AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-19)

Report of Reference Committee B

Charles Rothberg, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 14 — Reforming the Orphan Drug Act (Resolution 217-A-18) An Optional National Prescription Drug Formulary (Resolution 227-A-18) Reform of Pharmaceutical Pricing: Negotiated Payment Schedules (Resolution 238-A-18)
2. Board of Trustees Report 19 — FDA Conflict of Interest (Resolution 216-A-18)
3. Board of Trustees Report 23 — Prior Authorization Requirements for Post-Operative Opioids (Resolution 208-A-18)
4. Board of Trustees Report 30 — Opioid Treatment Programs Reporting to Prescription Monitoring Programs (Resolution 507-A-18)
5. Resolution 213 — Financial Penalties and Clinical Decision-Making
6. Resolution 223 — Simplification and Clarification of Smoking Status Documentation in the Electronic Health Record
7. Resolution 242 — Improving Health Information Technology Products to Properly Care for LGBTQ Patients
8. Resolution 244 — EHR-Integrated Prescription Drug Monitoring Program Rapid Access

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

9. Board of Trustees Report 9 — Council on Legislation Sunset Report
10. Board of Trustees Report 17 — Ban on Medicare Advantage "No Cause" Network Terminations
11. Board of Trustees Report 18 — Increased Use of Body-Worn Cameras by Law Enforcement Officers (Resolution 208-I-17)
12. Board of Trustees Report 20 — Safe and Efficient e-Prescribing
13. Board of Trustees Report 21 — Augmented Intelligence in Health Care
14. Board of Trustees Report 22 — Inappropriate Use of CDC Guidelines for Prescribing Opioids (Resolution 235-I-18)
    Resolution 229 — Clarification of CDC Opioid Prescribing Guidelines
15. Resolution 201 — Assuring Patient Access to Kidney Transplantation
16. Resolution 204 — Holding the Pharmaceutical Industry Accountable for Opioid-Related Costs
17. Resolution 208 — Repeal or Modification of the Sunshine Act
18. Resolution 211 — Use of Fair Health
19. Resolution 212 — Pharmacy Benefit Managers
20. Resolution 214 — The Term Physician
    Resolution 216 — Eliminate the Word Provider from Healthcare Contracts
21. Resolution 217 — Medicare Vaccine Billing

22. Resolution 218 — Payment for Medications Used Off Label for Treatment of Pain
    Resolution 235 — Prescription Coverage of the Lidocaine Transdermal Patch
23. Resolution 220 — Study of Confidentiality and Privacy Protection in the Treatment of Substance Disorders
    Resolution 231 — Alignment of Federal Privacy Law and Regulations Governing Substance Use Disorder Treatment (42 CFR Part 2) with the Health Insurance Portability and Accountability Act

24. Resolution 221 — Extending Medicaid Coverage to 12-Months Postpartum
    Resolution 224 — Extending Pregnancy Medicaid to One Year Postpartum
25. Resolution 228 — Truth in Advertising
26. Resolution 232 — COPD National Action Plan
27. Resolution 233 — GME Cap Flexibility
28. Resolution 237 — Opportunities in Blockchain for Healthcare
29. Resolution 241 — Facilitation of Research with Medicare Claims Data
30. Resolution 246 — Call for Transparency Regarding the Announcement of 17,000 Cuts to Military Health Providers

RECOMMENDED FOR REFERRAL

31. Resolution 203 — Medicare Part B and Part D Drug Price Negotiation
32. Resolution 207 — Direct-to-Consumer Genetic Tests
33. Resolution 219 — Medical Marijuana License Safety
34. Resolution 226 — Physician Access to Their Medical and Billing Records
35. Resolution 243 — Improving the Quality Payment Program and Preserving Patient Access
36. Resolution 245—Sensible Appropriate Use Criteria in Medicare
    Resolution 247—Sensible Appropriate Use Criteria in Medicare

RECOMMENDED FOR NOT ADOPTION

37. Resolution 227 — Controlled Substance Management
38. Resolution 239 — Improving Access to Medical Care Through Tax Treatment of Physicians

RECOMMEND FOR REAFFIRMATION IN LIEU OF

39. Resolution 206 — Changing the Paradigm: Opposing Present and Obvious Restraint of Trade
    Resolution 240 — Formation of Collective Bargaining Workgroup
40. Resolution 210 — Air Ambulances
41. Resolution 236 — Support for Universal Basic Income Pilot Studies

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

Resolution 202 – Reducing the Hassle Factor in Quality Improvement Programs
Resolution 205 – Use of Patient or Co-Worker Experience/Satisfaction Surveys Tied to Employed Physician Salary
Resolution 209 – Mandates by ACOs Regarding Specific EMR Use
Resolution 215 – Reimbursement for Health Information Technology

Resolution 222 – Protecting Patients from Misleading and Potentially Harmful "Bad Drug" Ads
Resolution 225 – DACA in GME
Resolution 230 – State legislation mandating electrocardiogram (ECG) and/or echocardiogram screening of scholastic athletes
Resolution 234 – Improved Access to Non-Opioid Therapies
Resolution 238 – Coverage Limitations and Non-Coverage of Interventional Pain Procedures Correlating to the Worsening Opioid Epidemic and Public Health Crisis

