dispense methadone. Your Reference Committee also heard testimony that our AMA does not need to study working with the state

and specialty societies regarding these issues but instead should work directly with the Federation members on enabling methadone treatment. However, your Reference Committee also heard that no appropriate educational tools that would support primary care practices in dispensing ongoing methadone exist at this moment and that this also needs study. Your Reference Committee heard testimony on the need for the physician community to continue reducing the stigma associated with methadone use and medication assisted treatment. Of note, your Reference Committee heard concerns about providing access to methadone to primary care physicians without sufficient training, and only for the singular indication of opioid use disorder. Given the nature of the testimony, your Reference Committee recommends referral.

(22) RESOLUTION 204 – RESTRICTION ON IMG MOONLIGHTING

RECOMMENDATION:

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

Resolution 204 asks that our American Medical Association advocate for changes to federal legislation allowing physicians with a J-1 visa in fellowship training programs the ability to moonlight. (New HOD Policy)

Your Reference Committee heard supportive but mixed testimony on Resolution 204. Your Reference Committee heard testimony that our AMA has strong policy regarding limiting duty hours for residents/fellows. Your Reference Committee heard testimony that International Medical Graduates moonlighting will improve access to care for underserved populations in certain areas around the U.S. facing a physician shortage. Your Reference Committee also heard testimony that J-1 visa classifications are explicitly reserved for educational and cultural exchange. Further testimony indicated that J-1 visa classifications are not a work visa and, therefore, J-1 physician participants are not permitted to engage in any work outside of their approved program of graduate medical education. Your Reference Committee also heard testimony that more research needs to be done on the impact of a potential shift of AMA Policy including policies related to patient safety, fatigue/stress on the fellow, professional licensing, payment, and liability. As a result, your Reference Committee believes that Resolution 204 should be referred.

(23) RESOLUTION 206 – REPEALING POTENTIAL PENALTIES ASSOCIATED WITH MIPS
RESOLUTION 231 – REDUCING THE REGULATORY BURDEN IN HEALTH CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolutions 206 and 231 be referred.

Resolution 206 asks that our American Medical Association advocate to repeal all potential penalties associated with the MIPS program. (Directive to Take Action) Resolution 231 asks that our American Medical Association work to support the repeal of the Merit-Based Incentive Payment System (MIPS) (Directive to Take Action); and be it further, that upon repeal of MIPS,

our AMA oppose any federal efforts to implement any pay-for-performance programs unless such programs add no significant regulatory or paperwork burdens to the practice of medicine and have been shown, by evidence-based research, to improve the quality of care for those served. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolutions 206 and 231. Your Reference Committee heard testimony that a similar resolution was debated in June at our Annual Meeting, and that the House of Delegates voted against adoption. Your Reference Committee heard testimony that Congress passed the Bipartisan Budget Act of 2018 and included five key MACRA improvements supported by our AMA. These improvements will allow CMS and physicians three additional years to gradually transition into the MIPS program. Your Reference Committee also heard testimony that our AMA continues to work closely with CMS to recommend a variety of improvements to the MIPS program including simplified scoring methodology, reduced reporting burden, and the ability for physicians to report data across multiple performance categories. Your Reference Committee heard further testimony that the cost of repealing MIPS penalties would need to be offset and would potentially come at the expense of bonuses or across the board cuts in physician payments; and that would impact even the physicians who are currently exempt from MIPS, such as small practices. Testimony also indicated that the second Resolve in Resolution 231 would effectively disallow our AMA to continue its support for the Administration's and Congress' efforts to advance successful, innovative payment models as well as the technologies needed to support the models. Your Reference Committee also heard testimony that our AMA should continue to work to simplify and improve the MIPS program, and work with state and specialty societies to help develop more opportunities for physicians to participate in Alternative Payment Models, which would allow them to be exempt from the MIPS program. Your Reference Committee has concerns that repealing penalties associated with MIPS or repealing the entire program could result in an alternative program that may be less desirable. Your Reference Committee understands the continued efforts made by our AMA and specialties to improve MIPS; however, given the Board of Trustees interest in evaluating this issue further, your Reference Committee recommend that Resolutions 206 and 231 be referred.

(24) RESOLUTION 210 – FORCED ORGAN HARVESTING FOR TRANSPLANTATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 210 be <u>referred for decision</u>.

Resolution 210 asks that our American Medical Association reaffirm Ethical Opinion E-6.1.1, "Transplantation of Organs from Living Donors,", and believes that transplant surgeons, especially those who come to the United States for training in transplant surgery, must agree to these guidelines, and that American medical and hospital institutions not be complicit in any ethical violations or conflicts of interest (New HOD Policy); and be it further, that our AMA representatives to the World Medical Association request an independent, interdisciplinary (not restricted to transplant surgeons), transparent investigation into the Chinese practices of organ transplantation including (but not limited to): the source of the organs as well as the guidelines followed; and to report back on these issues as well as the status of Prisoners of Conscience as sources of transplantable organs (Directive to Take Action); and be it further that our AMA call upon the U.S. Government to protect the large number of transplant tourists by implementing legislation to regulate the evolving, ethical challenges by initiating a Reciprocal Transplant Transparency Act which would blacklist countries that do not meet the same transparency and ethical standards practiced in the U.S. (such as the public listing of annual transplant numbers by every transplant center to permit scrutiny). (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 210. Testimony was presented by the sponsor and supporters of the resolution that according to the Executive Director and founder of Doctors Against Forced Organ Harvesting, a medical non-governmental organization, there are substantiated allegations of "state-sponsored domestic organ trafficking and harvesting" in China from executed prisoners, and from prisoners of conscience, including Uighurs, House Christians, Tibetans and Falun Gong practitioners. There was further testimony that although the Chinese Medical Association has stated that the practice of harvesting organs from the deceased prisoners was outlawed as of January 1, 2015, and that organ tourism is prohibited by Chinese law, there have been reports of dramatic increases in transplant tourism and evidence suggesting that the supply of organs in China could not realistically come from legitimate organ donation programs. Your Reference Committee also heard that transplant tourism has become a lucrative source of income in China, leading to a rapid expansion of the transplant infrastructure in China, and China has declared the Hainan Islands to be a special economic zone for medical tourism.

Testimony was also presented that ethical guidelines for transplantation are set forth by our AMA, the World Medical Association (WMA), and the World Health Organization, and the U.S. Congress passed House Resolution 343 in 2016, calling for an end to forced organ harvesting from Falun Gong prisoners of conscience in China; that a Resolution was introduced in the U.S. Senate in 2017; and the European Parliament also passed Written Declaration 48 in 2016, calling for investigations and an end to forced organ harvesting from Falun Gong prisoners of conscience in China.

Testimony was presented that the first Resolve clause of Resolution 210 is problematic and should not be adopted because technically, opinions in the Code of Medical Ethics, such as E-6.1.1, are not reaffirmed—they are AMA ethics policy in perpetuity until or unless CEJA proposes a revision at its own initiative or in response to a request from the HOD or the Board. Testimony was further presented that the ask in the second Resolve clause, for the WMA to conduct an investigation, is not within the scope of WMA's activity. While the WMA can conduct, and has conducted, fact-finding missions, the organization does not engage in investigations of member nations. Your Reference Committee also heard testimony that third Resolved clause is also problematic because it would require our AMA to call upon the federal government to initiate a treaty process to regulate the evolving, ethical challenges of transplant tourism. Your Reference Committee heard testimony that this is beyond our AMA's

resources, and it is generally our AMA's practice to work through the WMA on international issues such as those raised in Resolution 210.

Accordingly, given the complicated and serious issue of forced organ harvesting and the concerns raised by the Resolve clauses of Resolution 210, your Reference Committee recommends that Resolution 210 be referred for decision.

(25) RESOLUTION 215 – EXTENDING THE MEDICAL HOME TO MEET FAMILIES WHEREVER THEY GO

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 215 not be adopted.

Resolution 215 asks that our American Medical Association develop model legislation to permit primary care physicians, who work in medical homes/primary care practices that satisfy the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home Recognition Program guidelines, and who have documented a face-to-face patient-care relationship, to provide telehealth services for the patient when the patient travels to any of the fifty states. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 215. Your Reference Committee also heard testimony that our AMA has strongly advocated to protect the long-standing position of licensure being state based including that state laws where the patient is located should apply including licensure, medical practice, and liability laws. Your Reference Committee heard additional testimony that state-based exceptions and carve outs will further complicate oversight and regulation, patient protections, and spawn challenging conflicts of laws problems. Furthermore, your Reference Committee heard testimony that our AMA already has strong policy promoting quality telemedicine. Accordingly, your Reference Committee recommends that Resolution 215 not be adopted.

(26) RESOLUTION 230 – NONPROFIT HOSPITALS AND NETWORK HEALTH SYSTEMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 230 not be adopted.

Resolution 230 asks that our American Medical Association lobby federal legislators, the Internal Revenue Service, and/or other appropriate federal officials to investigate and review whether non-profit hospitals and other applicable health systems are meeting the provisions of Internal Revenue Code relating to their tax-exempt status when they restrict or otherwise limit medical staff privileges or maintain closed medical staffs, and take appropriate action to ensure that non-profit hospitals and other applicable health systems continue to meet charitable purposes as required under applicable sections of the Internal Revenue Code. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 230. Your Reference Committee heard testimony that the Internal Revenue Service does not strictly say that limiting or closing a medical staff will cost a hospital its 501(c)(3) status and that this policy is long-

standing. Your Reference Committee heard testimony that an effort to change this would likely be strenuously opposed by the hospital industry. Your Reference Committee heard testimony that existing AMA policy does not support this resolution—our AMA policy does not say that hospitals cannot close or limit their medical staffs or enter into exclusive contracts with select physicians; it says that the medical staff should be consulted before such actions are taken and that physicians who are not included on the medical staff need to be given due process before being excluded in support of referral. Accordingly, your Reference Committee recommends that Resolution 230 be not adopted.

(27) RESOLUTION 234 – NEGLIGENT CREDENTIALING ACTIONS AGAINST HOSPITALS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 234 not be adopted.

Resolution 234 asks that our American Medical Association recognize that "negligent credentialing" lawsuits undermine the overall integrity of the credentialing process, potentially resulting in adverse impacts to patient access and quality of care (New HOD Policy); and be it further, that our AMA actively oppose state legislation and court action recognizing "negligent credentialing" as a cause of action that would allow for patients to sue a hospital and medical staff (Directive to Take Action); and be it further, that our AMA work with state medical societies and medical specialty associations in those states that recognize the tort of negligent credentialing to advocate that such claims should place the highest standard of proof on the plaintiff. (Direct to Take Action)

Your Reference Committee heard mixed testimony on Resolution 234. Your Reference Committee heard testimony that patients are already protected under various medical liability or medical malpractice laws and that the threat of liability for negligent credentialing may result in hospitals and health plans adopting more stringent criteria to credential licensed physicians. Your Reference Committee also heard testimony that negligent credentialing is an action that is taken against a hospital and not a physician. Testimony further indicated that our AMA should focus our resources on protecting physicians from liability. Your Reference Committee also heard testimony that removing the hospital from a liability action could be at the expense of the physician and leave the physician with having greater liability. Your Reference Committee heard further testimony that asking our AMA to argue for the highest standard of proof (which is reasonable doubt) for a negligence case weakens AMA's advocacy efforts because proof beyond reasonable doubt is only meant for criminal cases. Accordingly, your Reference Committee recommends that Resolution 234 not be adopted.

(28) RESOLUTION 218 – ALTERNATIVES TO TORT FOR MEDICAL LIABILITY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-435.943, H-435.978, H-435.993, D-435.974, and D-435.992 be reaffirmed in lieu of Resolution 218.

That our American Medical Association study and/or develop options for alternatives to the tort system that will: assure fair compensation to individuals harmed as a result of systems or clinician error in the process of receiving medical care and separately; identify and hold accountable physicians, other practitioners and health care delivery systems for questionable practice through professional review and quality management as well as identify opportunities for improving systems to maximize the safety of medical care (as in New Zealand and other countries or the Candor strategy). (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 218. Your Reference Committee heard testimony that our AMA remains on the forefront on the medical liability issue by advocating at both the federal and state levels and conducting research to improve the liability system. Our AMA remains committed to advocate for proven reforms—such as caps on non-economic damages—to resolve this problem. Your Reference Committee also heard testimony that based on existing AMA policy our AMA will continue advocating for innovative reforms, such as health courts and early disclosure models, to complement traditional reforms. Your Reference Committee also heard testimony that a fair or no-fault compensation system as proposed in Resolution 218 runs contrary to AMA policy by lowering the standard of proof required for a judgment against a physician, lacks requirements that medical experts have the same or similar expertise as the defendant, and could increase National Practitioner Databank Reporting. Accordingly, given the strong AMA policy on medical liability, your Reference Committee recommends reaffirming policy in lieu of Resolution 218.

AMA Support for State Medical Societies' Efforts to Implement MICRA-Type Legislation H-435.943
Our AMA supports state medical associations in their opposition to proposals to replace a state medical liability system with a no-fault liability or Patient Compensation System, unless those proposals are consistent with AMA policy. (BOT Rep. 02, I-16)

Federal Medical Liability Reform H-435.978
Our AMA: (1) supports federal legislative initiatives implementing the following medical liability reforms: (a) limitation of $250,000 or lower on recovery of non-economic damages; (b) the mandatory offset of collateral sources of plaintiff compensation; (c) decreasing sliding scale regulation of attorney contingency fees; and (d) periodic payment for future awards of damages; (2) reaffirms its support for the additional reforms identified in Report L (A-89) as appropriate for a federal reform vehicle. These are: (a) a certificate of merit requirement as a prelude to filing medical liability cases; and (b) basic medical expert witness criteria; (3) supports for any federal initiative incorporating provisions of this type would be expressly conditional. Under no circumstances would support for federal preemptive legislation be extended or maintained if it would undermine effective tort reform provisions already in place in the states or the ability of the states in the future to enact tort reform tailored to local needs. Federal preemptive legislation that endangers state-based reform will be actively opposed. Federal initiatives incorporating extended or ill-advised regulation of the practice of medicine also will not be supported. Effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform. (BOT Rep. S, I-89, BOT Rep. I-93-53, Reaffirmed: BOT Rep. 8, I-98, Reaffirmation A-00, Reaffirmation I-03, Reaffirmed: Sub. Res. 910, I-03, Reaffirmed: Res. 206, I-09, Reaffirmation A-10, Reaffirmed: Sub. Res. 222, I-10, Reaffirmed: Res. 206, A-11, Reaffirmed in lieu of Res. 205, I-11, Reaffirmed in lieu of first resolve of Res. 214, I-15)

Tort Liability Reform H-435.993
Our AMA: (1) supports the efforts of state medical societies to form coalitions supporting tort reform in each state and representing the numerous interests adversely affected by present escalating tort liability costs; and (2) believes these coalitions should address such issues as reform of laws governing product and professional liability, and development of appropriate public education programs regarding the impact and cost to consumers of present liability laws. (Sub. Res. 6, A-84, Reaffirmed by CLRPD Rep. 3 - I-94, Reaffirmation A-00, Reaffirmation I-08, Reaffirmed: BOT Rep. 09, A-18)

Health System and Litigation Reform D-435.974
Our AMA will: (1) press vigorously and creatively for inclusion of effective medical litigation reforms as part of the comprehensive federal health system/insurance reform debate now underway in Washington, DC; and (2) consider and, as necessary, negotiate with federal policymakers on a wide range of litigation reform policy options to gain inclusion of a remedy in the health system reform package. These options might include traditional tort reforms, recovery limitations similar to those of the Veterans Administration (VA) system, demonstration/pilot programs on alternate dispute resolution systems such as the VA model and health courts, and/or other effective options to preserve patient access to care. (Res. 209, A-09, Reaffirmed: Sub. Res. 222, I-10)

Liability Reform D-435.992
Our AMA: (1) in concert with a coalition for civil liability reform, shall develop a broad-based and sustained grassroots member mobilization campaign to communicate its call for immediate legislative relief from the current tort system to our congressional representatives and senators; (2) will work for passage of significant legislation in both houses of the US Congress on liability reform in this congressional year; and (3) will work with state and national medical specialty societies to develop and implement a comprehensive strategic plan that will address all aspects of the growing medical liability crisis to ensure that federal medical liability reform legislation continues to move forward through the legislative process. (Sub. Res. 215, A-02, Reaffirmation I-03, Appended: Sub. Res. 910, I-03, Modified: BOT Rep. 28, A-13)

(29) RESOLUTION 225 – “SURPRISE” OUT OF NETWORK BILLS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-285.904 be reaffirmed in lieu of Resolution 225.

Resolution 225 asks that our American Medical Association advocate that any federal legislation on “surprise” out of network medical bills be consistent with AMA Policy H-285.904, “Out-of-Network Care,” and apply to ERISA plans not subject to state regulation (New HOD Policy); and be it further, that our AMA advocate that such federal legislation protect state laws that do not limit surprise out of network medical bills to a percentage of Medicare or health insurance fee schedules. (New HOD Policy)

Your Reference Committee heard testimony that our AMA is committed to developing patient-centered solutions to unanticipated out-of-network care and addressing the financial burden patients may face when they incur unexpected expenses for care not covered by their health

insurance company. Your Reference Committee heard that concepts addressed in Resolution 225 already addressed in existing out-of-network policy H-285-904, which was recently adopted after substantial conversation with state and specialty societies. Testimony also stated that this policy clearly outlines both a fair payment standard and requires that advocacy around our out-of-network policy should be directed at all health plans, including ERISA-regulated plans.

Your Reference Committee heard testimony for and against the addition of a recommendation that our AMA develop model federal legislation consistent with existing policy relative to this subject. Testimony for adoption suggested that our AMA develop model federal legislation consistent with existing policy. Testimony against adding this language raised concerns that drafting a federal model bill could limit our AMA's and other physician groups' flexibility to work with Congress to craft a workable solution. Your Reference Committee heard that if our AMA drafted a federal bill, and then Congress uses different language or a different statutory pathway than what our AMA proposed, our AMA would potentially be in a position of having to oppose or not support the bill that would otherwise achieve the same result, while other physician groups and other stakeholders would not be under the same constraint. Your Reference Committee agrees with these concerns, and notes that our current AMA Policy H-285.904 was just amended at our 2018 Annual Meeting with language that is very clear—our AMA will advocate for Policy H-285.904 "for all health plans, including ERISA plans." Your Reference Committee heard testimony that this means our AMA will continue to advocate for federal legislation, whether it is achieved through the Public Health Service Act, the Social Security Act, the Internal Revenue Code, ERISA, or other federal statutes, as long as it meets the criteria of our policy. Furthermore, your Reference Committee heard testimony that our AMA is currently engaged in discussions with Members of Congress who are attempting to draft a federal solution to balance billing. These discussions include working with other physician groups, and that these physician groups have all been largely aligned around current AMA policy as the basis for negotiations. Your Reference Committee agrees with the concerns raised that altering course now could impact not just our AMA's progress, but that of other physician groups engaged in this advocacy activity. Accordingly, your Reference Committee recommends that Policy H-285.904 be reaffirmed in lieu of Resolution 225.

Out-of-Network Care H-285.904

1. Our AMA adopts the following principles related to unanticipated out-of-network care: A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider. B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans. C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur. D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians. E. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered. F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company. G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular

health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization. H. Mediation should be permitted in those instances where a physicians unique background or skills (e.g. the Gould Criteria) are not accounted for within a minimum coverage standard. 2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans. (Res. 108, A-17; Reaffirmation: A-18; Appended: Res. 104, A-18)

(30) RESOLUTION 228 – MEDICATION ASSISTED TREATMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-185.931, H-95.944, and D-160.981 be reaffirmed in lieu of Resolution 228.

Resolution 228 asks that our American Medical Association advocate for all insurance plans (public and private payers) to provide coverage for medication assisted treatment of opioid use disorder by all qualified physicians. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 228. Your Reference Committee heard testimony that all insurance plans should provide coverage for medication assisted treatment (MAT) of opioid use disorder. Testimony also indicated that our AMA already has existing policy that our AMA advocate for all payers to provide coverage for MAT. Further testimony stated that our AMA is also already advocating for all forms of MAT to be on the lowest cost-sharing tier of a plan formulary and also to remove prior authorization and other health plan barriers to MAT. Accordingly, your Reference Committee recommends reaffirming Policies H-185.931, H-95.944, and D-160.981.

Workforce and Coverage for Pain Management H-185.931
1. Our AMA supports efforts to improve the quality of care for patients with pain, ensuring access to multiple analgesic strategies, including non-opioid options and interventional approaches when appropriate, with a focus on achieving improvement in function and activities of daily living. 2. Our AMA supports guidance on pain management for different clinical indications developed by the specialties who manage those conditions and disseminated the same way other clinical guidelines are promoted, such as through medical journals, medical societies, and other appropriate outlets. 3. Our AMA will advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician led, and recognize the interdependency of treatment methods in addressing chronic pain. 4. Our AMA supports health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits. 5. Our AMA supports efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, as well as an expanded behavioral health workforce to improve the availability of services to

address the psychological, behavioral, and social aspects of pain and pain management within multidisciplinary pain clinics. Patients and their caregivers should be involved in the decision-making process. 6. Our AMA supports an expanded availability of comprehensive multidisciplinary pain medicine clinics for patients in both urban and rural areas, and an improvement in payment models for comprehensive multidisciplinary pain clinics services such that such services can become more financially viable. (CMS/CSAPH Rep. 1, A-15 Reaffirmed: BOT Rep. 5, I-15 Reaffirmed: BOT Rep. 19, A-16 Reaffirmed in lieu of Res. 117, A-16 Modified: BOT Rep. 38, A-18)

Third-Party Payer Policies on Opioid Use Disorder Pharmacotherapy H-95.944
Our AMA opposes federal, state, third-party and other laws, policies, rules and procedures, including those imposed by Pharmacy Benefit Managers working for Medicaid, Medicare, TriCare, and commercial health plans, that would limit a patient's access to medically necessary pharmacological therapies for opioid use disorder, whether administered in an office-based opioid treatment setting or in a federal regulated Opioid Treatment Program, by imposing limitations on the duration of treatment, medication dosage or level of care. (Res. 710, A-13)

Promotion of Better Pain Care D-160.981
1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; and (b) encourages relevant specialties to collaborate in studying the following: (i) the scope of practice and body of knowledge encompassed by the field of pain medicine; (ii) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care; (iii) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (iv) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic. 2. Our AMA encourages relevant stakeholders to research the overall effects of opioid production cuts. 3. Our AMA strongly urges the US Drug Enforcement Administration to base any future reductions in aggregate production quotas for opioids on actual data from multiple sources, including prescribing data, and to proactively monitor opioid quotas and supply to prevent any shortages that might develop and to take immediate action to correct any shortages. 4. Our AMA encourages the US Drug Enforcement Administration to be more transparent when developing medication production guidelines. 5. Our AMA and the physician community reaffirm their commitment to delivering compassionate and ethical pain management, promoting safe opioid prescribing, reducing opioid-related harm and the diversion of controlled substances, improving access to treatment for substance use disorders, and fostering a public health based-approach to addressing opioid-related morbidity and mortality. (Res. 321, A-08 Appended: Res. 522, A-10 Reaffirmed in lieu of Res. 518, A-12 Reaffirmed: BOT Rep. 19, A-16 Reaffirmed in lieu of Res. 117, A-16)

Madam Speaker, this concludes the report of Reference Committee B. I would like to thank Sue Bornstein, MD, Tilden Childs, MD, Daniel P. Edney, MD, Ross F. Goldberg, MD, Raymond Lorenzoni, MD, Bruce A. MacLeod, MD, and all those who testified before the Committee.

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Chair

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-18)

Report of Reference Committee C

Peter C. Amadio, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Medical Education Report 5 – Reconciliation of AMA Policy on Medical Student Debt
2. Council on Medical Education Report 6 – Reconciliation of AMA Policy on Resident/Fellow Contracts and Duty Hours
3. Resolution 951 – Prevention of Physician and Medical Student Suicide
4. Resolution 953 – Support for the Income-Driven Repayment Plans
5. Resolution 954 – VHA GME Funding
6. Resolution 955 – Equality for COMLEX and USMLE

RECOMMENDED FOR ADOPTION AS AMENDED

7. Council on Medical Education Report 1 – Competency of Senior Physicians
8. Council on Medical Education Report 3 – Developing Physician-Led Public Health/Population Health Capacity in Rural Communities
9. Council on Medical Education Report 4 – Reconciliation of AMA Policy on Primary Care Workforce
10. Resolution 956 – Increasing Rural Rotations During Residency
11. Resolution 957 – Board Certifying Bodies
12. Resolution 961 – Protect Physician-Led Medical Education

RECOMMENDED FOR REFERRAL

13. Resolution 959 – Physician and Medical Student Mental Health and Suicide

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

14. Resolution 960 – Inadequate Residency Slots

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

Resolution 958 – National Health Service Corps Eligibility

Note: The following two items were withdrawn and not considered.

Resolution 952 – IMG Section Member Representation on Committees/Task Forces/Councils

Resolution 962 – Improve Physician Health Programs

(1) COUNCIL ON MEDICAL EDUCATION REPORT 5 - RECONCILIATION OF AMA POLICY ON MEDICAL STUDENT DEBT

RECOMMENDATION:

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

Council on Medical Education Report 5 asks:
1. That our American Medical Association (AMA) adopt as policy "Principles of and Actions to Address Medical Education Costs and Student Debt" the language shown in column 1 of Appendix A of this report; and
2. That our AMA rescind the following policies, as shown in Appendix C:

- D-305.956, "AMA Participation in Reducing Medical Student Debt"
- D-305.957, "Update on Financial Aid Programs"
- D-305.962, "Tax Deductibility of Student Loan Payments"
- D-305.966, "Reinstatement of Economic Hardship Loan Deferment"
- D-305.970, "Proposed Revisions to AMA Policy on Medical Student Debt"
- D-305.975, "Long-Term Solutions to Medical Student Debt"
- D-305.977, "Deductibility of Medical Student Loan Interest"
- D-305.978, "Mechanisms to Reduce Medical Student Debt"
- D-305.979, "State and Local Advocacy on Medical Student Debt"
- D-305.980, "Immediate Legislative Solutions to Medical Student Debt"
- D-305.981, "Financing Federal Consolidation Loans"
- D-305.993, "Medical School Financing, Tuition, and Student Debt"
- D-405.986, "Student Loans and Medicare / Medicaid Participation"
- H-305.926, "Supporting Legislation to Create Student Loan Savings Accounts"
- H-305.928, "Proposed Revisions to AMA Policy on Medical Student Debt"
- H-305.932, "State and Local Advocacy on Medical Student Debt"
- H-305.948, "Direct Loan Consolidation Program"
- H-305.954, "Repayment of Medical School Loans"
- H-305.965, "Student Loans"
- H-305.980, "Student Loan Repayment Grace Period"
- H-305.991, "Repayment of Educational Loans"

Your Reference Committee heard testimony uniformly in favor of the Council on Medical Education's work on consolidating and reconciling multiple AMA policies on this important topic. Limited testimony was received requesting addition of the word "service" to item 5 of the proposed new policy ("Encourage the National Health Service Corps to have service repayment policies that are consistent with other federal loan forgiveness programs"), but your Reference Committee believes this addition is not currently reflected in existing policy, and therefore would be outside the permissible parameters of a reconciliation report. (See AMA Policy G-600.111, "Consolidation and Reconciliation of AMA Policy," which states: "(4) The consolidation process permits editorial amendments for the sake of clarity, so long as the proposed changes are transparent to the House and do not change

the meaning.") Therefore, your Reference Committee recommends that Council on Medical Education Report 5 be adopted and the remainder of the report be filed.

(2) COUNCIL ON MEDICAL EDUCATION REPORT 6 - RECONCILIATION OF AMA POLICY ON RESIDENT/ FELLOW CONTRACTS AND DUTY HOURS

RECOMMENDATION:

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

Council on Medical Education Report 6 asks:
1. That our American Medical Association (AMA) adopt the proposed revisions shown in Appendix A, column 1, for the following three policies:

- H-310.907, "AMA Duty Hours Policy" (with revised title: "Resident/Fellow Clinical and Educational Work Hours")
- H-310.912, "Residents and Fellows' Bill of Rights"
- H-310.929, "Principles for Graduate Medical Education"

2. That our AMA rescind the following seven policies, as shown in Appendix C, and incorporate relevant portions of four of these policies into existing AMA policy:

- D-310.987, "Impact of ACGME Resident Duty Hour Limits on Physician Well-Being and Patient Safety"
- H-310.922, "Determining Residents' Salaries"
- H-310.932, "Annual Contracts for Continuing Residents"
- H-310.947, "Revision of the 'General Requirements' of the Essentials of Accredited Residency Programs"
- H-310.979, "Resident Physician Working Hours and Supervision"
- H-310.988, "Adequate Resident Compensation"
- H-310.999, "Guidelines for Housestaff Contracts or Agreements"

Your Reference Committee heard testimony uniformly in favor of the Council on Medical Education's work on consolidating and reconciling multiple AMA policies on this important topic. Limited testimony was provided that a revision to H-310.912, "Residents and Fellows' Bill of Rights," section E.(3), to replace "maternity and paternity leave" with "family and medical leave," could be problematic for PGY-1 resident physicians, if interpreted as referring to the federal Family Medical Leave Act (FMLA). The Council on Medical Education clarified the intent of the policy to be broader than the FMLA; your Reference Committee therefore recommends adoption of Council on Medical Education Report 6.

(3) RESOLUTION 951 - PREVENTION OF PHYSICIAN AND MEDICAL STUDENT SUICIDE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 951 be adopted.

Resolution 951 asks: That our American Medical Association request that the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education collect data on medical student, resident and fellow suicides to identify patterns that could predict such events.

Online testimony regarding this item was supportive of the resolution's intent, although some testimony noted that the Council on Medical Education is currently writing a report related to this topic, and suggested referral. Your Reference Committee heard impassioned in-person testimony regarding the devastating effects of burnout and depression, and all who spoke were in agreement regarding the urgency of this issue. Additional testimony agreed that collection of data by the bodies named in this resolution is an important step, but also highlighted that those named groups work only with medical students and residents, and that these data are also needed for physicians who have completed their training. Your Reference Committee agrees, and encourages the Council on Medical Education to consider this data gap when presenting their related report to the HOD at the 2019 Annual Meeting. Overall, however, this resolution commanded widespread support. Therefore, your Reference Committee recommends that Resolution 951 be adopted.

(4) RESOLUTION 953 - SUPPORT FOR THE INCOME-DRIVEN REPAYMENT PLANS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 953 be adopted.

Resolution 953 asks: That our American Medical Association advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student loan burden.

Your Reference Committee heard uniformly positive testimony on this item. Our AMA policy supports maintaining and expanding both state and federal programs that minimize the impact of student loan debt on the pursuit of a career in medicine. As such, income-driven repayment plans are critical programs that enable a diverse range of students the ability to specialize in their desired discipline within the profession's workforce. These plans relieve the burden of medical student loan debt by setting loan payments as a percentage of the new physician's income. Payments become more manageable with the repayment period extended from the standard 10 years to up to 25 years, and the remaining balance can be forgiven at the end of that period. Lifting the burden of medical student debt through the evaluation and development of feasible and effective loan

forgiveness programs is a laudable goal for our AMA; your Reference Committee believes this resolution provides our AMA the means to this end. Therefore, your Reference Committee recommends that Resolution 953 be adopted.

(5) RESOLUTION 954 - VHA GME FUNDING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolves 1 and 2 of Resolution 954 be adopted.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolve 3 in Resolution 954 be referred.

Resolution 954 asks: That our American Medical Association continue to support the mission of the Department of Veterans Affairs Office of Academic Affiliations for expansion of graduate medical education (GME) residency positions; That our AMA collaborate with appropriate stakeholder organizations to advocate for preservation of Veterans Health Administration (VHA) funding for GME and support its efforts to expand GME residency positions in the federal budget and appropriations process; and That our AMA oppose service obligations linked to VHA GME residency or fellowship positions, particularly for resident physicians rotating through the VA for only a portion of their GME training.

Your Reference Committee heard mixed testimony on this resolution. Our AMA has long been an advocate for preservation and expansion of GME funding to mitigate projected physician shortages and ensure that positions are available for medical school graduates applying to residency programs. Currently, there are no service obligations for VA residency programs, and our AMA does not have existing policy opposing a GME expansion plan linked to a service obligation. However, it was noted that all funding for residency/fellowship positions, whether from private, Veterans Administration (VA), and/or Centers for Medicare & Medicaid Services (CMS) sources, carries with it the expectation that residents/fellows perform service for patients during their years in the training program. Due to the complicated rules at institutions that sponsor residency programs related to full funding for a resident full-time employee, it was recommended that Resolve 3 be referred for further study. Therefore, your Reference Committee recommends that Resolves 1 and 2 of Resolution 954 be adopted and Resolve 3 be referred.

(6) RESOLUTION 955 - EQUALITY FOR COMLEX AND USMLE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 955 be adopted.

Resolution 955 asks: That our American Medical Association promote equal acceptance of the USMLE and COMLEX at all United States residency programs; That our AMA work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores; and That our AMA work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system.

Your Reference Committee heard strong testimony in support of this resolution. Testimony acknowledged that the United States Medical Licensing Examination (USMLE) and Comprehensive Osteopathic Medical Licensing Examination (COMLEX) are credentialing examinations that have been increasingly used in recent years as selection criteria for acceptance into a residency program, which is not their intended purpose. Testimony also noted the high costs of these examinations and the large disparity between program directors' usage of the examinations for residency selection criteria, with greater preference for the USMLE over the COMLEX, despite testimony indicating a strong correlation of scores among people who take both exams. This resolution is calling for equal acceptance of the USMLE and COMLEX at all U.S. residency programs. This is consistent with HOD Policy H-275.953, "The Grading Policy for Medical Licensure Examinations," which promotes the principle that selection of residents should be based on a broad variety of evaluative criteria, and proposes that ACGME program requirements state clearly that residency program directors not use NBME or USMLE ranked passing scores as a screening criterion for residency selection. This issue is timely as the single accreditation pathway and National Resident Matching Program will be the primary avenue that all osteopathic medical students will participate in for residency application. In addition, the COMLEX examination is a graduation requirement for all osteopathic medical students, and the examination taken by one in five future physicians is a measurement tool that all program directors should be familiar with and accept. Therefore, your Reference Committee recommends that Resolution 955 be adopted.

(7) COUNCIL ON MEDICAL EDUCATION REPORT 1 - COMPETENCY OF SENIOR PHYSICIANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1.a and 1.e in Council on Medical Education Report 1 be amended by addition and deletion, to read as follows:

1. That our American Medical Association (AMA) make available to all interested parties the Assessment of Senior/Late Career Physicians Guiding Principles:

a) Evidence-based: The development of guidelines for assessing and screening senior/late career physicians is based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. ~~Current research suggests that physician competency and practice performance decline with increasing years in practice~~ Some physicians may suffer from declines in practice performance with advancing age. ~~However, r~~Research ~~also~~ suggests that the effect of age on an individual physician's competency can be highly variable, and wide variations are seen in cognitive performance with aging.

e) Fair and equitable: The goal of screening and assessment is to optimize physician competency and performance through education, remediation, and modifications to physicians' practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care. ~~When public health or patient safety is directly threatened, removal from practice is one potential outcome.~~

RECOMMENDATION B:

Madam 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 be filed.

Council on Medical Education Report 1 asks: 1. That our American Medical Association (AMA) make available to all interested parties the Assessment of Senior/Late Career Physicians Guiding Principles: a) Evidence-based: The development of guidelines for assessing and screening senior/late career physicians is based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. Current research suggests that physician competency and practice performance decline with increasing years in practice. However, research also suggests that the effect of age on an individual physician's competency can be highly variable, and wide variations are seen in cognitive performance with aging. b) Ethical: Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines/standards for monitoring and assessing both their own and their colleagues' competency. c) Relevant: Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians' ability to perform the tasks specifically required in their practice environment. d) Accountable: The ethical obligation of the profession to the health of the public and patient safety should be the primary driver for establishing guidelines and informing decision making about physician screening and assessment results. e) Fair and equitable: The goal of screening and assessment is to optimize physician competency and performance through education, remediation, and modifications to physicians' practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care. When public health or patient safety is directly threatened, removal from practice is one potential outcome. f) Transparent: Guidelines, procedures or methods of screening and assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations and standards against which performance will be judged, and the possible outcomes of the screening or assessment. g) Supportive: Education and/or remediation practices that result from screening and /or assessment procedures should be supportive of physician wellness, ongoing, and proactive. h) Cost conscious: Procedures and screening mechanisms that are distinctly different from "for cause" assessments should not result in undue cost or burden to senior physicians providing patient care. Hospitals and health care systems should provide easily accessible screening assessments for their employed senior physicians. Similar procedures and screening mechanisms should be available to senior physicians who are not employed by hospitals and health care systems; 2. That our AMA encourage the Federation of State Medical Boards, Council of Medical Specialty Societies, and other interested organizations to develop educational materials on the effects of age on physician practice for senior/late career physicians; and 3. That Policy D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians," be rescinded, as having been fulfilled by this report.

Your Reference Committee heard strong support for Council on Medical Education Report 1. This report outlines a set of Guiding Principles developed by the Council on Medical Education, with extensive feedback and assistance from our AMA's Work Group on Assessment of Senior/Late Career Physicians, which included key stakeholders representing physicians, medical specialty societies, accrediting and certifying organizations, hospitals and other health care institutions, and patients' advocates, as well as other content experts who research physician competence and administer assessment

programs. The Guiding Principles provide direction and serve as a reference for the development of guidelines for screening and assessing senior/late career physicians. Other testimony alluded to the application of the Guiding Principles, and queried whether our AMA was advocating for a screening process for senior/late career physicians. Further testimony from the Council on Medical Education clarified that this is not the case, and that the Principles are intended to ensure that physicians can self-advocate when discussions regarding their competency are raised by their institutions or practices. In addition, the first recommendation (Guiding Principle 1.a) was amended to reflect testimony that not all physicians suffer from declines in practice performance with advancing age. Your Reference Committee also deleted text in Guiding Principle 1.e that appeared to be redundant. Your Reference Committee therefore recommends that Council on Medical Education Report 1 be adopted as amended.

(8) COUNCIL ON MEDICAL EDUCATION REPORT 3 - DEVELOPING PHYSICIAN-LED PUBLIC HEALTH/ POPULATION HEALTH CAPACITY IN RURAL COMMUNITIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 3 in Council on Medical Education Report 3 be amended by addition and deletion, to read as follows:

That our AMA encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and Accreditation Council for Graduate Medical Education (ACGME) to highlight public/population health leadership learning opportunities to all learners, but especially encourage dissemination to women physician groups and other groups typically ~~and those who are~~ underrepresented in medicine. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 3 be adopted as amended and the remainder of the report be filed.

Council on Medical Education Report 3 asks:
1. That Policy D-295.311, “Developing Physician Led Public Health / Population Health Capacity in Rural Communities,” be rescinded, as having been fulfilled by this report;
2. That our American Medical Association (AMA) reaffirm the following policies:

- D-295.327, “Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum”

- D-305.964, "Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion"
- D-305.974, "Funding for Preventive Medicine Residencies"
- H-425.982, "Training in the Principles of Population-Based Medicine"
- D-440.951, "One-Year Public Health Training Options for all Specialties"
- H-440.954, "Revitalization of Local Public Health Units for the Nation"
- H-440.888, "Public Health Leadership"
- H-440.969, "Meeting Public Health Care Needs Through Health Professions Education"

3. That our AMA encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and Accreditation Council for Graduate Medical Education (ACGME) to highlight public/population health leadership learning opportunities to all learners, but especially to women and those who are underrepresented in medicine; and 4. That our AMA encourage public health leadership programs to evaluate the effectiveness of various leadership interventions.

Online testimony regarding this report was unanimously supportive. Testimony specifically applauded the report's thorough listing of currently available training opportunities across the continuum, as well as the call for relevant organizations to highlight learning opportunities in rural and public health. Your Reference Committee also heard overwhelmingly positive in-person testimony, which noted that the report effectively addresses the HOD mandate to study innovative approaches that support interested physicians as they seek qualifications and credentials in preventive medicine/public health to strengthen public health leadership. Testimony also, however, identified important related policy gaps, and your Reference Committee agrees that our AMA should consider future policy that addresses these gaps, such as emphasizing concrete steps physicians currently practicing in rural areas can take to enhance their own public/population health skills. A minor editorial change was proposed to one of the report's recommendations, which your Reference Committee agrees will strengthen the report's policy impact. Therefore, your Reference Committee recommends that Council on Medical Education Report 3 be adopted as amended.

(9) COUNCIL ON MEDICAL EDUCATION REPORT 4 - RECONCILIATION OF AMA POLICY ON PRIMARY CARE WORKFORCE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 in Council on Medical Education 4 be <u>amended by addition and deletion</u>, to read as follows:

That our American Medical Association (AMA) adopt as policy "Principles of and Actions to Address Primary Care Workforce" the language shown in column 1 in Appendix A to this report<u>, with the following deletion to item 8</u>. (New HOD Policy)

8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued~~, including such innovations as a three-year medical school curriculum that leads directly to primary care residency programs~~. The establishment of appropriate administrative units for family medicine should be encouraged.