(1) BOARD OF TRUSTEES REPORT 14 – REFORMING THE ORPHAN DRUG ACT (RESOLUTION 217-A-18) AN OPTIONAL NATIONAL PRESCRIPTION DRUG FORMULARY (RESOLUTION 227-A-18) REFORM OF PHARMACEUTICAL PRICING: NEGOTIATED PAYMENT SCHEDULES (RESOLUTION 238-A-18)

RECOMMENDATION:

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

The Board of Trustees recommends that the following be adopted in lieu of Resolutions 217-A-18, 227-A-18, and 238-A-18, and the remainder of this report be filed. 1.That our AMA reaffirm Policy H-110.987, "Pharmaceutical Costs," which outlines a series of measures to address anti-competitive actions by pharmaceutical manufacturers as well as policies to promote increased transparency along the pharmaceutical supply chain including among PBMs. (Reaffirm HOD Policy); 2. That our AMA support legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations. (New HOD Policy)

Your Reference Committee heard positive testimony on Board of Trustees Report 14. Your Reference Committee heard testimony that the report highlights the need to focus on increasing transparency and competition to improve access to affordable prescription medication. Your Reference Committee heard testimony that both efforts to advance transparency and competition are driving congressional and federal agency action. Your Reference Committee also heard testimony that current policy that has been central to this advocacy should be affirmed and additional policy to further combat anticompetitive practices should be adopted. Accordingly, your Reference Committee recommends that Board of Trustees Report 14 be adopted and the remainder of the report be filed.

(2) BOARD OF TRUSTEES REPORT 19 – FDA CONFLICT OF INTEREST (RESOLUTION 216-A-18)

RECOMMENDATION:

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

The Board of Trustees recommends that the following be adopted in lieu of Resolution 216-A-18 and the remainder of this report be filed: 1. That our AMA reaffirm Policy H-100.992, "FDA," which supports that FDA conflicts of interest should not overrule scientific evidence in making policy decisions and the FDA should include clinical experts on advisory committees. (Reaffirm HOD Policy); 2. That our AMA adopt the following new policy: It is the position of the American Medical Association that decisions of the Food and Drug Administration (FDA) must be trustworthy. Patients, the public, physicians, other health care professionals and health administrators, and policymakers must have confidence that FDA decisions and the recommendations of FDA advisory committees are ethically and scientifically credible and derived through a process that is rigorous, independent, transparent, and accountable.

Rigorous policies and procedures should be in place to minimize the potential for financial or other interests to influence the process at all key steps. These should include, but not necessarily be limited to: a) required disclosure of all relevant actual or potential conflicts of interest, both financial and personal; b) a mechanism to independently audit disclosures when warranted; c) clearly defined criteria for identifying and assessing the magnitude and materiality of conflicts of interest; and d) clearly defined processes for preventing or terminating the participation of a conflicted member, and mitigating the influence of identified conflicts of interest (such as prohibiting individuals from participating in deliberations, drafting, or voting on recommendations on which they have conflicts) in those limited circumstances when an individual's participation cannot be terminated due to the individual's unique or rare skillset or background that is deemed highly valuable to the process. Further, clear statements of COI policy and procedures, and disclosures of FDA advisory committee members' conflicts of interest relating to specific recommendations, should be published or otherwise made public. Finally, it is recognized that, to the extent feasible in accordance with the principles stated above, participation on advisory committees should be facilitated through appropriate balancing of the relative scarcity or uniqueness of an individual's expertise and ability to contribute to the process, on the one hand, as compared to the feasibility and effectiveness of mitigation measures including those noted above. (New HOD Policy); 3. That our AMA adopt the following new policy: It is the position of the American Medical Association that the FDA should undertake an evaluation of pay-later conflicts of interest (e.g., where a FDA advisory committee member develops a financial conflict of interest only after his or her initial appointment on the advisory committee has expired) to assess whether these undermine the independence of advisory committee member recommendations and whether policies should be adopted to address this issue. (New HOD Policy)

Your Reference Committee heard mixed testimony on Board of Trustees Report 19. Your Reference Committee heard testimony that additional restrictions on Conflict of Interest waivers will negatively impact the U.S. Food and Drug Administration's (FDA's) ability to obtain expertise on regulated products, ultimately harming patient access and undermining safety. Your Reference Committee further heard testimony that trust in the FDA's decision-making is compromised when relying on advisory panels with individuals with conflicts and the decisions skew against patient interests. Your Reference Committee also heard testimony that our AMA Code of Medical Ethics has a section that governs conflicts of interest and research and clinical practice guidelines, which can address concerns raised by the original resolution. Accordingly, your Reference Committee recommends adoption of Board of Trustees Report 19 and the remainder of the report be filed.

(3) BOARD OF TRUSTEES REPORT 23 – PRIOR AUTHORIZATION REQUIREMENTS FOR POST-OPERATIVE OPIOIDS (RESOLUTION 208-A-18)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in the Board of Trustees Report 23 be adopted and the remainder of the report be filed.

The Board recommends that the following recommendation be adopted in lieu of Resolution 208-A-18, and that the remainder of the report be filed. 1. That our American Medical Association (AMA) advocate for state legislatures and other policymakers, health insurance companies and pharmaceutical benefit management companies to remove barriers, including

prior authorization, to non-opioid pain care; (New HOD Policy) 2. That our AMA support amendments to opioid restriction policies to allow for exceptions that enable physicians, when medically necessary in the physician's judgment, to exceed statutory, regulatory or other thresholds for post-operative care and other medical procedures or conditions. (New HOD Policy); 3. That our AMA oppose health insurance company and pharmacy benefit management company utilization management policies, including prior authorization, that restrict access to post-operative pain care, including opioid analgesics, if those policies are not based upon sound clinical evidence, data and emerging research. (New HOD Policy)

Your Reference Committee heard positive testimony on Board of Trustees Report 23. Your Reference Committee agrees with testimony that clinical decision making must remain the purview of physicians rather than legislatures, health insurance companies, pharmacies, or pharmacy benefit managers. Your Reference Committee agrees with our Board of Trustees that physicians have been taking tangible steps to make more judicious prescribing decisions before the advent of different national guidelines, arbitrary prescribing restrictions, and other barriers to evidence-based patient care.

Your Reference Committee heard that there has been a 33 percent reduction in opioid prescribing yet health insurance companies, pharmacy benefit management companies, and other payers have not provided any substantive increase in non-opioid alternatives. Your Reference Committee heard further testimony that patients with pain—whether post-surgery or in other settings—have suffered because of multiple barriers to pain care, including prior authorization requirements and blind adherence to arbitrary guidelines. Accordingly, your Reference Committee recommends that the recommendations in Board of Trustees Report 23 be adopted and the remainder of the report be filed.

(4) BOARD OF TRUSTEES REPORT 30 – OPIOID TREATMENT PROGRAMS REPORTING TO PRESCRIPTION MONITORING PROGRAMS (RESOLUTION 507-A-18)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in the Board of Trustees Report 30 be adopted and the remainder of the report be filed.

The Board of Trustees recommends that Resolution 507-A-18 not be adopted and the remainder of this report be filed.

Your Reference Committee heard extensive and conflicting information on Board of Trustees Report 30. Your Reference Committee notes that, at the outset, it is important to clarify that the debate on BOT 30 should be focused squarely on whether our AMA should continue support for state flexibility to determine whether state Opioid Treatment Programs should be required to report to state prescription monitoring programs (PDMP). Understandably, issues covered by the Board of Trustees in its report highlighted areas that included patient privacy, care coordination, and concerns for inappropriate disclosure of a patient's personal health information. Those issues were also extensively addressed by testimony surrounding Resolutions 220 and 231. Your Reference Committee addresses those issues in more detail in consideration of those resolutions.

Your Reference Committee heard testimony that state laws regarding access to a state PDMP vary considerably and some states allow access to the PDMP by law enforcement with minimal patient protections (e.g. California), and some have considerable patient protections (e.g., Maryland)—although those do not always prevent disclosure of personal health information to law enforcement and others outside the patient-physician relationship. Testimony indicated that BOT 30 simply highlights the issues raised by including personal health information from an Opioid Treatment Program into a state PDMP. Your Reference Committee heard testimony that states are well-equipped to determine whether to take action depending on what federal law may allow—issues that are covered by Resolutions 220 and 231.

Furthermore, your Reference Committee points out that support for state flexibility is consistent with multiple different AMA policies (see, for example, Federal Preemption of State Professional Liability Laws H-435.964; Any Willing Provider Provisions and Laws H-285.984; Federal Preemption of State Professional Liability Laws H-435.964; Corporate Practice of Medicine H-215.981; Medicare Balance Billing D-390.986 Balance Billing for All Physicians D-380.996). Accordingly, your Reference Committee does not believe our AMA should dictate how states approach this issue. Therefore, your Reference Committee recommends the issues concerning HIPAA and 42 CFR Part 2 be focused in the discussion of Resolution 220 and 231, that BOT 30 be adopted and the remainder of the report be filed.

(5) RESOLUTION 213 – FINANCIAL PENALITIES AND CLINICAL DECISION-MAKING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 213 be adopted.

Resolution 213 asks that our American Medical Association oppose the practice of a payer utilizing statistical targets alone (and not outcomes data) to determine ‘cost effectiveness’ of a therapeutic choice (New HOD Policy); and be it further; that our AMA oppose the practice of a payer imposing financial penalties upon physicians and/or associated physicians based upon the use of statistical targets without first considering the clinical factors unique to each patient’s claim. (New HOD Policy)

Your Reference Committee heard positive testimony on Resolution 213. Your Reference Committee heard testimony that our AMA opposes the use of utilization reviews and penalties against physicians that are based on statistical analysis alone. Your Reference Committee heard strong opposition to insurer penalties given the clinical complexity of delivering care. Your Reference Committee heard further testimony about concerns regarding limiting what clinical information should be considered when assessing the cost effectiveness of a therapeutic choice to patient outcomes. Your Reference Committee heard testimony seeking to add language that would further oppose financial penalties for patients, in addition to physicians and other associated physicians. However, financial penalties most often have been exclusively applied to physicians and other health care professionals. Accordingly, your Reference Committee recommends that Resolution 213 be adopted.