RECOMMENDATION B:

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

Council on Medical Education Report 4 asks:

1. That our American Medical Association (AMA) adopt as policy "Principles of and Actions to Address Primary Care Workforce" the language shown in column 1 in Appendix A to this report;

2. That our AMA rescind the following policies, as shown in Appendix C:

- D-200.979, "Barriers to Primary Care as a Medical School Choice"
- D-200.994, "Appropriations for Increasing Number of Primary Care Physicians"
- H-200.956, "Appropriations for Increasing Number of Primary Care Physicians"
- H-200.966, "Federal Financial Incentives and Medical Student Career Choice"
- H-200.973, "Increasing the Availability of Primary Care Physicians"
- H-200.975, "Availability, Distribution and Need for Family Physicians"
- H-200.977, "Establishing a National Priority and Appropriate Funding for Increased Training of Primary Care Physicians"
- H-200.978, "Loan Repayment Programs for Primary Care Careers"
- H-200.982, "Significant Problem of Access to Health Care in Rural and Urban Underserved Areas"
- H-200.997, "Primary Care"
- H-295.956, "Educational Grants for Innovative Programs in Undergraduate and Residency Training for Primary Care Careers"
- H-300.957, "Promoting Primary Care Services Through Continuing Medical Education"
- H-310.973, "Primary Care Residencies in Community Hospitals"

3. That H-200.972, "Primary Care Physicians in the Inner City," be amended by addition and deletion, and a title change, to read as follows:

"Primary Care Physicians in Underserved Areas"

Our AMA should pursue the following plan to improve the recruitment and retention of physicians in ~~the inner city~~ underserved areas: (1) Encourage the creation and pilot-testing of school-based, ~~church~~ faith-based, and community-based urban/rural "family ~~H~~health clinics, with an emphasis on health education, prevention, primary care, and prenatal care. (2) Encourage the affiliation of these family health clinics with ~~urban~~ local medical schools and teaching hospitals. ~~(3) Promote medical student rotations through the various inner-city neighborhood family health clinics, with financial assistance to the clinics to compensate their teaching efforts. (4) Encourage medical schools and teaching hospitals~~

~~to integrate third- and fourth-year undergraduate medical education and residency training into these teams.~~ (~~5~~3) Advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies. ~~(6) Study the concept of having medical schools with active outreach programs in the inner city offer additional training to physicians from nonprimary care specialties who are interested in achieving specific primary care competencies. (7) Consider expanding opportunities for practicing physicians in other specialties to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family practice, internal medicine, pediatrics, etc. These may be developed so that they are part-time, thereby allowing physicians enrolling in these programs to practice concurrently.~~ (~~8~~4) Encourage the AMA Senior Physicians ~~Services Group~~ Section to consider the ~~use~~ involvement of retired physicians in underserved ~~urban~~ settings ~~of retired physicians~~, with appropriate mechanisms to ensure their competence. (~~9~~5) Urge ~~urban~~ hospitals and medical societies to develop opportunities for physicians to work part-time to staff ~~urban~~ health clinics that help meet the needs of underserved patient populations. (~~10~~6) Encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who ~~serve the inner-city poor~~ help meet the needs of underserved patient populations. ~~(11) Urge medical schools to seek out those students whose profiles indicate a likelihood of practicing in underserved urban areas, while establishing strict guidelines to preclude discrimination. (12) Encourage medical school outreach activities into secondary schools, colleges, and universities to stimulate students with these profiles to apply to medical school. (13) Encourage medical schools to continue to change their curriculum to put more emphasis on primary care.(14) Urge state medical associations to support the development of methods to improve physician compensation for serving this population, such as Medicaid case management programs in their respective states.~~(~~15~~7) Urge ~~urban~~ hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to ~~fill gaps in urban care~~ help meet the needs of underserved patient populations. (~~16~~) ~~Urge CMS to explore the use of video and computer capabilities to improve access to and support for urban primary care practices in underserved settings. (17) Urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.(18) Continue to urge measures to enhance payment for primary care in the inner city.~~

Your Reference Committee heard testimony overwhelmingly in support of the work of the Council on Medical Education on reconciling multiple AMA policies on this important topic. One friendly amendment was proffered to the Council on Medical Education prior to the Reference Committee hearing by the Young Physicians Section, which noted that a phrase in item 8 of the proposed new policy was not currently reflected in existing policy, and therefore would be outside the permissible parameters of a reconciliation report. (See AMA Policy G-600.111, "Consolidation and Reconciliation of AMA Policy," which states: "[4.] The consolidation process permits editorial amendments for the sake of clarity, so long as the proposed changes are transparent to the House and do not change the meaning.") This deletion was supported by other delegations that testified. Therefore, your Reference Committee recommends that Council on Medical Education Report 4 be adopted as amended.

(10) RESOLUTION 956 - INCREASING RURAL ROTATIONS DURING RESIDENCY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolve 1 of Resolution 956 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors~~,~~ and volunteer faculty~~,~~ ~~etc.~~ for rural rotations in residency (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolve 2 of Resolution 956 be amended by deletion, to read as follows:

~~RESOLVED, That our AMA work with the ACGME, the American Board of Medical Specialties, the Federation of State Medical Boards, CMS and other interested stakeholders to lessen or remove regulations or requirements on residency training and physician practice that preclude formal educational experiences and rotations for residents in rural areas (Directive to Take Action); and be it further~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolve 3 of Resolution 956 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates and that our AMA work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas. (Directive to Take Action)~~; and be it further~~

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolve 4 of Resolution 956 be amended by deletion, to read as follows:

~~RESOLVED, That our AMA work with state and specialty societies and other interested stakeholders to identify appropriately qualified rural physicians who would be willing to serve as preceptors for rural rotations in residency (Directive to Take Action); and be it further~~

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolve 5 of Resolution 956 be amended by deletion, to read as follows:

~~RESOLVED, That our AMA work with the ACGME and other interested stakeholders to lessen the documentation requirements for off-site rural rotations during residency so that affiliated rural supervising faculty can focus on educating rotating residents (Directive to Take Action); and be it further~~

RECOMMENDATION F:

Madam Speaker, your Reference Committee recommends that Resolve 6 of Resolution 956 be amended by deletion, to read as follows:

~~RESOLVED, That our AMA work with interested stakeholders to study other ways to increase training in rural areas (Directive to Take Action); and be it further~~

RECOMMENDATION G:

Madam Speaker, your Reference Committee recommends that Resolve 7 of Resolution 956 be amended by deletion, to read as follows:

~~RESOLVED, That our AMA formulate an actionable plan of advocacy based on the results of the above study with the goal of increasing residency training in rural areas. (Directive to Take Action)~~

RECOMMENDATION H:

Madam Speaker, your Reference Committee recommends that Resolution 956 be adopted as amended.

Resolution 956 asks: That our American Medical Association work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to encourage and incentivize qualified rural physicians to serve as preceptors, volunteer faculty, etc. for rural rotations in residency; That our AMA work with the ACGME, the American Board of Medical Specialties, the Federation of State Medical Boards, CMS and other interested stakeholders to lessen or remove regulations or requirements on residency training and physician practice that preclude formal educational experiences and rotations for residents in rural areas; That our AMA work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; That our AMA work with state and specialty societies and other interested stakeholders to identify appropriately qualified rural physicians who would be willing to serve as preceptors for rural rotations in residency; That our AMA work with the ACGME and other interested stakeholders to lessen the documentation requirements for off-site rural rotations during residency so that affiliated rural supervising faculty can focus on educating rotating residents; That our AMA work with interested stakeholders to study other ways to increase training in rural areas; and That our AMA formulate an actionable plan of advocacy based on the results of the above study with the goal of increasing residency training in rural areas.

Online testimony was mostly supportive of the resolution's intent, although Resolves 2 and 5 were recommended against adoption by the Council on Medical Education because our AMA lacks authority to define residency regulations or requirements. In-person testimony also strongly supported this resolution, with multiple delegates highlighting the problems associated with physician maldistribution, the importance of exposure to rural practice for all trainees, and the barriers programs face when attempting to provide this exposure. Significant amendments were offered during the hearing, which help to clarify and focus the impact of this item. Your Reference Committee therefore recommends that Resolution 956 be adopted as amended.

(11) RESOLUTION 957 - BOARD CERTIFYING BODIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolve 1 of Resolution 957 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association ~~conduct a~~continue study<u>ing</u> ~~of~~ the certifying bodies that compete with the American Board of Medical Specialties and ~~issue~~<u>provide</u> a<u>n update in the Council on Medical Education's annual</u> report <u>on maintenance of certification at A-19</u> ~~opining on the qualifications of each such certifying body and whether each such certifying body should be added to the list of approved certifying entities in states where they are not currently approved;~~<u>.</u>

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolve 2 of Resolution 957 be amended by deletion, to read as follows:

~~RESOLVED, That our AMA develop model state legislation that would encourage competition among qualified certifying bodies and would modify board certification requirements such that maintenance of certification participation would not be a requirement for board recertification.~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 957 be <u>adopted as amended</u>.

Resolution 957 asks: That our American Medical Association conduct a study of the certifying bodies that compete with the American Board of Medical Specialties and issue a report opining on the qualifications of each such certifying body and whether each such certifying body should be added to the list of approved certifying entities in states where they are not currently approved; and That our AMA develop model state legislation that would encourage competition among qualified certifying bodies and would modify board certification requirements such that maintenance of certification participation would not be a requirement for board recertification.

Your Reference Committee heard mixed online and in-person testimony on this item. Testimony noted that the Council on Medical Education studied the available certification processes for physicians and reported to the HOD in Council on Medical Education Reports 2-A-16 and 2-A-17, both of which were adopted. It was also noted that the resolution's reference to the list of certifying entities may be potentially inaccurate since

only those state medical boards that regulate physician use of the term “board certified” maintain a list of “approved certifying entities.” Our AMA maintains robust policy on maintenance of certification (MOC), including policy related to state legislative efforts. Our AMA has also developed two model bills, including the Right to Treat Act, which prohibits licensing boards, hospitals, and insurers from requiring a physician to maintain certification for licensure, licensure renewal, hospital staff or admitting privileges, or reimbursement. In addition, our AMA’s Truth in Advertising Act contains a drafting note that allows for physicians certified by the American Board of Medical Specialties (ABMS) and American Osteopathic Association (AOA) and certain alternative specialty certification boards to advertise themselves as being board certified. This model legislation specifically allows a pathway by which non-ABMS/AOA specialty boards may demonstrate their validity. The ABMS and AOA are both private entities whose standards are not subject to regulation by the AMA, and thus, model legislation to that effect would not be effective. Furthermore, action by our AMA to develop model legislation that separates continuing board certification/MOC from board certification could eventually invite government intervention and oversight, resulting in more tedious physician bureaucracy and regulation. That said, there was still concern expressed via testimony about lowering the costs for physicians to be certified and improving the quality of certification services. The Council continues to be actively engaged in following the work of the Vision for the Future Commission, which is scheduled to release recommendations to the ABMS regarding the future of continuing certification in February 2019. The Council will address the Vision Commission’s recommendations fully in its A-19 report on this topic. Accordingly, for all of the above reasons, your Reference Committee recommends that Resolution 957 be adopted as amended.

(12) RESOLUTION 961 - PROTECT PHYSICIAN-LED MEDICAL EDUCATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy H-310.912 and H-295.955 be reaffirmed in lieu of Resolve 1 of Resolution 961.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolve 2 of Resolution 961 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA ~~provide~~ publicize to medical students, residents, and fellows ~~a clear online resource outlining~~ their rights, as per Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education guidelines, to physician-led education and a means to report violations without fear of retaliation. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 961 be adopted as amended.

Resolution 961 asks: That our American Medical Association, in their role as a member organization of the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education, strongly advocate for the rights of medical students, residents, and fellows to be trained, supervised, and evaluated by licensed physicians; and That our AMA provide medical students, residents, and fellows a clear online resource outlining their rights, as per Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education guidelines, to physician-led education and a means to report violations without fear of retaliation.

Your Reference Committee heard mixed testimony on this item, with support for adoption, referral, and reaffirmation of current policy, highlighting both the complexity and importance of this issue. Many of those who testified on all sides of the issue prefaced their statements with accolades for the role of non-physician educators in their own education and training—analogous to our AMA's model of a physician-led team-based care paradigm that encourages non-physician involvement in a patient's care, under the overall guidance of a physician. That said, it is difficult to question the effectiveness of the physician educator/mentor in this role; physicians should provide education to the next generation of experts. In addition, students and trainees should be able to express concerns about the quality of their education, and their instructors, without fear of retribution from their respective institutions. Your Reference Committee believes that Resolve 1 is already reflected in two existing AMA policies, and recommends their reaffirmation in lieu of Resolve 1. These existing policies support the primacy of physician educators in the clinical setting, yet clearly value the contribution of non-physician educators. Your Reference Committee suggests additions and deletions to Resolve 2 to clarify the intended action and adoption of the Resolve as amended.

Policy recommended for reaffirmation:

H-310.912, "Residents and Fellows' Bill of Rights"

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.

2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.

3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders through various publication methods (e.g., the AMA GME e-letter) this Residents and Fellows' Bill of Rights.

4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.

5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.

6. Our AMA adopts the following 'Residents and Fellows' Bill of Rights' as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENTS AND FELLOWs' BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to

assume progressive responsibility appropriate to their level of education, competence, and experience.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience, and that reflect cost of living differences based on geographical differences.

(3) With Regard to Benefits, Residents and Fellows Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care; b. Education on the signs of excessive fatigue, clinical depression, and substance abuse and dependence; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, maternity and paternity leave and educational leave during each year in their training

program the total amount of which should not be less than six weeks; and e. Leave in compliance with the Family and Medical Leave Act.

F. Duty hours that protect patient safety and facilitate resident well-being and education.

With regard to duty hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with duty-hour requirements set forth by the ACGME or other relevant accrediting body; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that duty-hour requirements are effectively circumvented.

G. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

H-295.955, “Teacher-Learner Relationship In Medical Education”

The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

CODE OF BEHAVIOR
The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a

learning environment that places strong focus on education, high quality patient care, and ethical conduct.

A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher.

In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty.

Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.

On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.

While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.

Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.

Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients.

(13) RESOLUTION 959 - PHYSICIAN AND MEDICAL STUDENT MENTAL HEALTH AND SUICIDE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 959 be referred.

Resolution 959 asks: That our American Medical Association create a new Physician and Medical Student Suicide Prevention Committee with the goal of addressing suicides and mental health disease in physicians and medical students. This committee will be charged with: 1) Developing novel policies to decrease physician and medical trainee stress and improve professional satisfaction. 2) Vociferous, repeated and widespread messaging to physicians and medical students encouraging those with mood disorders to seek help. 3) Working with state medical licensing boards and hospitals to help remove any stigma of mental health disease and to alleviate physician and medical student fears about the consequences of mental illness and their medical license and hospital privileges. 4) Establishing a 24-hour mental health hotline staffed by mental health professionals whereby a troubled physician or medical student can seek anonymous advice. Communication via the 24-hour help line should remain anonymous. This service can be directly provided by the AMA or could be arranged through a third party, although volunteer physician counselors may be an option for this 24-hour phone service.

Online testimony regarding this item was supportive of the resolution’s intent, but testimony also noted that the Council on Medical Education is currently writing a report related to this topic, and therefore recommended referral of this topic for inclusion in that report when it is presented to the HOD at the 2019 Annual Meeting. Your Reference Committee heard in-person testimony in support of much of the resolution, but testimony was mixed regarding calls for the establishment and staffing of a 24-hour mental health hotline. Many called for referral, noting that the Council on Medical Education could consider appropriate deliverables to further establish our AMA’s leadership role in this space, and to make a recommendation regarding the establishment of and role for an AMA committee or task force related to this topic. The Council on Medical Education testified that it will incorporate this content into its planned report to the HOD for the 2019 Annual Meeting. Therefore, your Reference Committee recommends that Resolution 959 be referred.

(14) RESOLUTION 960 - INADEQUATE RESIDENCY SLOTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy D-305.967(32) be reaffirmed in lieu of Resolution 960.

Resolution 960 asks: That our American Medical Association adopt policy to establish parity between the number of medical school graduates and the number of match positions and withhold support for any further increase in medical school enrollment, unless there is a corresponding increase in residency positions; and That our AMA lobby the federal government for increased funding for residency spots, to investigate other sustainable models for residency position funding and to advocate for loan repayment waivers for individuals who fail to match.

Your Reference Committee heard mixed testimony on this item, with the majority, however, in favor of reaffirmation of current policy. In June 2018, the House of Delegates approved the recommendations of Council on Medical Education Report 3-A-18, which was in turn incorporated into Policy D-305.967(32), further clarifying our AMA's policy on funding of residency slots. Some testimony noted a shortage of residency program slots for medical students seeking entry into graduate medical education, but this is not numerically factual unless international medical graduates are included in the total count of available residency slots. It was expressed that any sort of cap on medical student enrollment could send the wrong message, given current and projected shortages in many specialties and geographic areas, and could lead to potential unintended consequences and exacerbation of physician maldistribution in medically underserved areas, and possible restraint of trade concerns. The bulk of testimony was also opposed to any sort of loan repayment waiver for those who fail to match, which could lead to perverse incentives. Reports by our AMA Council on Medical Education are a better and more finely tuned mechanism for the continued evolution of AMA policy on this critical topic for physicians and our patients. In summary, your Reference Committee believes that existing policy covers the intent of this item, and recommends reaffirmation of this policy in lieu of Resolution 960.

Policy recommended for reaffirmation:

Policy D-305.967(32), "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education"

Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school rates of placement into GME as well as GME completion.

Madam Speaker, this concludes the report of Reference Committee C. I would like to thank Jerry P. Abraham, MD, MPH; John C. Moorhead, MD; Lucy Nam; Brigitta J. Robinson, MD, FACS; Martin D. Trichtinger, MD, FACP; and Roxanne Tyroch, MD, FACP; and all those who testified before the committee, as well as our AMA staff, including Catherine Welcher; Carrie Radabaugh; Fred Lenhoff; and Susan Skochelak, MD, MPH.

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John C. Moorhead, MD
American College of Emergency Physicians

Lucy Nam
Medical Student Section
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Brigitta J. Robinson, MD, FACS
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Martin D. Trichtinger, MD, FACP
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Roxanne Tyroch, MD, FACP
(Alternate) Texas

Peter C. Amadio, MD
American Association for Hand Surgery
Chair

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-18)

Report of Reference Committee F

Greg Tarasidis, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Report of the House of Delegates Committee on Compensation of the Officers

2. Council on Long Range Planning and Development Report 1 – Women Physicians Section Five-Year Review

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

3. Board of Trustees Report 1 – Data Used to Apportion Delegates

4. Board of Trustees Report 10 – Training Physicians in the Art of Public Forum

5. Resolution 603 – Support of AAIP's "Desired Qualifications for Indian Health Service Director"

RECOMMENDED FOR REFERRAL

6. Resolution 604 – Physician Health Policy Opportunity

The following resolutions were Recommended Against Consideration:

- Resolution 601 – Creation of an AMA Election Reform Committee
- Resolution 602 – AMA Policy Statement with Editorials

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

RECOMMENDATION:

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

The Report of the House of Delegates Committee on Compensation of the Officers recommends the following recommendations be adopted and the remainder of the report be filed:

1. That there be no change to the current Definitions effective July 1, 2018 as they appear in the Travel and Expenses Standing Rules for AMA Officers for the Governance Honorarium, Per Diem for External Representation and Telephonic Per Diem for External Representation.

2. Annual Health Insurance Stipend (Stipend) – The purpose of this payment is to provide a Health Insurance Stipend (Stipend) to compensate the President, President-Elect and Immediate Past President under age 65, when the President(s) loses his/her employer-provided medical insurance coverage during his/her term. President(s) who lose his/her employer insurance will substantiate his/her eligibility for the Stipend by written notice to the Board Chair detailing the effective date of the loss of coverage and listing covered family members. The President receiving the Stipend will have the sole discretion to determine the appropriate health insurance coverage for the himself/herself and the family, and provide proof of purchasing such coverage to the Board Chair.

   The amount of the Stipend will be 70% of the then current Gold Plan premium in the President(s) state/county of residence for each covered family member. If there are multiple Gold Plans in the state/county, the Stipend will be based on the average of the then current Gold Plan premiums. The amount of the Stipend will be updated January 1 of each Plan year based on then Gold Plan premiums and covered family members. Should a President reach age 65 during his/her term(s), the Stipend will end the month Medicare coverage begins. In all cases the Stipend will end the sooner the President(s) obtains other health insurance coverage, reaches age 65 or the month following the end of his/her term as Immediate Past President. The Stipend will be paid monthly. The amount of the Stipend will be reported as taxable income for the President each calendar year and will be included in this Committee's annual report to the House which documents compensation paid to Officers and the IRS reported taxable value of benefits, perquisites, services and in-kind payments.

3. Except as noted above, there will be no other changes to the Officers' compensation for the period beginning January 1, 2019. (Directive to Take Action)

Your Reference Committee noted that the report reflected the level of commitment needed in supporting our AMA may necessitate the President, President-Elect, and Immediate

Past President reduce his/her work schedule with his/her employer to a part-time status, which may result in the President, President-Elect, and Immediate Past President losing his/her eligibility for employer's health insurance coverage. For this reason, the Compensation Committee is recommending that the President, President-Elect, and Immediate Past President, who are not Medicare-eligible, receive a stipend based on 70% of the then current Gold Plan premium in the Presidents' state/county of residence for each covered family member. The amount of the stipend will be reported as taxable income for the President, President-Elect, and Immediate Past President each calendar year and will be included in the Compensation Committee's annual report to the House of Delegates.

Your Reference Committee received limited testimony in response to the introduction of the revised Report of the House of Delegates Committee on Compensation of the Officers. However, the testimony did raise a specific concern regarding insurance coverage for our Presidents if the President turns 65 years of age during his/her term and the family is ineligible for Medicare. In turn, a representative of the Compensation Committee responded that the issue was noted and will be addressed in a subsequent report at the 2019 Annual Meeting.

Your Reference Committee extends its appreciation to the Compensation Committee for its thorough work on behalf of our House of Delegates.

(2) COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT 1 - WOMEN PHYSICIANS SECTION FIVE-YEAR REVIEW

RECOMMENDATION:

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

Council on Long Range Planning and Development Report 1 recommends that our American Medical Association renew delineated section status for the Women Physicians Section through 2023 with the next review no later than the 2023 Interim Meeting and that the remainder of the report be filed. (Directive to Take Action)

Having received no testimony in opposition to the Council on Long Range Planning and Development Report 1, your Reference Committee wishes to extend its appreciation to the Council and the Women Physicians Section for their cooperative and collaborative efforts to present a thorough review of the Section.

(3) BOARD OF TRUSTEES REPORT 1 - DATA USED TO APPORTION DELEGATES

RECOMMENDATION A:

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

1. Our AMA shall issue an annual, midyear report on or around June 30 to inform each national medical specialty and state medical society of its current AMA membership count status report. (Directive to Take Action)

2. ~~For these reasons, the~~ The Board of Trustees recommends that Resolution 604-A-18 not be adopted and the remainder of this report be filed.

RECOMMENDATION B:

Madam 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.

Board of Trustees Report 1 is presented in response to Resolution 604-A-18, "AMA Delegation Entitlements," which called upon our American Medical Association to continue to provide a count of AMA members for AMA delegation entitlements to the House of Delegates as of December 31 and also provide a second count of AMA members within the first two weeks of the new year and that the higher of the two counts be used for state and national specialty society delegation entitlements during the current year. (Directive to Take Action)

Additionally, Resolution 604 called upon the Council on Constitution and Bylaws to prepare appropriate language to add a second period of time to determine AMA delegation entitlements to be considered by the AMA House of Delegates at its earliest opportunity. (Modify AMA Bylaws)

In their report, the Board of Trustees recommends that Resolution 604-A-18 not be adopted and the remainder of the report be filed.

Your Reference Committee heard testimony supporting original Resolution 604-A-18. Your Reference Committee also sought further clarification as to how the current apportionment process functions. Each state and specialty society receives delegate apportionment for the HOD based on the prior year's membership count as of December 31. As an example, a non-member who chooses to pay next year's dues during the current calendar year is not an actual member of the AMA until January 1 of the ensuing year, although said non-member does receive AMA benefits immediately. If a society wishes to have a new member "count" toward apportionment of delegate seats applied to the

immediate following year, it would need the member to pay appropriate current year dues and, thus, be an actual AMA member during the current calendar year. This process is the same for all state and specialty societies.

Your Reference Committee recognizes there may be delegations in our AMA House of Delegates whose AMA membership count places them on the threshold of acquiring an additional Delegate; therefore, your Reference Committee supports the proffered, amendment to the Board of Trustees report, which serves to provide every delegation in our AMA House of Delegates with a mid-year membership status report with which to adjust recruitment efforts during the latter half of the year to achieve the desired year-end goal.

(4) BOARD OF TRUSTEES REPORT 10 - TRAINING PHYSICIANS IN THE ART OF PUBLIC FORUM

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 10 be amended by addition and deletion to read as follows:

1. Physicians who want to learn more about public speaking can leverage existing resources both within and outside the AMA. AMA can make public speaking tips available through online tools and resources that would be publicized on our website. Physicians and physicians-in-training who want to publicly communicate about the AMA's ongoing work are invited to learn more through the AMA Ambassador program.

   Meanwhile, STEPS Forward provides helpful tips to physicians and physicians-in-training wanting to improve communication within their practice and AMPAC is available for physicians and physicians-in-training who want to advocate and communicate about the needs of patients, ~~and~~ physicians, and physicians-in-training in the pursuit of public office. There are also resources provided to physicians and physicians-in-training at various Federation organizations and through the American Association of Physician Leadership (AAPL) to support those who are interested in training of this nature.

   Because public speaking is a skill that is best learned through practice and coaching in a small group or one-on-one setting, we also encourage individuals to pursue training through their state or specialty medical society or through a local chapter of Toastmasters International.

The Board of Trustees recommends that the AMA's Enterprise Communications and Marketing department work to develop online tools and resources that would be published on the AMA website to help physicians and physicians-in-training learn more about public speaking ~~in lieu of Resolution 606-A-18 and the remainder of the report to be filed~~.

2. That our AMA offer live education sessions at least annually for AMA members to develop their public speaking skills. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 10 be adopted as amended in lieu of Resolution 606-A-18 and the remainder of the Report be filed.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Board of Trustees Report 10 be changed to read as follows:

TRAINING PHYSICIANS AND PHYSICIANS-IN-TRAINING IN THE ART OF PUBLIC SPEAKING

Board of Trustees Report 10 is presented in response to Resolution 606-A-18, which called upon our American Medical Association to establish a program for training physicians in the art and science of conducting public forums in order to ensure that the public is well informed on the health care system of our country. (Directive to Take Action)

In their report, the Board of Trustees recommends that the AMA's Enterprise Communications and Marketing department work to develop online tools and resources that would be published on the AMA website to help physicians learn more about public speaking in lieu of Resolution 606-A-18 and that the remainder of the report to be filed. (Directive to Take Action)

While your Reference Committee received testimony favoring adoption of Board of Trustees Report 10, there was considerable testimony in support of providing in-person training to enhance public speaking skills. Therefore, your Reference Committee recommends that Board of Trustees Report 10 be amended to include live education sessions in conjunction with meetings that are hosted regularly by our AMA.

(5) RESOLUTION 603 - SUPPORT OF AAIP'S "DESIRED QUALIFICATIONS FOR INDIAN HEALTH SERVICE DIRECTOR"

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 603 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support the ~~"Desired Qualifications for the~~ following qualifications for the Director of the Indian Health Service~~"~~ ~~set forth by the Association of American Indian Physicians.~~:

1. Health profession, preferably an MD or DO, degree and at least five years of clinical experience at an Indian Health Service medical site or facility.
2. Demonstrated long-term interest, commitment, and activity within the field of Indian Health.
3. Lived on tribal lands or rural American Indian or Alaska Native community or has interacted closely with an urban Indian community.
4. Leadership position in American Indian/Alaska Native health care or a leadership position in an academic setting with activity in American Indian/ Alaska Native health care.
5. Experience in the Indian Health Service or has worked extensively with Indian Health Service, Tribal, or Urban Indian health programs.
6. Knowledge and understanding of social and cultural issues affecting the health of American Indian and Alaska Native people.
7. Knowledge of health disparities among Native Americans / Alaska Natives, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities.
8. Experience working with Indian Tribes and Nations and an understanding of the Trust Responsibility of the Federal Government for American Indian and Alaska Natives as well as an understanding of the sovereignty of American Indian and Alaska Native Nations.
9. Experience with management, budget, and federal programs.

(New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 603 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 603 be changed to read as follows:

DESIRED QUALIFICATIONS FOR INDIAN HEALTH SERVICE DIRECTOR

Resolution 603 calls upon our AMA to support the "Desired Qualifications for the Director of the Indian Health Service" set forth by the Association of American Indian Physicians. (New HOD Policy)

Having received limited but supportive testimony, your Reference Committee favors our AMA's support of the Association of American Indian Physicians desired qualifications for the Director of the Indian Health Service. Testimony also indicated the importance of having a Director of the Indian Health Service that possess a comprehensive understanding of the needs of this population and qualifications for this position should be outlined in AMA policy.

(6) RESOLUTION 604 - PHYSICIAN HEALTH POLICY OPPORTUNITY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 604 be referred.

Resolution 604 calls upon our AMA, in collaboration with the state and specialty societies, to make it a priority to give physicians the opportunity to serve in federal and state health care agency positions by providing the training and transitional opportunities to move from clinical practice to health policy. (New HOD Policy)

Additionally, Resolution 604 calls upon our AMA to study and report back to the House of Delegates at the 2019 Interim Meeting with findings and recommendations for action on how best to increase opportunities to train physicians in transitioning from clinical practice to health policy. (Directive to Take Action)

Resolution 604 further calls upon our AMA to explore the creation of an AMA health policy fellowship, or work with the Robert Wood Johnson Foundation to ensure that there are designated physician fellowship positions within their Health Policy Fellowship program to train physicians in transitioning from clinical practice to health policy. (Directive to Take Action)

Your Reference Committee heard testimony that it is critical to have physicians with clinical experience serve in government regulatory agencies to help shape health policy. However, testimony regarding identifying a partnership with the Robert Wood Johnson Foundation was mixed. Testimony indicated that there has been a steady decline in the number of spots for physicians in the Robert Wood Johnson health policy fellowship program and recommended that our AMA consider broadening any potential partnerships. Further, it was noted that developing a health policy fellowship program can be an intricate process that should be carefully evaluated.

Your Reference Committee received testimony favoring our AMA conducting a study to determine how best to increase opportunities to train physicians in transitioning from clinical practice to health policy. For these reasons, your Reference Committee recommends that Resolution 604 be referred to allow our AMA to conduct a study with a report at the 2019 Interim Meeting that details the impact our AMA can have on this issue and to consider potential partnerships.

Madam Speaker, this concludes the report of Reference Committee F. I would like to thank Michael D. Chafty, MD, JD, Melissa J. Garretson, MD, Jerry L. Halverson, MD, Candace E. Keller, MD, MPH, A. Lee Morgan, MD, Ann R. Stroink, MD, and all those who testified before the Committee.

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Melissa J. Garretson, MD
American Academy of Pediatrics

A. Lee Morgan, MD
Colorado

Jerry L. Halverson, MD
American Psychiatric Association

Ann R. Stroink, MD
Congress of Neurological Surgeons

Greg Tarasidis, MD
South Carolina
Chair

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-18)

Report of Reference Committee J

Steven Chen, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Medical Service Report 2 - Air Ambulance Regulations and Payments
2. Council on Medical Service Report 3 - Sustain Patient-Centered Medical Home Practices
3. Joint Report of the Council on Medical Service and the Council on Science and Public Health - Aligning Clinical and Financial Incentives for High-Value Care
4. Resolution 801 - Encourage Final Evaluation Reports of Section 1115 Demonstrations at the End of the Demonstration Cycle
5. Resolution 804 - Arbitrary Documentation Requirements for Outpatient Services
6. Resolution 810 - Medicare Advantage Step Therapy

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

7. Board of Trustees Report 9 - Hospital Closures and Physician Credentialing
8. Council on Medical Service Report 1 - Prescription Drug Importation for Personal Use
9. Council on Medical Service Report 4 - The Site-of-Service Differential
10. Resolution 802 - Due Diligence for Physicians and Practices Joining an ACO with Risk Based Models (Up Side and Down Side Risk)
11. Resolution 803 - Insurance Coverage for Additional Screening Recommended in States with Laws Requiring Notification of “Dense Breasts” on Mammogram
12. Resolution 805 - Prompt Pay
13. Resolution 806 - Telemedicine Models and Access to Care in Post-Acute and Long-Term Care
14. Resolution 808 - The Improper Use of Beers or Similar Criteria and Third-Party Payer Compliance Activities (H-185.940)
15. Resolution 812 - ICD Code for Patients Harm From Payer Interference
16. Resolution 814 - Prior Authorization Relief in Medicare Advantage Plans
17. Resolution 820 - Ensuring Quality Health Care for Our Veterans

RECOMMENDED FOR REFERRAL

18. Resolution 826 - Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients

RECOMMENDED FOR NOT ADOPTION

19. Resolution 822 - Bone Density Reimbursement

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

20. Resolution 807 - Emergency Department Copayments for Medicaid Beneficiaries
21. Resolution 818 - Drug Pricing Transparency
22. Resolution 823 - Medicare Cuts to Radiology Imaging

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

- Resolution 809 - Medicaid Clinical Trials Coverage
- Resolution 813 - Direct Primary Care Health Savings Account Clarification
- Resolution 815 - Uncompensated Physician Labor
- Resolution 816 - Medicare Advantage Plan Inadequacies
- Resolution 817 - Increase Reimbursement for Psychiatric Services
- Resolution 819 - Medicare Reimbursement Formula for Oncologists Administering Drugs
- Resolution 821 - Direct Primary Care and Concierge Medicine Based Practices

The following resolution was withdrawn by the sponsor:

- Resolution 811 - Infertility Benefits for Active-Duty Military Personnel

The following resolutions were recommended against consideration:

- Resolution 824 – Impact on the Medical Staff of the Success or Failure in Generating Savings of Hospital Integrated System ACOs
- Resolution 825 – Preservation of the Patient-Physician Relationship

(1) COUNCIL ON MEDICAL SERVICE REPORT 2 - AIR AMBULANCE REGULATIONS AND PAYMENTS

RECOMMENDATION:

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

Council on Medical Service Report 2 recommends that our AMA amend Policy, H-130.954 by addition to support the education of first responders about the costs associated with inappropriate use of emergency patient transportation systems; support increased data collection and data transparency of air ambulance providers and services to the appropriate state and federal agencies, particularly increased price transparency; work with relevant stakeholders to evaluate the Airline Deregulation Act as it applies to air ambulances; support stakeholders sharing air ambulance best practices across regions; and rescind Policy D-130.964.

Testimony on Council on Medical Service Report 2 was unanimously supportive. A member of the Council on Medical Service introduced the report noting that there is little reliable data on the costs and charges of air ambulance services. Additionally, the Council explained that it declined to call for increased consumer education on the costs of air ambulance services out of concern that it would result in patients declining potentially life-saving transportation and care. The Council further stated that the profound lack of data on air ambulances precludes it from proposing amendment to the Airline Deregulation Act. Importantly, the Council highlighted that the recent Federal Aviation Administration Reauthorization called for the establishment of a consumer hotline for consumer complaints, and an advisory committee to look into surprise billing and create industry best practices.

Numerous speakers highlighted that air ambulances often fly across state lines and stated that this ability must be preserved, as conserved in the Council report. An amendment was offered by an individual representing the air ambulance industry calling for increased payment of air ambulance services from Medicare and Medicaid. However, your Reference Committee declines to accept this amendment and believes that increased data transparency and availability is critical before calling for such a request. Another speaker noted that individuals often can pay a monthly fee to air ambulance companies that protect them from high bills for utilizing the company's services. However, additional testimony stated that this suggestion amounts to additional patient burden and expense, and your Reference Committee believes that this practice may be problematic in areas where there are multiple air ambulance providers or if an accident necessitating air ambulance care occurs outside of that provider's service area. Accordingly, your Reference Committee recommends that the recommendations in Council on Medical Service Report 2 be adopted and the remainder of the report be filed.

(2) COUNCIL ON MEDICAL SERVICE REPORT 3 - SUSTAIN PATIENT-CENTERED MEDICAL HOME PRACTICES

RECOMMENDATION:

Madam 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.

Council on Medical Service Report 3 recommends that our AMA reaffirm Policies H-160.919 and H-385.908; amend Policy H-160.918 to also urge CMS to assist physician practices seeking to sustain medical home status with financial and other resources, and delete [d] which states that our AMA "will advocate that all health plans and CMS use a single standard to determine whether a physician practice qualifies to be a patient-centered medical home;" advocate that all payers support and assist PCMH transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care recognizing that payer support is crucial to the long-term sustainability of delivery reform; and encourage health agencies, health systems, and other stakeholders to support and assist patient-centered medical home transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care.

Testimony on Council on Medical Service Report 3 was unanimously supportive. Testimony thanked the Council for its thoughtful report. A member of the Council on Medical Service introduced the report noting that the Council believes that primary care and the PCMH are bedrocks of high-quality, patient-centered care. However, in order to make the transition to and sustain a PCMH, practices of all sizes and settings must have the support to confront the challenges of practice transformation from the Centers for Medicare and Medicaid Services, third-party insurers, and other stakeholders. Accordingly, your Reference Committee recommends that the recommendations in Council on Medical Service Report 3 be adopted and the remainder of the report be filed.

(3) JOINT REPORT OF THE COUNCIL ON MEDICAL SERVICE AND THE COUNCIL ON SCIENCE AND PUBLIC HEALTH - ALIGNING CLINICAL AND FINANCIAL INCENTIVES FOR HIGH-VALUE CARE

RECOMMENDATION:

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

The Joint Report of the Council on Medical Service and the Council on Science and Public Health recommends that our AMA reaffirm Policies H-155.960, H-185.939 and H-165.856; support VBID plans designed in accordance with the tenets of “clinical nuance,”

recognizing that (1) medical services may differ in the amount of health produced, and (2) the clinical benefit derived from a specific service depends on the person receiving it, as well as when, where, and by whom the service is provided; support initiatives that align provider-facing financial incentives created through payment reform and patient-facing financial incentives created through benefit design reform, to ensure that patient, provider, and payer incentives all promote the same quality care. Such initiatives may include reducing patient cost-sharing for the items and services that are tied to provider quality metrics; develop coding guidance tools to help providers appropriately bill for zero-dollar preventive interventions and promote common understanding among health care providers, payers, patients, and health care information technology vendors regarding what will be covered at given cost-sharing levels; develop physician educational tools that prepare physicians for conversations with their patients about the scope of preventive services provided without cost-sharing and instances where and when preventive services may result in financial obligations for the patient; continue to support requiring private health plans to provide coverage for evidence-based preventive services without imposing cost-sharing (such as co-payments, deductibles, or coinsurance) on patients; continue to support implementing innovative VBID programs in Medicare Advantage plans; support legislative and regulatory flexibility to accommodate VBID that (a) preserves health plan coverage without patient cost-sharing for evidence-based preventive services; and (b) allows innovations that expand access to affordable care, including changes needed to allow High Deductible Health Plans paired with Health Savings Accounts to provide pre-deductible coverage for preventive and chronic care management services; and encourage national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services.

Testimony on the Joint Report of the Council on Medical Service and the Council on Science and Public Health was generally supportive. A member of the Council on Medical Service introduced the report and underscored that the recommendations of the report expand the AMA's leadership on coverage for high-value care and build on AMA policy regarding value-based insurance design (VBID). A member of the Council on Science and Public Health testified that the recommendations of the report recognize that health insurance must provide ongoing access to care for patients with chronic disease. Your Reference Committee believes that the Joint Report of the Council on Medical Service and the Council on Science and Public Health addresses challenges associated with the preventive services benefit of the Affordable Care Act and opportunities to better align incentives around high-value care, including through application of VBID. Accordingly, your Reference Committee recommends that the recommendations of the Joint Report of the Council on Medical Service and the Council on Science and Public Health be adopted and the remainder of the report be filed.

(4) RESOLUTION 801 - ENCOURAGE FINAL EVALUATION REPORTS OF SECTION 1115 DEMONSTRATIONS AT THE END OF THE DEMONSTRATION CYCLE

RECOMMENDATION:

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

Resolution 801 asks that our AMA encourage the Centers for Medicare & Medicaid Services to establish written procedures that require final evaluation reports of Section 1115 Demonstrations at the end of each demonstration cycle, regardless of renewal status.

Your Reference Committee heard supportive testimony on Resolution 801. Your Reference Committee believes Resolution 801 is consistent with existing AMA policy regarding the evaluation of demonstration programs, and recommends its adoption.

(5) RESOLUTION 804 - ARBITRARY DOCUMENTATION REQUIREMENTS FOR OUTPATIENT SERVICES

RECOMMENDATION:

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

The revised Resolution 804 asks that our AMA agree that documentation for outpatient physician services should be completed in a timely manner; and work with government health plans and private insurers to help them better understand the unintended consequences of imposing documentation rules with unrealistically short timeframes, and that our AMA oppose the use of such rules or regulations in determining whether submitted claims are valid and payable.

Testimony on Resolution 804 was unanimously supportive. Testimony stated that our AMA should help prevent public and private payers from implementing onerous documentation requirements on physicians, and your Reference Committee agrees. Accordingly, your Reference Committee recommends that Resolution 804 be adopted.

(6) RESOLUTION 810 - MEDICARE ADVANTAGE STEP THERAPY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 810 be adopted.

Resolution 810 asks that our AMA continue strong advocacy for the rejection of step therapy in Medicare Advantage plans and impede the implementation of the practice before it takes effect on January 1, 2019.

Your Reference Committee heard highly supportive testimony on Resolution 810. Your Reference Committee notes that our AMA and 93 state medical associations and national medical specialty societies raised extensive concerns with CMS in a sign-on letter regarding its new policy allowing Medicare Advantage plans, starting in 2019, to utilize step-therapy protocols for physician-administered drugs covered under Medicare Part B. Your Reference Committee believes that Resolution 810 is highly consistent not only with AMA advocacy efforts to date, but also with existing policy that opposes regulations and demonstration programs that are likely to undermine access to the best course of treatment for individual patients. As such, your Reference Committee recommends that Resolution 810 be adopted.

(7) BOARD OF TRUSTEES REPORT 9 - HOSPITAL CLOSURES AND PHYSICIAN CREDENTIALING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 3 in Board of Trustees Report 9 be amended by addition and deletion as follows:

3. That our AMA: (a) continue to monitor the development and implementation of physician credentialing repository databases that track hospital affiliations, including tracking hospital closures, as well as how and where these closed hospitals are storing physician credentialing information; and (b) explore the feasibility of developing a universal clearinghouse that centralizes the verification of credentialing information ~~as it relates to physician practice and affiliation history~~, and report back to the House of Delegates at the 2019 Interim Meeting. (Directive to Take Action)

RECOMMENDATION B:

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

Board of Trustees Report 9 recommends that our AMA reaffirm Policy H-230.956; develop model state legislation and regulations that would require hospitals to: (a) implement a procedure for preserving medical staff credentialing files in the event of the closure of the hospital; and (b) provide written notification to its state health agency and medical staff before permanently closing its facility indicating whether arrangements have been made for the timely transfer of credentialing files and the exact location of those files; continue to monitor the development and implementation of physician credentialing repository databases that track hospital affiliations; and explore the feasibility of developing a universal clearinghouse that centralizes the verification of credentialing information as it relates to physician practice and affiliation history, and report back to the House of Delegates at the 2019 Interim Meeting.