(6) RESOLUTION 223 – SIMPLIFICATION AND CLARIFICATION OF SMOKING STATUS DOCUMENTATION IN THE ELECTRONIC HEALTH RECORD

RECOMMENDATION:

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

Resolution 223 asks that our American Medical Association support the streamlining of the SNOMED categories for smoking status and passive smoking exposure documentation in the electronic medical record so that the categories are discrete, non-overlapping, and better understood per The Association for the Treatment of Tobacco Use and Dependence 2019 recommendations as follows: Smoking status categories: Current Every Day Smoker, Current Some Day Smoker Former Smoker, Never Smoker, and Smoking Status Unknown and Passive smoking exposure: Exposure to Second Hand Tobacco Smoke, Past Exposure to Second Hand Tobacco Smoke, No Known Exposure to Second Hand Tobacco Smoke (Directive to Take Action)

Your Reference Committee heard overall positive testimony on Resolution 223. Your Reference Committee heard testimony that our AMA has already written to the Office of the National Coordinator for Health Information Technology recommending the streamlining of SNOMED categories for smoking status and passive smoking exposure documentation in the electronic health record. Your Reference Committee heard singular testimony that considered the SNOMED categories too limited. Your Reference Committee also heard testimony that expanding reporting requirements could result in more administrative burden and yield less viable data for clinical and research utilization. Accordingly, your Reference Committee recommends that Resolution 223 be adopted.

(7) RESOLUTION 242 – IMPROVING HEALTH INFORMATION TECHNOLOGY PRODUCTS TO PROPERLY CARE FOR LGBTQ PATIENTS

RECOMMENDATION:

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

Resolution 242 asks that our American Medical Association research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity (Directive to Take Action); and be it further; that our AMA investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter (Directive to Take Action); and be it further; that our AMA advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians. (Directive to Take Action)

Your Reference Committee heard limited but overwhelmingly positive testimony on Resolution 242. Accordingly, your Reference Committee recommends that Resolution 242 be adopted.

(8) RESOLUTION 244 – EHR-INTEGRATED PRESCRIPTION DRUG MONITORING PROGRAM RAPID ACCESS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 244 be adopted.

Resolution 244 asks that our American Medical Association advocate, at the state and national levels, to promote Prescription Drug Monitoring Program (PDMP) integration/access within Electronic Health Record workflows (of all developers/vendors) at no cost to the physician or other authorized health care provider. (Directive to Take Action)

Your Reference Committee heard limited but supportive testimony for Resolution 244. Your Reference Committee heard testimony that our AMA has existing policy that supports initiatives to improve the functionality of state Prescription Drug Monitoring Programs (PDMP) including directing state-based PDMPs to support improved integrated electronic health records interfaces. Your Reference Committee heard further testimony that Resolution 244 would add to this existing policy. Accordingly, your Reference Committee recommends that Resolution 244 be adopted.

(9) BOARD OF TRUSTEES REPORT 9 – COUNCIL ON LEGISLATION SUNSET REPORT

RECOMMENDATION A:

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

The Board of Trustees recommends that the House of Delegates policies listed in Appendix 1 to this report be acted upon in the manner indicated, except for Policy D-65.993, which should be retained, and the remainder of this report be filed.

RECOMMENDATION B:

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

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Policy D-65.993 be amended by addition and deletion to read as follows:

Our American Medical Association will ~~write to Secretary of State Hillary Rodham Clinton, the World Medical Association, and the World Health Organization in reference to the complex situations in Darfur and Sri Lanka, stating (1) our concerns related to the health~~ (1) implore all parties at all times to understand and minimize the health costs of war on civilian populations generally and the adverse effects of physician persecution in particular, (2) ~~that we~~ support the efforts of physicians around the world to practice medicine ethically in any and all circumstances, including during wartime or episodes of civil strife, and that we condemn the military targeting of health care facilities and personnel and using denial of medical services as a weapon of war, ~~as has occurred in Darfur and Sri Lanka,~~ by any party, wherever and whenever it occurs, and (3) ~~that our AMA will~~ advocate for the protection of physicians' rights to provide ethical care without fear of persecution.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the title of Policy D-65.993 be changed to read as follows:

WAR CRIMES AS A THREAT TO PHYSICIANS' HUMANITARIAN RESPONSIBILITIES

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

Your Reference Committee heard and agrees with testimony that D-65.993 includes policy that remains important and relevant regarding the threat of war crimes on physicians' humanitarian responsibilities. Your Reference Committee agrees with testimony that D-65.993 should be amended to delete reference to AMA advocacy activities that have been accomplished and retain the language that remains relevant. Your Reference Committee therefore recommends that D-65.993 should be retained, amended, and that the title be changed to reflect the substance of the amended language.