Testimony was supportive of Board of Trustees Report 9. A member of the Board of Trustees introduced the report highlighting that the AMA should encourage emulation of appropriate existing laws and regulations by developing model state legislation that supports timely access to credentialing files following the closure of a hospital. An amendment was offered to include tracking hospital closures, and your Reference Committee accepts this amendment. An additional amendment was offered to limit the credentialing information available on the clearinghouse to undergraduate and graduate medical education training. However, your Reference Committee believes that it is likely that the Board of Trustees intended to have additional information available in the clearinghouse besides education, and your Reference Committee proposes an amendment to allow for leeway in what information can and should be made available in the forthcoming clearinghouse. Accordingly, your Reference Committee recommends that the recommendations in Board of Trustees Report 9 be adopted as amended and the remainder of the report be filed.

(8) COUNCIL ON MEDICAL SERVICE REPORT 1 - PRESCRIPTION DRUG IMPORTATION FOR PERSONAL USE

RECOMMENDATION A:

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

1. That our American Medical Association (AMA) support the in-person purchase and importation of Health Canada-approved prescription drugs obtained directly from a licensed Canadian pharmacy when product integrity can be assured, provided such drugs are for personal use and of a limited quantity. (New HOD Policy)

RECOMMENDATION B:

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

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Council on Medical Service Report 1 be changed to read as follows:

CANADIAN PRESCRIPTION DRUG IMPORTATION FOR PERSONAL USE

Council on Medical Service Report 1 recommends that our AMA support the in-person purchase and importation of prescription drugs obtained directly from a licensed

Canadian pharmacy when product integrity can be assured, provided such drugs are for personal use and of a limited quantity; advocate for an increase in funding for the US Food and Drug Administration to administer and enforce a program that allows the in-person purchase and importation of prescription drugs from Canada, if the integrity of prescription drug products imported for personal use can be assured; and reaffirm Policies D-100.983 and D-100.985.

Your Reference Committee heard predominantly supportive testimony on Council on Medical Service Report 1, with testimony also in support of broadening the focus of its recommendations. In introducing the report, a member of the Council on Medical Service underscored that the recommendations of the report aim to provide patients with an option to lower their out-of-pocket costs for prescription drugs while ensuring that the prescription drugs that are imported in-person from a licensed, “brick-and-mortar” Canadian pharmacy are of the same quality and chemical makeup as those currently distributed in the US. The Council member also noted that the FDA has voiced its confidence in Health Canada in providing effective oversight of drugs approved for use by Canadian patients. A member of the Council on Legislation testified in support of the report, noting that the recommendations of the report are consistent with our AMA’s existing policy on prescription drug importation, which the Council on Legislation has used to guide its assessment of legislation introduced to date.

Some speakers were in support of our AMA also advocating for personal importation of prescription drugs using mail-order and online pharmacies. Your Reference Committee notes that existing Policy D-100.983 listed on the first page of the report, and recommended for reaffirmation, already guides AMA policy with respect to personal importation of prescription drugs via the Internet and mail-order. Namely, the policy predicates AMA support for such importation on ensuring the authenticity and integrity of prescription drugs that are imported. Members of the Council on Medical Service and the Council on Legislation noted that the mechanism outlined in the policy of our AMA to ensure product integrity is the implementation and utilization of “track-and-trace” technology. Testimony underscored that track-and-trace remains an important mechanism to ensure medication efficacy, and that the priority of our AMA with respect to personal importation of prescription drugs needs to be on our patients – that they are able to import prescription drugs for personal use that are of the same potency and purity as they otherwise would have access to in the US.

Your Reference Committee recognizes the potential for an increased risk to patients of receiving counterfeit or substandard drugs when such drugs are not purchased and imported in-person. In fact, a study by the Food and Drug Administration (FDA) revealed that although nearly half of imported drugs in the study were reported to be Canadian or from Canadian pharmacies, 85 percent of those drugs originated elsewhere and were fraudulently misrepresented as Canadian. Domestically, steps are being taken to implement track-and-trace technology. Namely, the FDA is working towards fully implementing the Drug Supply Chain Security Act by 2023, which outlines steps to build an electronic, interoperable system to identify and trace certain prescription drugs as they are distributed in the US.

There was also an amendment offered to study and report back regarding the in-person importation of prescription drugs obtained directly from a properly licensed non-US pharmacy beyond Canada, including in Mexico. Your Reference Committee notes that

referred Resolution 226-I-17 to which this report responded solely addressed the in-person purchase and importation of prescription drugs from Canada, not other countries. A member of the Council on Medical Service raised concerns with the regulatory and safety standards of Mexico pertaining to prescription drugs and pharmacies. In addition, the member noted that the FDA's enforcement discretion pertaining to prescription drugs imported in-person from other countries would remain, and as such questioned whether such a study would be warranted and be a prudent use of AMA resources.

Your Reference Committee is offering an amendment to the first recommendation of the report to include a requirement that prescription drugs purchased and imported in-person must be approved by Health Canada. The inclusion of Health Canada in the first recommendation continues our AMA's prioritization of patient safety in prescription drug importation as the agency is the equivalent to the FDA in Canada. As such, your Reference Committee recommends that the recommendations of Council on Medical Service Report 1 be adopted as amended and the remainder of the report be filed.

(9) COUNCIL ON MEDICAL SERVICE REPORT 4 - THE SITE-OF-SERVICE DIFFERENTIAL

RECOMMENDATION A:

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

5. That our AMA support Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments. <u>Site-neutral payments should be based on the actual costs of providing those services and not defined as equal payments or reducing all payments to the lowest amount paid in any setting.</u> (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendation 6 in Council on Medical Service Report 4 be <u>amended by addition and deletion</u> to read as follows:

6. That our AMA support Medicare payments for the same service routinely and safely provided in multiple outpatient settings (eg, physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the ~~real~~ <u>actual</u> costs of providing the service in each setting. (New HOD Policy)

RECOMMENDATION C:

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

Council on Medical Service Report 4 recommends that our AMA reaffirm Policies H-240.993, D-330.997, H-400.957 and H-400.966; support Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments; support Medicare payments for the same service routinely and safely provided in multiple outpatient settings (eg, physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the real costs of providing the service in each setting; urge CMS to update the data used to calculate the practice expense component of the Medicare physician fee schedule by administering a physician practice survey (similar to the Physician Practice Information Survey administered in 2007-2008) every five years, and that this survey collect data to ensure that all physician practice costs are captured; encourage CMS to both: a) base disproportionate share hospital payments and uncompensated care payments to hospitals on actual uncompensated care data; and b) study the costs to independent physician practices of providing uncompensated care; and collect data and conduct research both: a) to document the role that physicians have played in reducing Medicare spending; and b) to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery.

Your Reference Committee heard supportive testimony on Council on Medical Service Report 4. In introducing the report, a member of the Council on Medical Service outlined amendments to the fifth and sixth recommendations of the report, after having spoken to members of the Integrated Physician Practice Section (IPPS). Your Reference Committee accepts the amendments and applauds the efforts done to unify the house of medicine behind the recommendations of Council on Medical Service Report 4. Your Reference Committee appreciates amendments that were offered to correct for underpayments made to physicians through the potential use of Medicare Part A savings, but agrees with the member of Council on Medical Service who stated that the ninth recommendation of the report needs to be implemented before such an amendment could be considered. The ninth recommendation of the report calls for our AMA to collect data and conduct research both: a) to document the role physicians have played in reducing Medicare spending; and b) to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in care delivery. Your Reference Committee believes that the recommendations of Council on Medical Service Report 4 recognize the high priority placed on the issue of the site-of-service differential by the members of our AMA, and recommends that the recommendations of Council on Medical Service Report 4 be adopted as amended and the remainder of the report be filed.

(10) RESOLUTION 802 - DUE DILIGENCE FOR PHYSICIANS AND PRACTICES JOINING AN ACO WITH RISK BASED MODELS (UP SIDE AND DOWN SIDE RISK)

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 802 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA develop educational resources and business tools ~~analytics~~ to help physicians complete due diligence in evaluating the performance of physician-led and hospital integrated systems before considering consolidation. Specific attention should be given to the evaluation of transparency on past savings results, system finances, quality metrics, physician workforce stability and physician job satisfaction, and the cost of clinical documentation software (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 802 be amended by deletion as follows:

RESOLVED, That our AMA evaluate the characteristics of successful physician owned MSSP ACOs and participation in alternative payment models (APMs) to create a framework of the resources and organizational tools needed to allow ~~smaller~~ practices to form virtual ACOs that would facilitate participation in MSSP ACOs and APMs. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 802 be adopted as amended.

Resolution 802 asks that our AMA advocate for the continuation of up side only risk Medicare Shared Savings ACO (MSSP ACO) program as an option from the Centers for Medicare and Medicaid Services, particularly for physician owned groups; develop educational resources and business analytics to help physicians complete due diligence in evaluating the performance of hospital integrated systems before considering consolidation. Specific attention should be given to the evaluation of transparency on past savings results, system finances, quality metrics, physician workforce stability and physician job satisfaction, and the cost of clinical documentation software; and evaluate the characteristics of successful physician owned MSSP ACOs and participation in alternative payment models (APMs) to create a framework of the resources and

organizational tools needed to allow smaller practices to form virtual ACOs that would facilitate participation in MSSP ACOs and APMs.

Testimony on Resolution 802 was unanimously supportive. Your Reference Committee notes that Resolution 802 coincides with ongoing AMA advocacy efforts seeking to better define ACO accountability to match its capabilities to withstand risk. Specifically, in our AMA's recent comment letter on the ACO proposed rule, our AMA urged the Centers for Medicare and Medicaid Services to retain the Track 1 model instead of forcing all ACOs into two-sided risk models and provided evidence that ACOs can achieve savings for Medicare without downside risk. An amendment was offered suggesting that our AMA develop educational information and a webinar directed towards small physician practices to encourage their participation in these payment model activities. However, your Reference Committee believes that the request to develop educational resources in the second resolve clause satisfies this ask. Additionally, your Reference Committee suggests several minor amendments to be inclusive of all practice sizes and notes that definitions of a "smaller practice" are variable. Moreover, your Reference Committee suggests calling for business tools believing that this language is broader than the call for analytics and will provide the AMA with more leeway in the business resources it makes available to physicians. Therefore, your Reference Committee recommends that Resolution 802 be adopted as amended.

(11) RESOLUTION 803 - INSURANCE COVERAGE FOR ADDITIONAL SCREENING RECOMMENDED IN STATES WITH LAWS REQUIRING NOTIFICATION OF "DENSE BREASTS" ON MAMMOGRAM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be <u>adopted in lieu of Resolution 803</u>:

RESOLVED, That our American Medical Association (AMA) reaffirm Policy H-525.993, which supports insurance coverage for screening mammography (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA reaffirm Policy H-525.977, which opposes state requirements for mandatory notification of breast tissue density to patients (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA encourage research on the benefits and harms of adjunctive screening for breast cancer for women identified to have dense breasts on an otherwise negative screening mammogram, in order to guide appropriate and evidence-based insurance coverage of the service (New HOD Policy); and be it further

RESOLVED, That our AMA support insurance coverage for and adequate access to supplemental screening recommended for patients with "dense breast" tissue following a discussion between the patient and their physician which integrates secondary risk characteristics. (New HOD Policy)

Resolution 803 asks that our AMA support insurance coverage for supplemental screening recommended for patients with "dense breast" tissue following a conversation between the patient and their physician; and advocate for insurance coverage for and adequate access to supplemental screening recommended for patients with "dense breast" tissue following a conversation between the patient and their physician.

Your Reference Committee heard mixed testimony on Resolution 803. Amendments were offered in support of insurance coverage for and adequate access to supplemental screening recommended for patients with dense breast tissue, which your Reference Committee incorporated in the alternate resolution. Based on testimony addressing the evidence behind screening mammography and concerns regarding state requirements for mandatory notification of breast tissue density to patients, your Reference Committee is recommending the reaffirmation of applicable AMA policy. Finally, several speakers stressed that AMA policy should not get ahead of the science on this issue, and as such your Reference Committee is including a recommendation to encourage research on the benefits and harms of adjunctive screening for breast cancer for women identified to have dense breasts on an otherwise negative screening mammogram. Accordingly, your Reference Committee recommends that the alternate resolution offered be adopted in lieu of Resolution 803.

H-525.993 Screening Mammography
Our AMA: a. recognizes the mortality reduction benefit of screening mammography and supports its use as a tool to detect breast cancer. b. recognizes that as with all medical screening procedures there are small, but not inconsequential associated risks including false positive and false negative results and overdiagnosis. c. favors participation in and support of the efforts of professional, voluntary, and government organizations to educate physicians and the public regarding the value of screening mammography in reducing breast cancer mortality, as well as its limitations. d. advocates remaining alert to new epidemiological findings regarding screening mammography and encourages the periodic reconsideration of these recommendations as more epidemiological data become available. e. believes that beginning at the age of 40 years, all women should be eligible for screening mammography. f. encourages physicians to regularly discuss with their individual patients the benefits and risks of screening mammography, and whether screening is appropriate for each clinical situation

given that the balance of benefits and risks will be viewed differently by each patient. g. encourages physicians to inquire about and update each patient's family history to detect red flags for hereditary cancer and to consider other risk factors for breast cancer, so that recommendations for screening will be appropriate. h. supports insurance coverage for screening mammography. i. supports seeking common recommendations with other organizations, informed and respectful dialogue as guideline-making groups address the similarities and differences among their respective recommendations, and adherence to standards that ensure guidelines are unbiased, valid and trustworthy. j. reiterates its longstanding position that all medical care decisions should occur only after thoughtful deliberation between patients and physicians. (CSA Rep. F, A-88; Reaffirmed: Res. 506, A-94; Amended: CSA Rep. 16, A-99; Appended: Res. 120, A-02; Modified: CSAPH Rep. 6, A-12)

H-525.977 Breast Density Notification
Our AMA supports the inclusion of breast tissue density information in the mammography report when appropriate and education of patients about the clinical relevance of such information, but opposes state requirements for mandatory notification of breast tissue density to patients. (Res. 502, A-14)

(12) RESOLUTION 805 - PROMPT PAY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution <u>be adopted in lieu of Resolution 805</u>:

RESOLVED, That our American Medical Association continue to encourage regulators to enforce existing prompt pay requirements. (Directive to Take Action)

Resolution 805 asks that Policy H-190.959 be amended by addition and deletion to seek regulatory and legislative relief to ensure that all health insurance and managed care companies pay for clean claims submitted electronically within three days instead of fourteen days; and when electronic claims are deemed to be lacking information to make the claim complete, the health insurance and managed care companies will be required to notify the health care provider within one day instead of five business days to allow prompt resubmission of a clean claim.

Testimony on Resolution 805 was supportive. A member of the Council on Medical Service testified that existing AMA policy addresses the intent of Resolution 805 and that the Council is unsure why our AMA would request to shorten the payment timeline when we are still struggling to achieve conformance with our 14-day policy. Additionally, the member expressed concern that asking this of payers may result in payers requesting faster claims submission of providers. Recognizing the importance of Resolution 805 and the concerns expressed in testimony, your Reference Committee suggests an alternate resolution for our AMA to continue to work with regulators to enforce existing prompt pay requirements. Your Reference Committee believes that the issue lies not with the exact number of days in which payment must be made but rather with the lack

of enforcement of current prompt pay regulations. Accordingly, your Reference Committee recommends that the alternate resolution be adopted in lieu of Resolution 805.

(13) RESOLUTION 806 - TELEMEDICINE MODELS AND ACCESS TO CARE IN POST-ACUTE AND LONG-TERM CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 806 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate for removal of arbitrary limits on telemedicine visits by medical practitioners in nursing facilities and instead base them purely on medical necessity, and collaborate with relevant national medical specialty societies ~~AMDA – The Society for Post-Acute and Long-Term Care Medicine~~ to effect a change in Medicare's policy regarding this matter under the provisions of Physician Fee Schedule (PFS) and Quality Payment Program (QPP) (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 806 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work with relevant national medical specialty societies ~~AMDA-The Society for Post-Acute and Long-Term Care Medicine~~ and other stakeholders to influence Congress to broaden the scope of telemedicine care models in post-acute and long-term care and authorize payment mechanisms for models that are evidence based, relevant to post-acute and long-term care and continue to engage primary care physicians and practitioners in the care of their patients.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 806 be adopted as amended.

Resolution 806 asks that our AMA advocate for removal of arbitrary limits on telemedicine visits by medical practitioners in nursing facilities and instead base them purely on medical necessity, and collaborate with AMDA – The Society for Post-Acute and Long-Term Care Medicine to effect a change in Medicare's policy regarding this

matter under the provisions of Physician Fee Schedule (PFS) and Quality Payment Program (QPP); and work with AMDA-The Society for Post-Acute and Long-Term Care Medicine and other stakeholders to influence Congress to broaden the scope of telemedicine care models in post-acute and long-term care and authorize payment mechanisms for models that are evidence based, relevant to post-acute and long-term care and continue to engage primary care physicians and practitioners in the care of their patients.

Your Reference Committee heard limited yet supportive testimony on Resolution 806. Your Reference Committee is offering amendments to the resolution to ensure that our AMA is able to work with all relevant national medical specialty societies to achieve the objectives of the resolution. Accordingly, your Reference Committee recommends that Resolution 806 be adopted as amended.

(14) RESOLUTION 808 - THE IMPROPER USE OF BEERS OR SIMILAR CRITERIA AND THIRD-PARTY PAYER COMPLIANCE ACTIVITIES (H-185.940)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be adopted in lieu of Resolution 808:

THE IMPROPER USE OF BEERS OR SIMILAR CRITERIA

RESOLVED, That our American Medical Association (AMA) reaffirm Policy H-185.940 (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA educate and urge health insurers, benefit managers, and other payers not to inappropriately apply the Beers or similar criteria to quality ratings programs in a way that may financially penalize physicians. (New HOD Policy)

Resolution 808 asks that our AMA identify and establish a workgroup with insurers that are inappropriately applying Beers or similar criteria to quality rating programs and work with the insurers to resolve internal policies that financially penalize physicians; study and report back to the House of Delegates the 2019 Interim Meeting, the potential inappropriate use of Beers Criteria by insurance companies looking at which companies are involved and the effect of the use of these criteria on physicians' practices; and provide a mechanism for members to report possible abuses of Beers criteria by insurance companies.

There was mixed testimony on Resolution 808. A member of the Council on Medical Service called for reaffirmation of Policy H-185.940 stating that the Council believes existing AMA policy satisfies Resolution 808. Moreover, the member questioned the necessity of a workgroup and a report back because the American Geriatric Society

(AGS) and our AMA state that the criteria should not be used in a punitive manner and the criteria is no longer used as part of the Medicare star ratings system. Your Reference Committee notes that, effective in 2017, it is simply a "display measure." Moreover, while the American Geriatric Society states that the criteria be used as both an educational tool and quality measure, it further states that the intent is not to apply the criteria in a punitive manner (*see* https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2017-Star-Ratings-Request-for-Comments.pdf). A member of the Beers Panel and the AGS testified against adoption stating that AGS published an article in 2015 about how to use the Beers Criteria and stated that that the workgroup called for in the resolution is an ineffective use of AMA resources and that instead our AMA should continue its work on the Beers Criteria and Prior Authorization. Testimony further stated that our AMA does and should continue to take advantage of comment periods relating to the Beers Criteria and that the next comment period will begin in early 2019.

With respect to the underlying intent of the third resolve of the original resolution, your Reference Committee notes that there already are a variety of forums in which members of the Federation can seek AMA assistance, such as through the Specialty and Service Society and the work of the Advocacy Resource Center. In addition, the AMA Advocacy Group engages health insurers directly on systemic issues that involve national insurers or cut across multiple health insurance markets, such as the AMA's current broad-based efforts to reduce the patient and practice burdens associated with prior authorization.

Based on testimony, your Reference Committee believes that the problem may not be the Beers Criteria itself but rather how payers are using clinical guidelines to financially penalize physicians. This belief was echoed by the author who stated that they simply wanted our AMA to assist in ensuring that insurers are not using the Beers Criteria in a punitive manner and was open to amendment of Resolution 808. Accordingly, your Reference Committee recommends adopting an alternate resolution that reaffirms Policy H-185.940. Your Reference Committee believes that the alternate resolution achieves the request of the authors and targets the source of the issue.

> H-185.940 Beers or Similar Criteria and Third Party Payer Compliances Activities
> Our AMA adopts policy: (1) discouraging health insurers, benefit managers, and other payers from using the Beers Criteria and other similar lists to definitively determine coverage and/or reimbursement, and inform health insurers and other payers of this policy; and (2) clarifying that while it is appropriate for the Beers Criteria to be incorporated in quality measures, such measures should not be applied in a punitive or onerous manner to physicians and must recognize the multitude of circumstances where deviation from the quality measure may be appropriate, and inform health insurers and other payers of this policy. (BOT Rep. 14, A-12)

(15) RESOLUTION 812 - ICD CODE FOR PATIENTS HARM FROM PAYER INTERFERENCE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be adopted in lieu of Resolution 812:

PRIOR AUTHORIZATION AND PATIENT HARM

RESOLVED, That our American Medical Association support efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm. (New HOD Policy)

Resolution 812 asks that our AMA support the creation and implementation of an ICD code(s) to identify administrator or payer influence that affects treatment and leads to or contributes to, directly or indirectly, patient harm.

Testimony was supportive of the intent of Resolution 812 and the importance of supporting efforts to track the harm to patients caused by payer interference via prior authorization requirements. A member of the Council on Medical Service proposed substitute language and testified that the ICD-10 code requested by Resolution 812 would require physicians to clearly document the correlation between payer policies and adverse clinical outcomes, which raises concerns about the appropriateness of documenting this information in the clinical record, timing of when the code would be reported during the patient's treatment, and potential repercussions to the physician for what he/she did for the patient to prevent the harm. Additionally, the Council member stated that this documentation burden would likely lead to underutilization of the code and that there may be more suitable ways to obtain this data. Your Reference Committee suggests that the Prior Authorization Physician Survey may be one way to obtain this data. In last year's survey, 92 percent of physicians reported that prior authorization can have a negative impact on patient clinical outcomes. And this year's version of the survey, which will be conducted in December, includes more questions addressing this point. Our AMA will have new data to report early next year. Taking into account these considerations and believing that an ICD-10 code is not the appropriate mechanism to address the issue, your Reference Committee recommends that the alternate resolution be adopted in lieu of Resolution 812.

(16) RESOLUTION 814 - PRIOR AUTHORIZATION RELIEF IN MEDICARE ADVANTAGE PLANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolve of Resolution 814 be amended by addition and deletion as follows:

RESOLVED, That our American Medical Association support legislation and/or regulations that would apply the following ~~legislative~~ processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans:

a. Listing services that require a PA on a website and ensuring that patient informational materials include full disclosure of any PA requirements.
b. Notifying providers of any changes at least 45 days prior to change.
c. Improving transparency by requiring plans to report on the scope of PA practices, including the list of services subject to PA and corresponding denial, delay, and approval rates.
d. Standardizing a PA request form.
e. Minimizing PA requirements as much as possible within each plan and eliminating the application of PA to services that are routinely approved.
f. Not denying payment for PA that has been approved unless fraudulently obtained ~~or ineligible at time of service~~.
g. Medications already being administered when a patient changes health plans cannot be changed by the health plan without discussion and approval of the ordering physician.
h. Making an easily accessible and responsive direct communication tool available to resolve disagreements between health plan and ordering provider.
i. Defining a consistent process for appeals and grievances, including to Medicaid and Medicaid managed care plans (New HOD Policy). ~~; and be it further~~

RECOMMENDATION B:

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

~~RESOLVED, That our AMA apply these same legislative processes and parameters to prior authorization (PA) for~~ Medicaid ~~and Medicaid managed care plans and Medicare Advantage plans, to include:~~

~~a. Medications already working when a patient changes health plans cannot be changed by the plan without discussion and approval of the ordering physician.~~

~~b. Minimizing PA requirements as much as possible within each plan.~~

~~c. Making an easily accessible and reasonably responsive direct communication tool available to resolve disagreements between plan and ordering provider. (New HOD Policy)~~

RECOMMENDATION C:

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

Resolution 814 asks that our AMA support legislation that would apply the following legislative processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans: 1) Listing services that require a PA on a website, 2) Notifying providers of any changes at least 45 days prior to change, 3) Standardizing a PA request form, 4) Not denying payment for PA that has been approved unless fraudulently obtained or ineligible at time of service and 5) Defining a consistent process for appeals and grievances, including to Medicaid and Medicaid managed care plans; and apply these same legislative processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans, to include: 1) Medications already working when a patient changes health plans cannot be changed by the plan without discussion and approval of the ordering physician, 2) Minimizing PA requirements as much as possible within each plan and 3) Making an easily accessible and reasonably responsive direct communication tool available to resolve disagreements between plan and ordering provider.

A member of the Council on Medical Service testified that, at the 2017 Annual Meeting, the Council presented a comprehensive report on prior authorization and utilization management reform that recommended that our AMA continue its widespread prior authorization advocacy and outreach, including promotion of the Prior Authorization and Utilization Management Reform Principles, model state legislation, the Prior Authorization Physician Survey, and our AMA Prior Authorization toolkit. The Council believes that these tools, coupled with existing AMA prior authorization policy, address the points outlined in Resolution 814. Policy H-320.939 supports prior authorization advocacy and outreach, including promotion/adoption of the Prior Authorization and Utilization Management Reform Principles and AMA model legislation aimed at reducing PA burdens and improving access to care. Policy H-320.961 supports legislation or regulations that prevent the retrospective denial of payment for services for which a physician had previously received authorization. Additional testimony echoed that the points raised in the resolution are addressed by numerous additional policies—including Policies H-320.968, H-320.952, H-285.965, and D-190.974—as well as the

aforementioned Principles, the Consensus Statement on Improving the Prior Authorization Process, and AMA model state legislation.

Amendments were offered to ensure that our AMA took action on PA both in the legislative and regulatory spheres and to take out wording that PA be approved unless ineligible at the time of service to reduce physician burden and inappropriate PA determinations. Your Reference Committee accepts these amendments. Overall, although your Reference Committee agrees with testimony stating that Resolution 814 is largely addressed by current policy, it believes portions of Resolution 814 are consistent and additive to current policy. Moreover, your Reference Committee understands the burdens imposed on physicians by PA and wants to ensure that our AMA continues to do all it can to reduce PA and its negative impacts on patients and physicians. Accordingly, your Reference Committee recommends that Resolution 814 be adopted as amended.

(17) RESOLUTION 820 - ENSURING QUALITY HEALTH CARE FOR OUR VETERANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 820 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our American Medical Association amend Policy H-510.986, “Ensuring Access to Care for our Veterans,” by addition to read as follows:

Ensuring Access to <u>Safe and Quality</u> Care for our Veterans
H-510.986
1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.
2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.
3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans.
4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration.

5. Our AMA will strongly advocate that the Veterans Health Administration and Congress develop and implement necessary resources, protocols, and accountability to ensure the Veterans Health Administration recruits, hires and retains ~~first-rate, competent, and ethical~~ physicians and other health care professionals to deliver the safe, effective and high-quality care that our veterans have been promised and are owed.

6. Our AMA will engage the Veterans Health Administration in dialogue on accreditation practices by the Veterans Health Administration to align its practices with external best practices ~~assure they are similar to those of hospitals, state medical boards, and insurance companies~~.

(Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 820 be adopted as amended.

Resolution 820 asks that our AMA amend Policy H-510.986 by addition to state that our AMA will strongly advocate that the Veterans Health Administration and Congress develop and implement necessary resources, protocols, and accountability to ensure the Veterans Health Administration recruits, hires and retains first-rate, competent, and ethical physicians and other health care professionals to deliver the safe, effective and high-quality care that our veterans have been promised and are owed; and engage the Veterans Health Administration in dialogue on accreditation practices by the Veterans Health Administration to assure they are similar to those of hospitals, state medical boards, and insurance companies.

Your Reference Committee heard mixed testimony on Resolution 820. An amendment was offered to remove language in Part 5 of the proposed policy addition because it is potentially inflammatory, and your Reference Committee agrees. Moreover, though your Reference Committee understands that while the VA is highly regulated on the federal side, such regulations and practices may diverge from those of local hospitals and states. Therefore, your Reference Committee believes that a dialogue with the VHA is appropriate to explore these differences to ensure the continued quality care of our veterans. Accordingly, your Reference Committee recommends that Resolution 820 be adopted as amended.

(18) RESOLUTION 826 - DEVELOPING SUSTAINABLE SOLUTIONS TO DISCHARGE OF CHRONICALLY-HOMELESS PATIENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 826 be referred.

Resolution 826 work with relevant stakeholders in developing sustainable plans for the appropriate discharge of chronically-homeless patients from hospitals, and reaffirm Policies H-270.962 and H-130.940.

Your Reference Committee heard mixed testimony on Resolution 826. Speakers stressed that the resolution could have unintended consequences and amount to an unfunded mandate. Your Reference Committee agrees and recommends referral of Resolution 826.

(19) RESOLUTION 822 - BONE DENSITY REIMBURSEMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 822 not be adopted.

Resolution 822 asks that our AMA advocate for the correction of the underpayment by Medicare, Medicaid, and third-party payers to medical practices for office-based DXA tests.

There was mixed testimony on Resolution 822. Several speakers were supportive of the resolution and stated that inadequate reimbursement often results in access to care issues. A member of the Council on Medical Service called for not adoption of Resolution 822 explaining that current payment rates for bone density are largely based off of Resource-Based Relative Value Scale Update Committee (RUC) recommendations. Moreover, the DXA is a covered service when provided once every two years as part of the Annual Wellness Visit, in addition to being part of the Welcome to Medicare exam, and beneficiaries no longer have to pay copayments for this preventive benefit. Additionally, an AMA representative to the RUC stated that the AMA supports resource-based payment, and that, if payment is inadequate, it should be nominated for a misvalued service and should go through the RUC process to be remedied. The representative also urged the authors to work with colleagues in radiology and other specialties for the best possible outcome. Numerous speakers echoed this sentiment that the best and most appropriate course of action is to go through the RUC process. Your Reference Committee strongly agrees and therefore recommends that Resolution 822 be not adopted.

(20) RESOLUTION 807 - EMERGENCY DEPARTMENT COPAYMENTS FOR MEDICAID BENEFICIARIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-290.965, H-130.970, H-385.921, and D-290.977 be reaffirmed in lieu of Resolution 807.

Resolution 807 asks that our AMA oppose imposition of copays for Medicaid beneficiaries seeking care in the emergency department. ESI triage level versus prudent layperson standards – 1115 waivers for increasing amounts and to use for emergent services.

There was mixed testimony on Resolution 807. Testimony indicated that the imposition of Medicaid copayments for “nonemergent” emergency room care does not appear to affect Medicaid beneficiary use of hospital emergency departments. Speakers stressed the need to promote the use of preventive care and encourage appropriate treatment settings by Medicaid beneficiaries. Some testimony also raised concerns that requiring Medicaid copayments for emergency care could place hospitals at risk of EMTALA violations.

The implied goal of imposing copays for Medicare beneficiaries seeking care in the emergency department is to promote more appropriate utilization of the emergency department by this segment of the population. Your Reference Committee believes that Policy H-290.965 addresses the goal that imposing ED copayments is attempting to achieve, while recognizing that other best practices may be more successful in impacting avoidable ED visits among Medicaid beneficiaries. Policy H-130.970 responds to testimony that raised concerns with state Medicaid policies that violate the “prudent layperson” standard of determining when to seek emergency care. Finally, several speakers stressed that steps need to be taken to ensure that Medicaid beneficiaries are better able to access primary care services, and as such is recommending the reaffirmation of Policies H-385.921, and D-290.977. To achieve the goal of ensuring Medicaid beneficiary access to care while promoting appropriate ED utilization, your Reference Committee recommends that Policies H-290.965, H-130.970, H-385.921, and D-290.977 be reaffirmed in lieu of Resolution 807.

H-290.965 Affordable Care Act Medicaid Expansion
1. Our AMA encourages state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access. 2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models. 3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries. 4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents.5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care. 6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs. 7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care. **8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.** 9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS. 10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016. 11. Our AMA supports maintenance of federal funding for Medicaid expansion

populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists. 12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches. **13. Our AMA supports the use of emergency department (ED) best practices that are evidence-based to reduce avoidable ED visits.** (CMS Rep. 02, A-16; Reaffirmation: A-17)

H-130.970 Access to Emergency Services
1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services: (A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part. (B) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96) (C) All health plans should be prohibited from requiring prior authorization for emergency services. (D) Health plans may require patients, when able, to notify the plan or primary physician at the time of presentation for emergency services, as long as such notification does not delay the initiation of appropriate assessment and medical treatment. (E) All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize an "emergency medical condition" as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer. (F) Failure to obtain prior authorization for emergency services should never constitute a basis for denial of payment by any health plan or third party payer whether it is retrospectively determined that an emergency existed or not. (G) States should be encouraged to enact legislation holding health plans and third party payers liable for patient harm resulting from unreasonable application of prior authorization requirements or any restrictions on the provision of emergency services. H) Health plans should educate enrollees regarding the appropriate use of emergency facilities and the availability of community-wide 911 and other emergency access systems that can be utilized when for any reason plan resources are not readily available. (I) In instances in which no private or public third party coverage is applicable, the individual who seeks emergency services is responsible for payment for such services. **2. Our AMA will work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the “prudent layperson” standard of determining when to seek emergency care**. (CMS Rep. A, A-89; Modified by CMS Rep. 6, I-95; Reaffirmation A-97; Reaffirmed by Sub. Res. 707, A-98; Reaffirmed: Res. 705, A-99; Reaffirmed: CMS Rep. 3, I-99; Reaffirmation A-00; Reaffirmed: Sub. Res. 706, I-00; Amended: Res. 229, A-01; Reaffirmation and

Reaffirmed: Res. 708, A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 07, A-16; Appended: Res. 128, A-17; Reaffirmation: A-18)

H-385.921 Health Care Access for Medicaid Patients
It is AMA policy that to increase and maintain access to health care for all, payment for physician providers for Medicaid, TRICARE, and any other publicly funded insurance plan must be at minimum 100% of the RBRVS Medicare allowable. (Res. 103, A-07; Reaffirmed: CMS Rep. 2, I-08; Reaffirmation A-12; Reaffirmed: Res 132, A-14; Reaffirmed in lieu of Res. 808, I-14; Reaffirmation A-15)

D-290.977 Medicaid Primary Care Payment Increases
Our AMA: (1) advocates that the Affordable Care Act's Medicaid primary care payment increases for Evaluation and Management codes and vaccine administration codes include obstetricians and gynecologists as qualifying specialists, and support flexibility to achieve the best possible outcome; and (2) advocates for the Affordable Care Act's Medicaid primary care payment increases to continue past 2014 in a manner that does not negatively impact payment for any other physicians. (CMS Rep. 7, I-14)

(21) RESOLUTION 818 - DRUG PRICING TRANSPARENCY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-110.987, H-110.984, H-110.986 and H-125.980 be reaffirmed in lieu of Resolution 818.

Resolution 818 asks that our AMA advocate to the U.S. Surgeon General for federal legislation that investigates all drug pricing.

Your Reference Committee heard mixed testimony on Resolution 818. In introducing the resolution, the sponsor offered an amendment to advocate for federal legislation to promote drug pricing transparency for essential medications. Members of the Council on Medical Service and Council on Legislation testified that even with the amendment, existing policy and advocacy efforts already address the intent of the resolution. First, a member of the Council on Medical Service stated that Policy H-110.987 already supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug by 10% or more each year or per course of treatment and provide justification for the price increase; and (b) legislation that authorizes the Attorney General and/or the FTC to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients.

A member of the Council on Legislation stated that through its legislative and regulatory efforts on the federal level, development and dissemination of model state legislation and working with interested state medical societies, our AMA is supporting requiring pharmaceutical supply chain transparency – among pharmaceutical manufacturers, pharmacy benefit managers and health plans. In particular, the AMA submitted a letter to Secretary Azar regarding the Trump Administration’s drug pricing blueprint, which

highlighted our policy priorities addressing drug price transparency and promoting and ensuring fair competition in the pharmaceutical marketplace. Also, our AMA has been active in testifying before Congress on the issue. Finally, our AMA also submitted letters of support of relevant federal legislation and amendments, including H.R. 6733, Know the Cost Act of 2018; S. 2554, The Patients Right to Know Drug Prices Act of 2018; and a bipartisan amendment to require pharmaceutical manufacturers to provide an appropriate disclosure of pricing information for their product in direct-to-consumer (DTC) advertisements.

Another amendment was offered that was more focused on addressing insulin pricing. A member of the Council on Medical Service testified that the Council just presented a report at the 2018 Annual Meeting on insulin pricing, which established Policy H-110.984 that states that our AMA will encourage the FTC and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate. Relevant to encouraging the use of value-based contracts, Policy H-110.986 outlines principles to guide the support of our AMA for value-based pricing programs, initiatives and mechanisms for pharmaceuticals. Addressing anticompetitive patent reforms, Policy H-110.987 states that our AMA will continue to support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system. The policy also states that our AMA encourages FTC actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives. Policy H-125.980 supports an abbreviated pathway for biosimilar approval.

Your Reference Committee believes that our AMA must continue to place a high priority on promoting prescription drug price transparency. However, your Reference Committee believes that Resolution 818 and all amendments offered are already addressed by existing AMA policy and ongoing advocacy efforts. As such, your Reference Committee recommends that Policies H-110.987, H-110.984, H-110.986 and H-125.980 be reaffirmed in lieu of Resolution 818.

H-110.987 Pharmaceutical Costs
1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives. 2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition. 3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry. 4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system. 5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies. 6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises

faster than inflation. 7. Our AMA supports legislation to shorten the exclusivity period for biologics. 8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens. 9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients. 10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment. 11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase. 12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency. (CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18)

H-110.984 Insulin Affordability
Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate; and (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies. (CMS Rep. 07, A-18)

H-110.986 Incorporating Value into Pharmaceutical Pricing
1. Our AMA supports value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by the following principles: (a) value-based prices of pharmaceuticals should be determined by objective, independent entities; (b) value-based prices of pharmaceuticals should be evidence-based and be the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes; (c) processes to determine value-based prices of pharmaceuticals must be transparent, easily accessible to physicians and patients, and provide practicing physicians and researchers a central and significant role; (d) processes to determine value-based prices of pharmaceuticals should limit administrative burdens on physicians and patients; (e) processes to determine value-based prices of pharmaceuticals should incorporate affordability criteria to help assure patient affordability as well as limit

system-wide budgetary impact; and (f) value-based pricing of pharmaceuticals should allow for patient variation and physician discretion. 2. Our AMA supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research. 3. Our AMA supports direct purchasing of pharmaceuticals used to treat or cure diseases that pose unique public health threats, including hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size. (CMS Rep. 05, I-16; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: CMS-CSAPH Rep. 01, A-17; Reaffirmed: CMS Rep. 07, A-18)

H-125.980 Abbreviated Pathway for Biosimilar Approval
Our AMA supports FDA implementation of the Biologics Price Competition and Innovation Act of 2009 in a manner that 1) places appropriate emphasis on promoting patient access, protecting patient safety, and preserving market competition and innovation; 2) includes planning by the FDA and the allocation of sufficient resources to ensure that physicians understand the distinctions between biosimilar products that are considered highly similar, and those that are deemed interchangeable. Focused educational activities must precede and accompany the entry of biosimilars into the U.S. market, both for physicians and patients; and 3) includes compiling and maintaining an official compendium of biosimilar products, biologic reference products, and their related interchangeable biosimilars as they are developed and approved for marketing by the FDA. (Res. 220, A-09; Reaffirmation A-11; Modified: CSAPH Rep. 1, I-11; Modified: CSAPH Rep. 4, A-14)

(22) RESOLUTION 823 - MEDICARE CUTS TO RADIOLOGY IMAGING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy D-390.969 be reaffirmed in lieu of Resolution 823.

Resolution 823 asks that our AMA advocate for elimination of the Medicare differential imaging payments for small practices versus facility payments, and for elimination of the Medicare computed radiography (CR) payment reductions.

Your Reference Committee heard mixed testimony on Resolution 823. While testimony was generally supportive of the first Resolve of the resolution, several speakers stressed that existing policy, as well as Council on Medical Service Report 4 being considered at this meeting, addresses its intent. Several speakers raised concerns with the second Resolve of Resolution 823. Namely, a member of the Council on Medical Service underscored that the time to weigh in on Medicare computed radiography payment reductions has passed, since these reductions were set in statute two years ago (Consolidated Appropriations Act of 2016). Also, testimony raised concerns that the second Resolve has the potential to adversely affect other specialties, because if the payment reductions to Medicare computed radiography were overturned, it would require a pay-for, which would likely be a reduction to all physician services via the Medicare conversion factor.

Your Reference Committee believes that both Resolves of Resolution 823 are already addressed by existing policy, as well as Council on Medical Service Report 4 being considered at this meeting. As such, your Reference Committee recommends the reaffirmation of Policy D-390.969 in lieu of Resolution 823.

D-390.969 Parity in Medicare Reimbursement
Our AMA will continue its comprehensive advocacy campaign to: (1) repeal the reductions in Medicare payment for imaging services furnished in physicians' offices, as mandated by the Deficit Reduction Act of 2005; (2) pass legislation allowing physicians to share in Medicare Part A savings that are achieved when physicians provide medical care that results in fewer in-patient complications, shorter lengths-of-stays, and fewer hospital readmissions; and (3) advocate for other mechanisms to ensure adequate payments to physicians, such as balance billing and gainsharing. (BOT Action in response to referred for decision Res. 236, A-06; Reaffirmation I-08; Modified: BOT Rep. 09, A-18)

Madam Speaker, this concludes the report of Reference Committee J. I would like to thank Timothy Beittel, MD, Nitin Damle, MD, Florence Jameson, MD, Steve Lee, MD, Adam Panzer, Susan Strate, MD, and all those who testified before the Committee. I would also like to thank AMA staff: Courtney Perlino, MPP, Andrea Preisler, JD, and Jane Ascroft, MPA.