(10) BOARD OF TRUSTEES REPORT 17 – BAN ON MEDICARE ADVANTAGE "NO CAUSE" NETWORK TERMINATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that BOT Report 17 be amended by addition as follows:

1.That our American Medical Association (AMA) urge Centers for Medicare & Medicaid Services (CMS) to further enhance the agency's efforts to ensure directory accuracy by:
a. Requiring Medicare Advantage (MA) plans to submit accurate provider directories to CMS every year prior to the

Medicare open enrollment period and whenever there is a significant change in the physicians included in the network
b. Conducting accuracy reviews on provider directories more frequently for plans that have had deficiencies
c. Publicly reporting the most recent accuracy score for each plan on Medicare Plan Finder,
d. Indicating to plans that failure to maintain complete and accurate directories, as well as failure to have a sufficient number of physician practices open and accepting new patients, may subject the MA plans to one of the following: 1. civil monetary penalties; 2. enrollment sanctions; or 3. incorporating the accuracy score into the Stars rating for each plan,
e. Offering plans the option of using AMA/Lexis-Nexis VerifyHCP system to update provider directory information. (Directive to Take Action),
f. Requiring MA plans immediately remove from provider directories providers who no longer participate in their network.

2.That our AMA urge CMS to ensure that network adequacy standards provide adequate access for beneficiaries and support coordinated care delivery by:
a. Requiring plans to report the percentage of the physicians, broken down by specialty and subspecialty, in the network who actually provided services to plan members during the prior year,
b. Publishing the research supporting the adequacy of the ratios and distance requirements CMS currently uses to determine network adequacy.
c. Conducting a study of the extent to which networks maintain or disrupt teams of physicians and hospitals that work together,
e. Evaluating alternative/additional measures of adequacy. (Directive to Take Action);

3. That our AMA urge CMS to ensure lists of contracted physicians are made more easily accessible by:
a. Requiring that MA plans submit their contracted provider list to CMS annually and whenever changes occur, and post the lists on the Medicare Plan Finder website in both a web-friendly and downloadable spreadsheet form. (Directive to Take Action);
b. Linking the provider lists to Physician Compare so that a patient can first find a physician and then find which health plans contract with that physician. That our AMA urge CMS to simplify the process for beneficiaries to compare network size and accessibility by expanding the information for each MA plan on Medicare Plan Finder to include: A. the number of contracted physicians in each specialty and county; B. the extent to which a plan's network exceeds minimum standards in each specialty, subspecialty, and county; and C. the percentage of the physicians in each specialty and county participating in

Medicare who are included in the plan's network. (Directive to Take Action);

4.That our AMA urge CMS to measure the stability of networks by calculating the percentage change in the physicians in each specialty and subspecialty in an MA plan's network compared to the previous year and over several years and post that information on Plan Finder. (Directive to Take Action);

5.That our AMA urge CMS to develop a marketing/communication plan to effectively communicate with patients about network access and any changes to the network that may directly or indirectly impact patients; including updating the Medicare Plan Finder website. (Directive to Take Action);

6.That our AMA urge CMS to develop process improvements for recurring input from in-network physicians regarding network policies by creating a network adequacy task force that includes multiple stakeholders including patients. (Directive to Take Action);

7.That our AMA rescind Policy D-285.961, which directed the AMA to conduct the study herein. (Rescind AMA Policy)

RECOMMENDATION B:

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

The Board of Trustees recommends that the following recommendations be adopted and that the remainder of the report be filed: 1.That our American Medical Association (AMA) urge Centers for Medicare & Medicaid Services (CMS) to further enhance the agency's efforts to ensure directory accuracy by: a. Requiring MA plans to submit provider directories to CMS every year prior to the Medicare open enrollment period and whenever there is a significant change in the physicians included in the network, b. Conducting accuracy reviews on provider directories more frequently for plans that have had deficiencies, c. Publicly reporting the most recent accuracy score for each plan on Medicare Plan Finder, d. Indicating to plans that failure to maintain complete and accurate directories, as well as failure to have a sufficient number of physician practices open and accepting new patients, may subject the MA plans to one of the following: 1. civil monetary penalties; 2. enrollment sanctions; or 3. incorporating the accuracy score into the Stars rating for each plan, e. Offering plans the option of using AMA/Lexis-Nexis VerifyHCP system to update provider directory information. (Directive to Take Action); 2.That our AMA urge CMS to ensure that network adequacy standards provide adequate access for beneficiaries and support coordinated care delivery by: a. Requiring plans to report the percentage of the physicians in the network who actually provided services to plan members during the prior year, b. Publishing the research supporting the adequacy of the ratios and distance requirements CMS currently uses to determine network adequacy. c. Conducting a study of the extent to which networks maintain or disrupt teams of physicians and hospitals that work together, d. Evaluating alternative/additional measures of adequacy.