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American Society of Clinical Oncology

Nitin Damle, MD
American College of Physicians

Adam Panzer
Colorado

Florence Jameson, MD
Nevada

Susan Strate, MD (Alternate)
College of American Pathologists

Steven Chen, MD
American Society of Breast Surgeons
Chair

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-18)

Report of Reference Committee K

Darlyne Menscer, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Resolution 901 – Support for Preregistration in Biomedical Research
2. Resolution 906 – Increased Access to Identification Cards for the Homeless Population
3. Resolution 908 – Increasing Accessibility to Incontinence Products
4. Resolution 927 – Oppose FDA's Decision to Approve Primatene Mist HFA for Over the Counter Use

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

5. Board of Trustees Report 12 – Information Regarding Animal-Derived Medications
6. Council on Science and Public Health Report 1 – Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals
7. Council on Science and Public Health Report 2 – Improving FDA Expedited Approval Pathways
8. Resolution 902 – Increasing Patient Access to Sexual Assault Nurse Examiners
9. Resolution 903 – Regulating Front-of-Package Labels on Food Products
10. Resolution 904 – Support for Continued 9-1-1 Modernization and the National Implementation of Text-to-911 Service
11. Resolution 905 – Support Offering HIV Post Exposure Prophylaxis to all Survivors of Sexual Assault
12. Resolution 911 – Regulating Tattoo and Permanent Makeup Inks
13. Resolution 912 – Comprehensive Breast Cancer Treatment
14. Resolution 913 – Addressing the Public Health Implications of Pornography
15. Resolution 916 – Ban on Tobacco Flavoring Agents with Respiratory Toxicity
16. Resolution 917 – Protect and Maintain the Clean Air Act
17. Resolution 918 – Allergen Labeling on Food Packaging
18. Resolution 920 – Continued Support for Federal Vaccination Funding
19. Resolution 921 – Food Environments and Challenges Accessing Healthy Food
20. Resolution 924 – Utilizing Blood from "Therapeutic" Donations
21. Resolution 926 – E-Cigarettes, Revisited

RECOMMENDED FOR REFERRAL

22. Resolution 915 – Mandatory Reporting
23. Resolution 919 – Opioid Mitigation

RECOMMENDED FOR NOT ADOPTION

24. Resolution 914 – Common Sense Strategy for Tobacco Control and Harm Reduction

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

25. Resolution 922 – Full Information on Generic Drugs
26. Resolution 923 – Scoring of Medication Pills

Resolutions not considered:

Resolution 907 – Developing Diagnostic Criteria and Evidence-Based Treatment Options for Problematic Pornography Viewing
Resolution 909 – Use of Person-Centered Language
Resolution 910 – Shade Structures in Public and Private Planning and Zoning Matters

(1) RESOLUTION 901 – SUPPORT FOR PREREGISTRATION IN BIOMEDICAL RESEARCH

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 901 be adopted.

Resolution 901 asks that our American Medical Association support preregistration in order to mitigate publication bias and improve the reproducibility of biomedical research. (New HOD Policy)

Your Reference Committee heard testimony largely in support of this resolution, including on behalf of the National Institutes of Health. Many who testified noted the need for negative data and results to be published in journals for a complete picture of an evidence-base. These results are not commonly published or made available because of the bias to publish positive results. Many peer-reviewed journals have already adopted pre-registration. Additionally, several noted that the pre-registration of research study protocols would ensure that researchers maintain research integrity, and do not alter study design for more favorable results. Some sentiment was expressed for broadening the concept beyond randomized controlled trials. Your Reference Committee believes the current language is sufficient and recommends that Resolution 901 be adopted.

(2) RESOLUTION 906 – INCREASED ACCESS TO IDENTIFICATION CARDS FOR THE HOMELESS POPULATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 906 be adopted.

Resolution 906 asks that our American Medical Association (AMA) recognize that among the homeless population, a lack of identification card serves as a barrier to accessing medical care as well as and fundamental services that support health and that our AMA support legislative and policy changes that streamline, simplify, and reduce or eliminate the cost of obtaining identification cards for the homeless population. (New HOD Policy)

Your Reference Committee heard testimony in strong support of this resolution. It was noted that many persons who are homeless lack photo identification due to the difficulty of maintaining important documents while homeless. People without photo identification have difficulty accessing critical services and benefits, including health care. A proposed amendment called for the development of model state legislation on this issue, but your Reference Committee believes that because the policy changes relate to simplifying existing processes and reducing or eliminating costs, this is not necessary. Therefore, your Reference Committee recommends that Resolution 906 be adopted.

(3) RESOLUTION 908 – INCREASING ACCESSIBILITY TO INCONTINENCE PRODUCTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 908 be adopted.

Resolution 908 asks that our American Medical Association support increased access to affordable incontinence products. (New HOD Policy)

Your Reference Committee heard mostly supportive testimony for this item, emphasizing lack of access to incontinence products as an important issue for patient health and safety. Some support was offered for referral and for broadening the therapeutic target to include "bowel and bladder management." In order to focus on the most common condition and terminology, your Reference Committee recommends that Resolution 908 be adopted as written.

(4) RESOLUTION 927 – OPPOSE FDA'S DECISION TO APPROVE PRIMATENE MIST HFA FOR OVER THE COUNTER USE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 927 be adopted in lieu of Policy H-115.972.

Resolution 927 asks that our American Medical Association send a letter to the US Food and Drug Administration (FDA) expressing: 1) our strong opposition to FDA making the decision to allow inhaled epinephrine to be sold as an over-the counter medication without first soliciting public input, and 2) our opposition to the approval of over-the-counter sale of inhaled epinephrine as it is currently not a recommended treatment for asthma. (Directive to Take Action).

Testimony voiced strong support for this resolution, opposing the return of an over-the-counter formulation of an epinephrine inhaler for the treatment of mild, intermittent asthma. Comments were directed to the belief that epinephrine is a potentially dangerous substance and its use is not endorsed in any treatment guidelines for asthma. Many noted that inexpensive, over-the-counter medications for asthma are a risk to patient safety. Your Reference Committee agrees and recommends that Resolution 927 be adopted. Policy H-115.972 is in conflict with this resolution. Therefore, we recommend that it be rescinded.

H-115.972, "Over-the-Counter Inhalers in Asthma"
Our AMA: (1) supports strengthening the product labeling for over-the-counter (OTC) epinephrine inhalers to better educate users about patterns of inappropriate use; to include clear statements that the use of OTC inhalers can be dangerous; to urge users to seek medical care if symptoms do not improve or if they meet criteria for the presence of persistent disease; and to encourage explicit discussions with physicians about dosage when these products are used; (2) encourages the FDA to reexamine whether OTC epinephrine inhalers should be removed from the market; and (3) In the event that these products continue to be marketed OTC, further information should be obtained to determine whether OTC availability is a risk factor for asthma morbidity and mortality.

(5) BOARD OF TRUSTEES REPORT 12 – INFORMATION REGARDING ANIMAL-DERIVED MEDICATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 12 be amended by deletion to read as follows:

Animal-Derived Ingredients
Our AMA:

1. Urges ~~the U.S. Food and Drug Administration to require~~ manufacturers to include all ingredients and components present in medical products on the product label, including both active and inactive ingredients, and denote any derived from an animal source. (New HOD Policy)
2. Encourages cultural awareness regarding patient preferences associated with medical products containing active or inactive ingredients or components derived from animal sources. (New HOD Policy)

RECOMMENDATION B:

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

Board of Trustees Report 12, in response to Resolution 515-A-18, summarizes the issue of animal-derived ingredients and current evidence related to animal-derived components of medical products. Some chemical products used as inactive excipients for prescription drugs, as well as some active prescription medications and also some surgical implants, dressings, and mesh, are derived from animal sources. The consumption or use of such products may be objectionable to certain religions or based on consumer choice. The Board of Trustees recommends the following be adopted in lieu of Resolution 515-A-18, and the remainder of the report be filed:

Animal-Derived Ingredients
Our AMA:

1. Urges the U.S. Food and Drug Administration to require manufacturers to include all ingredients and components present in medical products on the product label, including both active and inactive ingredients, and denote any derived from an animal source. (New HOD Policy)
2. Encourages cultural awareness regarding patient preferences associated with medical products containing active or inactive ingredients or components derived from animal sources. (New HOD Policy)

Your Reference Committee heard limited and mixed testimony regarding this report developed by the Board of Trustees. The FDA noted that it would require an enormous undertaking for them to require manufacturers to include this information on product labels and suggested urging manufacturers to include more informative labeling. Additional

testimony noted that determining the make-up of sourced inactive ingredients is a difficult task, as was noted in the report. Your Reference Committee agrees that asking the FDA to take on this issue is overly-burdensome. Therefore, your Reference Committee recommends that the recommendations in Board of Trustees Report 12 be adopted as amended.

(6) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 1 – IMPROVING SCREENING AND TREATMENT GUIDELINES FOR DOMESTIC VIOLENCE AGAINST LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER/QUESTIONING, AND OTHER INDIVIDUALS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that recommendation 1 in Council on Science and Public Health Report 1 be amended by addition and deletion to read as follows:

Policy D-515.980, "Improving Screening and Treatment Guidelines for ~~Domestic~~ Intimate Partner Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals"

Our AMA will: (1) ~~study recent domestic violence data and the unique issues faced by the LGBTQ population; and (2)~~ promote crisis resources for LGBTQ patients that cater to the specific needs of LGBTQ ~~victims~~ survivors of domestic violence, (2) encourage physicians to familiarize themselves with resources available in their communities for LGBTQ survivors of intimate partner violence (IPV), ~~and~~ (3) advocate for federal funding to support programs and services for survivors of IPV ~~intimate partner violence~~ that do not discriminate against underserved communities, including on the basis of sexual orientation and gender identity, and (4) encourage the dissemination of research to educate physicians and the community regarding the prevalence of IPV in the LGBTQ population, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening. (Modify Current HOD policy)

RECOMMENDATION B:

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

Council on Science and Public Health Report 1 is in response to Policy D-515.980 and notes that the lifetime prevalence of IPV in the LGBTQ community is estimated to be comparable to or higher than that among heterosexual couples. There is limited information available on the aspects of IPV that are unique to same-sex relationships and the effects on LGBTQ survivors' mental and physical health. Despite the limited research available on this topic, physicians should be alert to the possibility of IPV among their LGBTQ patients and should familiarize themselves with resources available in their communities for LGBTQ survivors of IPV. The Council on Science and Public Health recommends that the following statements be adopted and the remainder of the report be filed:

1. That Policy D-515.980, "Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals" be amended by addition and deletion to read as follows:

   Our AMA will: (1) ~~study recent domestic violence data and the unique issues faced by the LGBTQ population; and (2)~~ promote crisis resources for LGBTQ patients that cater to the specific needs of LGBTQ ~~victims~~ survivors of domestic violence, (2) encourage physicians to familiarize themselves with resources available in their communities for LGBTQ survivors of intimate partner violence, and (3) advocate for federal funding to support programs and services for survivors of intimate partner violence that do not discriminate against underserved communities, including on the basis of sexual orientation and gender identity. (Modify Current HOD policy)

2. Our AMA encourages research on intimate partner violence in the LGBTQ community to include studies on the prevalence, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening. (New HOD Policy)

3. That Policy H-160.991, "Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations," be reaffirmed.

   Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors. (Reaffirm HOD Policy)

Your Reference Committee heard testimony in strong support of this Council on Science and Public Health report and its recommendations. While the Council found limited research on this topic, the available data suggests that IPV in the LGBTQ community is comparable to or higher than that among heterosexual couples. Physicians should be aware of the possibility of IPV in their LGBTQ patients. Testimony called for an amendment to support education in addition to research on this topic. CSAPH supported the amendment. Your Reference Committee felt this amendment was more appropriate in the existing directive rather than in the research policy. Therefore, your Reference Committee recommends adoption of the report's recommendations as amended.

(7) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 2 – FDA EXPEDITED REVIEW PROGRAMS AND PROCESSES

RECOMMENDATION A:

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

1(b) the~~is~~ evidence for drug approval should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies, as appropriate;

1(d) confirmatory trials for drugs approved under ~~expedited programs~~ accelerated approval should be planned and underway at the time of expedited approval;

1(g) FDA should make the annual summary of drugs approved under expedited programs more readily available and consider adding information on confirmatory clinical trials for such drugs to the drugs trials snapshot ~~a simple system to assign a grade for each approval of prescription drugs occurring via expedited programs in order to signal, and provide in a transparent manner, the quality of clinical trial evidence used to establish safety and effectiveness, and whether confirmatory trials are required for labeled indications~~.

RECOMMENDATION B:

Madam 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 be filed.

Council on Science and Public Health Report 2 is in response to Resolution 201-I-17 and examines expedited FDA drug approval programs or processes in place in the United States, including so-called fast track, accelerated approval, designated breakthrough therapies, and "priority review" for drugs and biologics, and whether the operation of such programs needs to be re-examined or modified. The Council on Science and Public Health recommends that Policy H-100.992 be amended by addition and deletion to read as follows in lieu of Res-201-I-17, and the remainder of the report be filed:

(1) Our AMA ~~reaffirms its~~ support~~s~~ ~~for~~ the principles that:
(a) an FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials and/or postmarket incident reports as provided by statute;
(b) the~~is~~ evidence for drug approval should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies;

(c) expedited programs for drug approval serve the public interest as long as sponsors for drugs that are approved based on surrogate endpoints or limited evidence conduct confirmatory trials in a timely fashion to establish the expected clinical benefit and predicted risk-benefit profile;
(d) confirmatory trials for drugs approved under expedited programs should be planned and underway at the time of expedited approval;
(e) the FDA should pursue having in place a systematic process to ensure that sponsors adhere to their obligations for confirmatory trials, and Congress should establish a firmer threshold to trigger expedited withdrawal when sponsors fail to fulfill their postmarketing study obligations;
(~~d~~ f) any risk-benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications; and,
(g) FDA should consider a simple system to assign a grade for each approval of prescription drugs occurring via expedited programs in order to signal, and provide in a transparent manner, the quality of clinical trial evidence used to establish safety and effectiveness, and whether confirmatory trials are required for labeled indications.

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

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

Generally supportive testimony was offered on Council on Science and Public Health Report 2 and the Council was thanked for developing an informative report. Testimony noted that FDA labeling guidance is not supportive of using letters, or other grades to signify levels of evidence, and that drugs approved under expedited programs or processes are ultimately held to the same evidentiary standard for determining safety and effectiveness. The Council offered amendments to reflect concerns expressed by the FDA and others. Your Reference Committee agrees with amending the recommendation to reflect those viewpoints.

(8) RESOLUTION 902 – INCREASING PATIENT ACCESS TO SEXUAL ASSAULT NURSE EXAMINERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 902 be amended by addition to read as follows:

RESOLVED, That our American Medical Association advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations. (New HOD Policy)

RECOMMENDATION B:

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

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 902 be changed to read as follows:

INCREASING PATIENT ACCESS TO SEXUAL ASSAULT MEDICAL FORENSIC EXAMINATIONS

Resolution 902 asks that our American Medical Association advocate for increased patient access to Sexual Assault Nurse Examiners in the emergency department. (New HOD Policy)

Your Reference Committee heard testimony largely in support of this resolution. Many noted that the registered nurses who have completed specialized education and clinical preparation in the medical forensic care of an individual who has experienced sexual assault or abuse are an important resource for these survivors. Additionally, several comments noted that other clinicians, in addition to nurses, are trained and qualified to perform medical forensic examinations. It was also stated that a medical forensic examination in a pre-pubertal patient could unintentionally induce additional trauma and an amendment was offered to specify this examination is optimal for post-pubertal patients. Your Reference Committee agrees that both nurses and other clinicians who are trained and qualified to perform medical forensic examinations are important for patient care and that the examination could be problematic for pre-pubertal patients, who should receive specialized care, and therefore recommends that Resolution 902 be adopted as amended.

(9) RESOLUTION 903 – REGULATING FRONT-OF-PACKAGE LABELS ON FOOD PRODUCTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate Resolution be adopted in lieu of Resolution 903.

FRONT-OF-PACKAGE LABELS FOR FOOD PRODUCTS WITH ADDED SUGARS

RESOLVED, That our AMA encourage the FDA to: (1) develop front-of-package warning labels for foods that are high in added sugars based on the established recommended daily value and (2) limit the amount of added sugars permitted in a food product containing front-of-package health or nutrient content claims. (New HOD Policy)

Resolution 903 asks that our American Medical Association support additional U.S. Food and Drug Administration criteria that limit the amount of added sugar a food product can contain if it carries any front-of-package label advertising nutritional or health benefits and that our AMA support the use of front-of-package warning labels on foods that contain excess added sugar. (New HOD Policy)

Your Reference Committee heard testimony supporting the intent of this resolution. Concerns were raised regarding the lack of a standard for excess added sugar. The sponsor addressed this issue by referencing the recommended daily value for added sugars. Testimony also noted there are several initiatives underway at FDA related to this issue including: the revised nutrition facts label requirements for added sugars that take effect in 2020 or 2021 depending on the company's annual food sales, and the final proposed rule to update the regulatory definition of the nutrient content claim "healthy" and how to depict "healthy" on the package. Your Reference Committee believes that expressing support for increased transparency for consumers related to high added sugars in food products is needed, but suggests alternate language to streamline the policy.

(10) RESOLUTION 904 – SUPPORT FOR CONTINUED 9-1-1 MODERNIZATION AND THE NATIONAL IMPLEMENTATION OF TEXT-TO-911 SERVICE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 904 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association support the funding ~~of federal grant programs for the modernization of the~~ for and modernization of 9-1-1 infrastructure, including incorporation of text-to-911 technology. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 904 be adopted as amended.

Resolution 904 asks that our American Medical Association support the funding of federal grant programs for modernization of the 9-1-1 infrastructure, including incorporation of text to 911 technology. (New HOD Policy)

Your Reference Committee heard testimony largely in support of Resolution 904. Your Reference Committee discussed that other funding, beyond federal grant programs, is likely also needed. Therefore, your Reference Committee suggests a minor amendment to also include support for additional avenues of funding and recommends adoption as amended.

(11) RESOLUTION 905 – SUPPORT OFFERING HIV POST EXPOSURE PROPHYLAXIS TO ALL SURVIVORS OF SEXUAL ASSAULT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that first Resolve of Resolution 905 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association (AMA) ~~advocate for~~ support education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines; (New HOD Policy), and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 905 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support increased access to, and coverage for, PEP for HIV ~~and~~, as well as enhanced public education on its ~~about the~~ effective use ~~of Post-Exposure Prophylaxis for HIV~~; (New HOD Policy) and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 905 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA amend policy H-20.900 by insertion as follows:

H-20.900, "HIV, Sexual Assault, and Violence"
Our AMA believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all ~~victims~~ survivors of sexual assault~~,~~ who present within 72 hours of a substantial exposure risk, that these ~~victims~~ survivors should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained. (Modify Current HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 905 be adopted as amended.

Resolution 905 asks that our American Medical Association (AMA) advocate for education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines; that our AMA support increased public education about the effective use of Post-Exposure Prophylaxis for HIV; and that our AMA amend policy H-20.900 by insertion as follows:

H-20.900, "HIV, Sexual Assault, and Violence"
Our AMA believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all ~~victims~~ survivors of sexual assault, that these ~~victims~~ survivors should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained. (Modify Current HOD Policy)

Testimony strongly supported the intent of the resolution and the need to enhance education and provide HIV prophylaxis in a timely fashion to survivors of sexual assault. Postexposure prophylaxis (PEP) should be used only in emergency situations and must be started within 72 hours after a recent possible exposure to HIV. "Updated Guidelines for Antiretroviral Postexposure" are available from the CDC along with an informational leaflet for patients (Prophylaxis After Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV—United States). The importance of improving treatment in this area is based on available data indicating a significant proportion of such victims are not offered treatment. Amendments were suggested on enhancing public education, improving access and coverage, and clarifying that treatment must be started within 72 hours to be effective. Your Reference Committee agrees and recommends adoption with those amendments.

(12) RESOLUTION 911 – REGULATING TATTOO AND PERMANENT MAKEUP INKS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy H-440.909 be amended by addition to read as follows:

1. The AMA encourages the state regulation of tattoo artists and tattoo facilities to ensure adequate procedures to protect the public health; and encourages tattoo artists, tattoo facilities, and physicians to report all adverse reactions associated with tattooing to the Food and Drug Administration MedWatch program.

2. The AMA encourages manufacturers of tattoo inks to provide a list of their ingredients to protect public health;

3. The AMA encourages tattoo artists and tattoo facilities to obtain informed consent from their clients, that includes potential risks, prior to performing a tattooing procedure;

4. The AMA, in consultation with relevant stakeholders, develop model state legislation for regulation of tattoo artists and tattoo facilities to ensure adequate procedures to protect the public health and safety. (Modify HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-440.909, as amended, be adopted in lieu of Resolution 911.

Resolution 911 asks that our American Medical Association encourage the Food and Drug Administration to adopt regulatory standards for tattoo and permanent makeup inks that include at minimum the disclosures expected for injectable drugs and cosmetics and mandate that this information be available to both the body licensed to perform the tattoo and to the person receiving the tattoo and that our AMA study the safety of any chemical in tattoo and permanent makeup inks. (Directive to Take Action)

Your Reference Committee heard limited and mixed testimony regarding this Resolution. Some stated that this is a critical need and others noted that the oversite of tattoo facilities is regulated by states and this is not necessary. Still others noted that the agencies that regulate the practice of tattooing need assistance. The authors of the resolution stated that informed consent was an important component that was misunderstood in their originally submitted resolution and submitted an alternate resolution that amends current policy; additional testimony was supportive of this alternate resolution. Your Reference Committee agrees that

the alternate resolution amending current policy is appropriate and recommends that Policy H-440.909 be adopted as amended.

(13) RESOLUTION 912 – COMPREHENSIVE BREAST CANCER TREATMENT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 912 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association amend Policy H-55.973, "Breast Reconstruction," by addition and deletion as follows:
Our AMA: (1) believes that reconstruction of the breast for post-treatment rehabilitation of patients ~~the postmastectomy cancer post-treatment patient~~ with in situ or invasive breast neoplasm should be considered reconstructive surgery rather than aesthetic surgery; (2) supports education for physicians and breast cancer patients on breast reconstruction and its availability; (3) recommends that third party payers provide coverage and reimbursement for medically necessary breast cancer treatments including but not limited to prophylactic contralateral mastectomy and/or salpingo-oophorectomy; and (4) recognizes the validity of contralateral breast procedures needed for the achievement of symmetry in size and shape, and urges recognition of these ancillary procedures by Medicare and all other third parties for reimbursement when documentation of medical necessity is provided. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 912 be adopted as amended.

Resolution 912 asks that our American Medical Association amend Policy H-55.973, "Breast Reconstruction," by addition and deletion as follows:

Our AMA: (1) believes that reconstruction of the breast for rehabilitation of the ~~postmastectomy cancer~~ post-treatment patient with in situ or invasive breast neoplasm should be considered reconstructive surgery rather than aesthetic surgery; (2) supports education for physicians and breast cancer patients on breast reconstruction and its availability; (3) recommends that third party payers provide coverage and reimbursement for medically necessary breast cancer treatments including but not limited to prophylactic contralateral mastectomy and/or oophorectomy; and (4) recognizes the validity of contralateral breast procedures needed for the achievement of symmetry in size and shape, and urges recognition of these ancillary procedures by Medicare and all other third parties for reimbursement when documentation of medical necessity is provided. (Modify Current HOD Policy)

Your Reference Committee heard extensive supportive testimony for this resolution and a minor amendment that was proposed. Your Reference Committee supports the amendments and has also chosen to alter the policy slightly to use person-first language. Therefore, your Reference Committee recommends that Resolution 912 be adopted as amended.

(14) RESOLUTION 913 – ADDRESSING THE PUBLIC HEALTH IMPLICATIONS OF PORNOGRAPHY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 913 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association support efforts to mitigate the negative public health impacts of pornography as it relates to vulnerable populations~~, including but not limited to women and children~~. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, you Reference Committee recommends that Resolution 913 be adopted as amended.

Resolution 913 asks that our American Medical Association support efforts to mitigate the negative public health impacts of pornography as it relates to vulnerable populations, including but not limited to women and children. (New HOD Policy)

A concern was expressed about use of the term “vulnerable” and whether it could be considered limiting and some sentiment was offered for referral. Otherwise, testimony was broadly supportive and noted the need to address the links between pornography, behavior, and sex trafficking. Your Reference Committee concurs with the general support offered for this resolution, but believes that truncating the language after populations allows for a more inclusive approach.

(15) RESOLUTION 916 – BAN ON TOBACCO FLAVORING AGENTS WITH RESPIRATORY TOXICITY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy H-495.971 be amended to read as follows:

H-495.971 Opposition to Addition of Flavors to ~~Cigarettes~~ Tobacco Products
Our AMA: (1) supports state and local legislation to prohibit the sale or distribution of flavored tobacco products; ~~and~~ (2) urges local and state medical societies and federation members to support state and local legislation to prohibit the sale or distribution of flavored tobacco products; and (3) encourages the FDA to prohibit the use of flavoring agents in tobacco products, which includes electronic nicotine delivery systems.

RECOMMENDATION B:

Madam Speaker, you Reference Committee recommends that Policy H-495.971 be adopted as amended in lieu of Resolution 916.

Resolution 916 asks that our American Medical Association call for the immediate ban on flavoring agents in electronic nicotine delivery systems (ENDS) and other tobacco products that have known respiratory toxicity including but not limited to diacetyl, 2,3 pentanedione, acetoin, cinnamaldehyde, benzaldehyde, eugenol, vanillin/ethyl vanillin, and menthol and that the AMA urge the U.S. Food and Drug Administration (FDA) to require comprehensive testing of flavoring agents used in ENDS and other tobacco products to assess the potential negative health effects of chronic exposure to these flavoring agents. (Directive to Take Action)

Your Reference Committee heard testimony both in support of and in opposition to Resolution 916. While the intent of the resolution was supported, it was noted that existing policy broadly supports banning flavors in electronic cigarettes, particularly those that appeal to youth. It was felt by some that focusing on eliminating flavors with known respiratory toxicity would be taking a step backwards, as not all toxicity is known or can be easily assessed. Your Reference Committee agreed that a strong statement calling for a ban on the use of flavoring agents in tobacco products was warranted. Therefore, your Reference Committee recommends amending existing policy as outlined.

(16) RESOLUTION 917 – PROTECT AND MAINTAIN THE CLEAN AIR ACT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 917 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association (AMA) oppose legislative or regulatory changes ~~provisions of the Affordable Clean Energy proposed rule~~ that would allow power plants to avoid complying with new source review requirements to install air pollution control equipment when annual pollution emissions increase (New HOD Policy); and be it further

RESOLVED, That our AMA ~~send a letter to the Environmental Protection Agency (EPA)~~ work with other organizations to promote a public relations campaign, strongly expressing our opposition to EPA's Affordable Clean Energy rule and its proposed amendments of the New Source Review requirements under the Clean Air Act. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 917 be adopted as amended.

Resolution 917 asks that our American Medical Association (AMA) oppose provisions of the Affordable Clean Energy proposed rule that would allow power plants to avoid complying with new source review requirements to install air pollution control equipment when annual pollution emissions increase and that our AMA send a letter to the Environmental Protection Agency (EPA) expressing our opposition to EPA's Affordable Clean Energy rule and its proposed amendments of the New Source Review requirements under the Clean Air Act. (Directive to Take Action)

Testimony strongly supported the intent of this resolution. The value of a letter was questioned given the deadline has passed for submission of comments on the Affordable Clean Energy rule, and the AMA has already signed on to such a letter as part of its participation in the Federation-based Climate Change Consortium. Instead, it was suggested that some sort of public campaign was necessary, a concept that received considerable support. A suggestion also was made to broaden the policy to express more general opposition to potential legislative or regulatory efforts intended to weaken provisions in the Clean Energy Act. Your Reference Committee agrees with the suggested amendments.

(17) RESOLUTION 918 – ALLERGEN LABELING ON FOOD PACKAGING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 918 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~petition the Food and Drug Administration~~ encourage food manufacturers to pursue more obvious ~~labeling on food~~ packaging distinctions between products that contain~~sing~~ the ~~eight~~ most common food allergens identified in the Food Allergen Labeling and Consumer Protection Act and products that do not contain these allergens ~~: milk, eggs, peanuts, tree nuts, wheat, soy, fish and crustacean shellfish~~. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 918 be adopted as amended.

Resolution 918 asks that our American Medical Association petition the Food and Drug Administration to pursue more obvious labeling on food packaging containing the eight most common food allergens: milk, eggs, peanuts, tree nuts, wheat, soy, fish and crustacean shellfish. (Directive to Take Action)

Your Reference Committee heard limited testimony in support of this resolution. The FDA already enforces the Food Allergen Labeling and Consumer Protection Act, which requires food labels to clearly identify the food source names of any ingredients that are one of the major food allergens. However, product packaging developed by food manufacturers could be improved to ensure that similar products that contain and do not contain common food allergens are not confused by consumers. Your Reference Committee removed the specific list of allergens should the FDA update that list in the future to include additional allergens (i.e. sesame). Therefore, your Reference Committee recommends that Resolution 918 be adopted as amended.

(18) RESOLUTION 920 – CONTINUED SUPPORT FOR FEDERAL VACCINATION FUNDING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy H-440.928 (3) be amended in lieu of Resolution 920 to read as follows:

H-440.928 Update on Immunizations and Vaccine Purchases

Our AMA: (3) ~~supports~~ will release a public statement and actively advocate for increased federal funding for vaccines, including activities funded through Section 317 of the Public Health Service Act, which supports purchasing vaccines and implementing the national vaccine strategy, and includes~~ing~~ monies for education of the American public about the importance of immunization, education and training for health professionals, and for support to state and local governments to remove barriers to effective immunization.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-440.928, as amended, be adopted in lieu of Resolution 920.

Resolution 920 asks that our American Medical Association release a public statement of support for federal vaccination funding efforts such as Section 317, and actively advocate for sustained funding. (Directive to Take Action)

Your Reference Committee heard testimony in strong support of federal funding for vaccines through Section 317 of the Public Health Service Act. It was asked that the resolution be amended to define the Section 317 Immunization Program. Since existing policy addresses funding for vaccines and the activities funded through the Section 317 immunization program, your Reference Committee believes that amending this policy was the best course of action. Therefore, your Reference Committee recommends adopting existing policy as amended.

(19) RESOLUTION 921 – FOOD ENVIRONMENTS AND CHALLENGES ACCESSING HEALTHY FOOD

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 921 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~work with~~ encourage the U.S. Department of Agriculture and appropriate stakeholders to ~~advocate for the~~ study ~~of~~ the national prevalence~~,~~ ~~and~~ impact, and solutions to the problems of food mirages, food swamps, and food oases as food environments distinct from food deserts. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 921 be adopted as amended.

Resolution 921 asks that our American Medical Association work with appropriate stakeholders to advocate for the study of the national prevalence and impact of food mirages, food swamps, and food oases as food environments distinct from food deserts. (Directive to Take Action)

Your Reference Committee heard testimony in strong support of this resolution. Food environments include the food available in our day-to-day environments and are a determinant of what we eat. Differences in income, education, and nutritional knowledge are major factors that shape our eating habits and impact our health. While many resources are available addressing access and affordability of healthy food, the U.S. Department of Agriculture's most recent report on "Access to Affordable and Nutritious Food: Measuring and Understanding Food Deserts and their Consequences" was from 2009. Your Reference Committee believes that an update of this report is warranted and that the United States Department of Agriculture is in the best position to conduct this study with input from stakeholders. The sponsor offered an amendment to include the identification of solutions to this problem. Your Reference Committee supports this amendment.

(20) RESOLUTION 924 – UTILIZING BLOOD FROM "THERAPEUTIC" DONATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 924 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association encourage ~~advocate for CMS~~ the U.S. Food and Drug Administration to engage in dialogue with the American Association of Blood Banks and relevant stakeholders~~Red Cross~~ to reanalyze their therapeutic phlebotomy policies on variances, ~~donor eligibility criteria, to accept blood from a broader category of individuals,~~including but not limited to hereditary hemochromatosis. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 924 be adopted as amended.

Resolution 924 asks that our American Medical Association advocate for CMS to engage in dialogue with Red Cross to reanalyze their donor eligibility criteria, to accept blood from a broader category of individuals, including but not limited to hereditary hemochromatosis. (Directive to Take Action)

Your Reference Committee heard testimony largely in support of the intent of this resolution. Testimony noted that CMS is not the appropriate organization to undertake this ask; the FDA is the agency responsible for regulations regarding blood donation. Testimony also noted that there are several other organizations besides the American Red Cross who perform therapeutic blood donations, and this should be reflected in the statement. Those who testified overwhelmingly noted that the ability to utilize blood donations from a larger cohort of individuals would aid in the alleviation of blood shortages. Your Reference Committee agrees and recommends that Resolution 924 be adopted as amended.

(21) RESOLUTION 926 – E-CIGARETTES, REVISITED

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 926 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association recognize the use of e-cigarettes and vaping as an urgent public health ~~crisis~~ epidemic and actively work with the Food and Drug Administration and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21. (Directive to Take Action)

RECOMMENDATION B:

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

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 924 be changed to read as follows:

ADDRESSING THE PUBLIC HEALTH EPIDEMIC OF E-CIGARETTES

Resolution 926 asks that our American Medical Association recognize the use of e-cigarettes and vaping as an urgent public health crisis and actively work with the Food and Drug Administration and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21. (Directive to Take Action)

Your Reference Committee heard testimony unanimously supportive of this resolution. A minor amendment was offered changing the terminology from “public health crisis” to “public health epidemic.” Your Reference Committee agrees with this change as the FDA has recently recognized the use of e-cigarettes among teens as an epidemic. Therefore, your Reference Committee recommends that Resolution 926 be adopted as amended.

(22) RESOLUTION 915 – MANDATORY REPORTING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 915 be referred.

Resolution 915 asks that our American Medical Association oppose mandated reporting of entire classes of patients and specific diagnoses unless compelling evidence exists to demonstrate that a serious public health and/or safety risk will be mitigated as a result of such reporting. (New HOD Policy)

Testimony on Resolution 915 was strongly in support of referral. It was noted that public health surveillance is an essential public health function that has traditionally relied on health care providers, hospitals, and laboratories to report to public health agencies specific conditions or outbreaks that may impact the broader population. It was also noted that efforts are underway to implement electronic case reporting, by which cases of reportable conditions are automatically generated from EHRs and transmitted to public health agencies for review and action. It was clear that the benefits of public health reporting need to be balanced against the burden that mandatory reporting places on physicians. Due to the complex nature of this issue, your Reference Committee agrees with referral.

(23) RESOLUTION 919 – OPIOID MITIGATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 919 be referred.

Resolution 919 asks that our American Medical Association review the following opioid mitigation strategies based on their effectiveness in Huntington, WV, and Clark County, IN, and provide feedback concerning their utility in dealing with opioids:

(1) The creation of an opioid overdose team that decreases the risk of future overdose and overdose death, increases access to opioid-related services and increases the likelihood that an individual will pursue drug rehabilitation.
(2) A needle exchange program that is open multiple days a week and is mobile offers not only a source for needles but also Narcan, other supplies, health care and information.
(3) The creation of a drug court that allows a judge to have greater flexibility in determining the legal consequences of an arrest for an opioid-related crime. It also allows for the judicial patience necessary to deal with the recidivism of this population.
(4) Offering more acute-care inpatient drug rehab beds, although those ready for treatment need to be willing to travel significant distances to get to a treatment bed.
(5) Make available Narcan intranasal spray OTC through pharmacies and the syringe exchange, overdose team, etc.
(6) Encourage prevention education in K-12 programs that uses multiple media with anti-drug messaging delivered in the school system but also in the home. (Directive to Take Action)

Extensive testimony reflected the continuing concerns about opioid-related morbidity and mortality and the fact that numerous community, state, federal, hospital and healthcare system, and other private and public initiatives have been undertaken or are underway to

combat the epidemic, including many that are aligned with the focus areas noted in this resolution. The AMA has already evaluated many of these approaches in reports to the House of Delegates and has extensive policy related to opioids, overdose, pain management, naloxone, drug courts, needle exchange, safe injection facilities, and education on risk mitigation and pain care. The AMA also has formed a federation-based Opioid Task Force and more recently a Pain Care Task Force. The AMA also hosts an end-the-opioid-epidemic website that maintains a repository of state and medical specialty society resources at the intersection of pain, opioids, and addiction. These activities will continue for the foreseeable future. Because of the multitude of parallel efforts, strong sentiment was expressed for a need to evaluate effective mitigation approaches and to provide practical guidance on best practices around the nation. Ultimately, because of the complexity of this issue your Reference Committee recommends referral, which would allow for a coordinated AMA effort to be implemented.

(24) RESOLUTION 914 – COMMON SENSE STRATEGY FOR TOBACCO CONTROL AND HARM REDUCTION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 914 not be adopted.

Resolution 914 asks that our American Medical Association advocate for a "protect adult choice and youth's health" "common sense" tobacco strategy (with a report back to the House of Delegates annually) under which:

- Current educational, promotional and policy initiatives (e.g. taxation) to reduce the use of tobacco products by inhalation and orally would continue, including advocating for the prohibition of the sale of ALL nicotine containing products to individuals under 21 years unless via prescription for medical purposes.
- E-cigarettes (non-tobacco products containing nicotine) would be accessible at an affordable price to adults who wish to use them, and would be available to individuals below 21 years of age only as part of state sanctioned tobacco cessation activities. States and local jurisdictions would be free to require vendors to post warnings regarding the possible health risks of the use of nicotine inhalation products.
- Non-nicotine, non-drug containing vaping and other inhalation products would not be considered tobacco products, but would be monitored by state and local jurisdictions as any other personal use product regarding safety and public accommodation. (New HOD Policy)

Your Reference Committee heard testimony mostly in opposition to Resolution 914. The Council on Science and Public Health testified that based on a recent review of the evidence, their report adopted by the House of Delegates at A-18 concluded that the use of electronic cigarettes is not harmless and significant concerns exist that novel, non-combustible products may pose a significant threat to tobacco cessation and prevention efforts. Furthermore, electronic cigarettes use among youth and young adults is a public health concern. Available data suggest that youth who use electronic cigarettes are more likely to smoke combustible cigarettes. While there was support for prohibiting the sale of nicotine products to individuals under the age of 21, that is existing policy. Therefore, your Reference Committee recommends that Resolution 914 not be adopted.

(25) RESOLUTION 922 – FULL INFORMATION ON GENERIC DRUGS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-125.981 and H-125.984 be reaffirmed in lieu of Resolution 922.

Resolution 922 asks that American Medical Association advocate that generic drugs have an FDA-approved package insert available when dispensed that discloses active and inactive ingredients and clear language with bio-equivalent data as compared to parent branded drug. (Directive to Take Action)

Limited testimony was offered on this resolution. Testimony from the Council on Science and Public health emphasized the two previous reports authored by the Council on this topic, and the fact that a common misconception exists that the average serum values between the brand and generic equivalents can vary by a factor of -20 to +25%, which could lead to large differences between multisource products. When evaluating the bioequivalence of a generic product for approval, results are analyzed according to whether the generic or “test” product, when substituted for the brand-name or “reference product,” is significantly less bioavailable, and alternatively, whether the brand-name product, when substituted for a generic product, is significantly less bioavailable (that is, compared by using the two 1-sided tests). By convention, all data are expressed as a ratio of the average response (area under the curve and serum concentration maximum) for test versus the reference product, so the limit expressed in the second analysis is 125% (the reciprocal of 80%). Tests are carried out using an analysis of variance and calculating a 90% confidence interval (CI) for the average of each pharmacokinetic parameter, which must be entirely within the 80% to 125% boundaries. The width of the Confidence Interval reflects, in part, the within-subject variability of the test and reference products. When applying the required statistical criteria to bioequivalence studies, generic products whose mean arithmetic bioavailability parameters differ by more than ~5% from the reference product begin failing the Confidence Interval requirement. Accordingly, your Reference Committee does not believe the asks of this resolution would provide meaningful information and recommends reaffirmation of existing policy.

Policies recommended for reaffirmation:

H-125.981, “Generic Medications”
Our AMA encourages the Food and Drug Administration to maintain standards and criteria used for approving generic medications to ensure bioequivalence under various conditions and in relevant patient populations.

H-125.984, “Generic Drugs”
Our AMA believes that:
(1) Physicians should be free to use either the generic or brand name in prescribing drugs for their patients, and physicians should supplement medical judgments with cost considerations in making this choice.
(2) It should be recognized that generic drugs frequently can be less costly alternatives to brand-name products.
(3) Substitution with Food and Drug Administration (FDA) "B"-rated generic drug products (i.e., products with potential or known bioequivalence problems) should be prohibited by law, except when there is prior authorization from the prescribing physician.
(4) Physicians should report serious adverse events that may be related to generic substitution, including the name, dosage form, and the manufacturer, to the FDA's MedWatch program.
(5) The FDA, in conjunction with our AMA and the United States Pharmacopoeia, should explore ways to more effectively inform physicians about the bioequivalence of generic drugs, including decisional criteria used to determine the bioequivalence of individual products.
(6) The FDA should fund or conduct additional research in order to identify the optimum methodology to determine bioequivalence, including the concept of individual bioequivalence, between pharmaceutically equivalent drug products (i.e., products that contain the same active ingredient(s), are of the same dosage form, route of administration, and are identical in strength).
(7) The Congress should provide adequate resources to the FDA to continue to support an effective generic drug approval process.

(26) RESOLUTION 923 – SCORING OF MEDICATION PILLS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-115.973 be reaffirmed in lieu of Resolution 923.

Resolution 923 asks that our American Medical Association advocate that the FDA require scoring of all tablets and pills depending on their composition, so that the patient may be able to dose adjust their medication number requirement as prescribed by their physician at a lower cost to the patient. (Directive to Take Action)

Your Reference Committee heard mixed testimony on this resolution. Several spoke in support and noted that cost issues necessitate the scoring of medications. Others spoke in opposition noting that some medications cannot be split because of safety reasons or because of composition, for example oral contraceptives. The Council on Science and Public Health noted that the FDA currently considers medication splitting during the drug approval process for the evaluation of safety issues and has also provided guidance for manufacturers regarding what criteria should be met when evaluating and labeling tablets that have been scored. Because the FDA already has a framework for manufacturers in place on this issue and because AMA has policy urging manufacturers to score medications when appropriate, your Reference Committee feels that reaffirmation of current AMA policy H-115.973 in lieu of this resolution is appropriate.

Policy recommended for reaffirmation:

H-115.973, “Medication Scoring”
Our AMA:
(1) recommends to pharmaceutical manufacturers that, when appropriate, tablets be scored on both sides and so constructed that they will more readily divide in half and not fragment upon attempts at division; and
(2) opposes third party policies that mandate the use of pill-splitting or pill-breaking to reduce pharmaceutical or healthcare costs without proper input from the pharmaceutical manufacturers and practicing physicians.

Madam Speaker, this concludes the report of Reference Committee K. I would like to thank Robert L. Allison, MD, Daniel B. Kimball, Jr, MD, Sarah Marsicek, MD, Daniel M. Meyer, MD, Reid Orth, MD, William S. Pease, MD, and all those who testified before the Committee. Additionally, I would like to thank our AMA staff, especially Barry Dickinson, who is serving on his 44th and final Reference Committee.

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