(Directive to Take Action); 3. That our AMA urge CMS to ensure lists of contracted physicians are made more easily accessible by: a. Requiring that MA plans submit their contracted provider list to CMS annually and whenever changes occur, and post the lists on the Medicare Plan Finder website in both a web-friendly and downloadable spreadsheet form. (Directive to Take Action), b. Linking the provider lists to Physician Compare so that a patient can first find a physician and then find which health plans contract with that physician. That our AMA urge CMS to simplify the process for beneficiaries to compare network size and accessibility by expanding the information for each MA plan on Medicare Plan Finder to include: A. the number of contracted physicians in each specialty and county; B. the extent to which a plan's network exceeds minimum standards in each specialty and county; and C. the percentage of the physicians in each specialty and county participating in Medicare who are included in the plan's network. (Directive to Take Action); 4. That our AMA urge CMS to measure the stability of networks by calculating the percentage change in the physicians in each specialty in an MA plan's network compared to the previous year and over several years and post that information on Plan Finder. (Directive to Take Action); 5. That our AMA urge CMS to develop a marketing/communication plan to effectively communicate with patients about network access and any changes to the network that may directly or indirectly impact patients; including updating the Medicare Plan Finder website. (Directive to Take Action); 6. That our AMA urge CMS to develop process improvements for recurring input from in-network physicians regarding network policies by creating a network adequacy task force. (Directive to Take Action); 7. That our AMA rescind Policy D-285.961, which directed the AMA to conduct the study herein. (Rescind AMA Policy)

Your Reference Committee heard positive testimony on Board of Trustees Report 17. Your Reference Committee heard testimony that our AMA and other physician groups have raised concerns that narrow physician networks create challenges for patients seeking care and pose potential patient protection issues. Your Reference Committee heard testimony that inaccurate information commonly found in Medicare Advantage (MA) provider directories delays timely access to medical care for beneficiaries. Your Reference Committee heard testimony that female physicians often receive lower quality ratings secondary to implicit bias, which can negatively impact the long-term ability for those physicians to remain within a MA network. Your Reference Committee heard testimony calling for additional network adequacy measures including evaluation of changes related to gender ratios for participating network physicians. Your Reference Committee determined that the inclusion of metrics specifically related to gender may proffer criticism for the lack of inclusion of other metrics such as sexual orientation, race, and ethnicity. Therefore, your Reference Committee recommends that the recommended language not be included in the report recommendations. Your Reference Committee heard testimony in support of including original language calling for outright bans on "no cause" terminations of MA network physicians during the initial term or any subsequent renewal of a physician's participation contract with that plan. Your Reference Committee heard additional testimony that access to subspecialists is important as medicine becomes increasingly specialized, and that MA plans should be required to ensure that a sufficient amount of physicians who can provide this type of care are present within their networks. Your Reference Committee heard testimony that to improve how MA plans develop and modify their physician networks, Board of Trustees Report 17 offers several policy proposals focused on network directory accuracy, network adequacy, network stability, communications with patients, and establishment of an external advisory group to better inform the Centers for Medicare and Medicaid Services regarding MA network issues. Accordingly, your Reference Committee recommends that Board of Trustees Report 17 be adopted as amended and the remainder of the report be filed.

(11) BOARD OF TRUSTEES REPORT 18 – INCREASED USE OF BODY-WORN CAMERAS BY LAW ENFORCEMENT OFFICERS (RESOLUTION 208-I-17)

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that recommendation three of Board of Trustees Report 18 be amended by addition as follows:

3. That our AMA recommend that law enforcement policies governing the use of body-worn cameras in health care settings be developed and evaluated with input from physicians and others in the medical community and not interfere with the patient-physician relationship.

RECOMMENDATION B:

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

The Board of Trustees recommends that the following be adopted in lieu of Resolution 208-I-17, and that the remainder of the report be filed: 1. That our American Medical Association (AMA) work with interested state and national medical specialty societies to support state legislation and/or regulation addressing implementation of body-worn camera programs for law enforcement officers, including funding for the purchase body-worn cameras, training for officers and technical assistance for law enforcement agencies. (Directive to Take Action); 2. That our AMA continue to monitor privacy issues raised by body-worn cameras in health care settings. (Directive to Take Action); and 3. That our AMA recommend that law enforcement policies governing the use of body-worn cameras in health care settings be developed and evaluated with input from the medical community and not interfere with the patient-physician relationship. (Directive to Take Action)

Your Reference Committee heard testimony unanimously in support of Board of Trustees Report 18. Your Reference Committee commends the Board of Trustees for their comprehensive report. To ensure that physicians have input into the development of law enforcement policies governing the use of body-worn cameras in health care settings, your Reference Committee recommends that Recommendation 3 be amended and the remainder of Board of Trustees Report 18 be filed.

(12) BOARD OF TRUSTEES REPORT 20 – SAFE AND EFFICIENT E-PRESCRIBING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that recommendation one of Board of Trustees Report 20 be amended by addition as follows:

1.That our American Medical Association (AMA) reaffirm the following policies:
a. H-125.979, "Private Health Insurance Formulary Transparency"
b. D-120.956, "Electronic Prescribing and Conflicting Federal Guidelines"
c. H-120.941, "e-Prescribing of Scheduled Medications"
d. D-120.958, "Federal Roadblocks to E-Prescribing"
e. D-120.945. "Completing the Electronic Prescription Loop for Controlled Substances"
f. H-478.983, "Electronic Prescription Cancellation" (Reaffirm HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that recommendation three of Board of Trustees Report 20 be amended by addition as follows:

3. That our AMA encourage health care stakeholders to improve electronic prescribing practices in meaningful ways that will result in increased patient safety, reduced medication error, improved care quality, and reduced administrative burden associated with e-prescribing processes and requirements. Specifically, the AMA encourages:

a. E-prescribing system implementation teams to conduct an annual audit to evaluate the number, frequency and user acknowledgment/dismissal patterns of e-prescribing system alerts and provide an audit report to the software vendors for their consideration in future releases.
b. Health care organizations and implementation teams to improve prescriber end-user training and on-going education.
c. Implementation teams to prioritize the adoption of features like structured and codified Sig formats that can help address quality issues, allowing for free text when necessary.
d. Implementation teams to enable functionality of pharmacy directories and preferred pharmacy options.
e. Organizational leadership to encourage the practice of inputting a patient's preferred pharmacy at registration, and re-confirming it upon check-in at all subsequent visits.
f. Implementation teams to establish interoperability between the e-prescribing system and the EHR to allow prescribers to easily confirm continued need for e-prescription refills and to allow for ready access to pharmacy choice and selection during the refill process.
g. Implementation teams to enhance EHR and e-prescribing system functions to require residents assign an authorizing attending physician when required by state law.
h. Organizational leadership to implement e-prescribing systems that feature more robust clinical decision support, and

ensure prescriber preferences are tested and seriously considered in implementation decisions.
i. Organizational leadership to designate e-prescribing as the default prescription method.
j. The DEA to allow for lower-cost, high-performing biometric devices (e.g., fingerprint readers on laptop computers and mobile phones) to be leveraged in two-factor authentication.
k. States to allow integration of PDMP data into EHR systems.
l. Health insurers, pharmacies and e-prescribing software vendors to enable real-time benefit check applications that enable more up to date prescription coverage information and allow notification when a patient changes health plans or a health insurer has changed a pharmacy's network status.
m. Functionality supporting the electronic transfer and cancellation of prescriptions. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 20 be adopted as amended and the remainder of the report be filed.

The Board of Trustees recommends that the following be adopted in lieu of Resolution 237-A-18 and that the remainder of this report be filed: 1. That our American Medical Association (AMA) reaffirm the following policies: a.H-125.979, "Private Health Insurance Formulary Transparency", b. D-120.956, "Electronic Prescribing and Conflicting Federal Guidelines," c. H-120.941, "e-Prescribing of Scheduled Medications," d. D-120.958, "Federal Roadblocks to E-Prescribing," e.D-120.945. "Completing the Electronic Prescription Loop for Controlled Substances" (Reaffirm HOD Policy); 2. That the second paragraph of AMA Policy D-120.972, "Electronic Prescribing," be rescinded as having been fulfilled by this report. (Rescind HOD Policy); 3. That our AMA encourage health care stakeholders to improve electronic prescribing practices in meaningful ways that will result in increased patient safety, reduced medication error, improved care quality, and reduced administrative burden associated with e-prescribing processes and requirements. Specifically, the AMA encourages: E-prescribing system implementation teams to conduct an annual audit to evaluate the number, frequency and user acknowledgment/dismissal patterns of e-prescribing system alerts and provide an audit report to the software vendors for their consideration in future releases; Health care organizations and implementation teams to improve prescriber end-user training and on-going education; Implementation teams to prioritize the adoption of features like structured and codified Sig formats that can help address quality issues; Implementation teams to enable functionality of pharmacy directories and preferred pharmacy options; Organizational leadership to encourage the practice of inputting a patient's preferred pharmacy at registration, and re-confirming it upon check-in at all subsequent visits. Implementation teams to establish interoperability between the e-prescribing system and the EHR to allow prescribers to easily confirm continued need for e-prescription refills and to allow for ready access to pharmacy choice and selection during the refill process; Implementation teams to enhance EHR and e-prescribing system functions to require residents assign an authorizing attending physician; Organizational leadership to implement e-prescribing systems that feature more robust clinical decision support, and ensure prescriber preferences are tested and seriously considered in implementation decisions; Organizational leadership to designate e-prescribing as the default prescription method; The DEA to allow for lower-cost, high-performing biometric devices (e.g.,

fingerprint readers on laptop computers and mobile phones) to be leveraged in two-factor authentication; States to allow integration of PDMP data into EHR systems; Health insurers, pharmacies and e-prescribing software vendors to enable real-time benefit check applications that enable more up to date prescription coverage information and allow notification when a patient changes health plans or a health insurer has changed a pharmacy's network status. (New HOD Policy)

Your Reference Committee heard positive testimony on Board of Trustees Report 20. Your Reference Committee heard testimony that while e-prescribing has many benefits, barriers to adoption exist such as system errors, network challenges, and the process of prescribing controlled substances. Your Reference Committee heard testimony that our AMA supports e-prescribing for both controlled and non-controlled substances and has numerous policies expressing its commitment to advocating for better regulations and better systems. Your Reference Committee heard testimony that this report builds upon existing policy by encouraging health care stakeholders to improve electronic prescribing practices in meaningful ways that will result in increased patient safety, reduced medication error, improved care quality, and reduced administrative burden associated with e-prescribing processes and requirements.

Your Reference Committee heard that additional existing policy should be reaffirmed regarding electronic prescription cancellations. Your Reference Committee heard testimony that prioritizing the adoption of features like structured formats should also take into account allowing for free text when necessary. Testimony also indicated that our AMA should support the functionality that supports both the electronic transfer and cancellation of prescriptions. Your Reference Committee agrees with the intent of the testimony to strike the language regarding having an attending physician authorization for resident physicians who are prescribing and believes that this issue can be solved by including such functionality when required by state law. Accordingly, your Reference Committee recommends that Board of Trustees Report 20 be adopted with amendments and the remainder of the report be filed.

(13) BOARD OF TRUSTEES REPORT 21 – AUGMENTED INTELLIGENCE IN HEALTH CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that recommendation three of Board of Trustees Report 21 be <u>amended by addition</u> as follows:

3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on (a) clinical validation; (b) alignment with clinical decision-making that is familiar to physicians; and (c) <u>high quality</u> clinical evidence.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that recommendation Board of Trustees Report 21 be <u>amended by addition</u> as follows:

10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the recommendations in the Board of Trustees Report 21 be adopted as amended and the remainder of the report be filed.

The Board of Trustees recommends that the following be adopted in lieu of the recommendation and the remainder of this report be filed: Our AMA supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that: 1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment; 2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws; 3.Payment and coverage for health care AI systems intended for clinical care must be conditioned on (a) clinical validation; (b) alignment with clinical decision-making that is familiar to physicians; and (c) clinical evidence; 4. Payment and coverage for health care AI systems must (a) be informed by real world workflow and human-centered design principles; (b) enable physicians to prepare for and transition to new care delivery models; (c) support effective communication and engagement between patients, physicians, and the health care team; (d) seamlessly integrate clinical, administrative, and population health management functions into workflow; and (e) seek end-user feedback to support iterative product improvement; 5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability; 6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes: a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage, b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment; 7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate: a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability, b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users, c. Health care AI systems that are subject to non-disclosure agreements concerning flaws,

malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm; 8. Our AMA, national medical specialty societies, and state medical associations—a. Identify areas of medical practice where AI systems would advance the quadruple aim, b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts, c. Outline new professional roles and capacities required to aid and guide health care AI systems; and d. Develop practice guidelines for clinical applications of AI systems; 9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)

Your Reference Committee heard positive testimony on Board of Trustees Report 21. Your Reference Committee heard testimony that physicians must be involved in rapidly evolving public policy discussions related to liability, payment, and regulation of Augmented Intelligence (AI) systems in health care. Your Reference Committee further heard testimony that Congress, federal agencies, and standards organizations along with other stakeholders are building the foundation for AI policy, and that our AMA is playing a key role in these discussions and expanded policy addresses key issues with greater specificity. Your Reference Committee heard testimony on the importance of high-quality clinical evidence. Further testimony indicated that AI should be designed to enhance human intelligence and the patient-physician relationship rather than replace it. Accordingly, your Reference Committee recommends adoption of Board of Trustees Report 21 and the remainder of the report be filed.

(14) BOARD OF TRUSTEES REPORT 22 – INAPPROPRIATE USE OF CDC GUIDELINES FOR PRESCRIBING OPIOIDS (RESOLUTION 235-I-18)
RESOLUTION 229 – CLARIFICATION OF CDC OPIOID PRESCRIBING GUIDELINES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 22 be amended by addition as follows:

3. That our American Medical Association reaffirm Policy D-120.932, “Inappropriate Use of Centers for Disease Control and Prevention Guidelines for Prescribing Opioids”; (Reaffirm HOD Policy) and be it further

4. That our AMA incorporate into their advocacy that clinical practice guidelines specific to cancer treatment, palliative care, and end of life be utilized in lieu of the CDC’s Guideline for Prescribing Opioids for Chronic Pain as per the CDC's clarifying recommendation. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations of the Board of Trustees Report 22 be adopted as amended in lieu of Resolution 229 and the remainder of the report be filed.

The Board of Trustees recommends that the following recommendations be adopted in lieu of the second resolve of alternate Resolution 235-I-18, and that the remainder of the report be filed: 1.That our American Medical Association (AMA) support balanced opioid-sparing policies that are not based on hard thresholds, but on patient individuality, and help ensure safe prescribing practices, minimize workflow disruption, and ensure patients have access to their medications in a timely manner, without additional, cumbersome documentation requirements. (New HOD Policy); 2. That our AMA oppose the use of "high prescriber" lists used by national pharmacy chains, pharmacy benefit management companies or health insurance companies when those lists do not provide due process and are used to blacklist physicians from writing prescriptions for controlled substances and preventing patients from having the prescription filled at their pharmacy of choice. (New HOD Policy) Resolution 229 asks that our American Medical Association reaffirm Policy D-120.932, "Inappropriate Use of Centers for Disease Control and Prevention Guidelines for Prescribing Opioids"; (Reaffirm HOD Policy) and be it further; that our AMA incorporate into their advocacy that clinical practice guidelines specific to cancer treatment, palliative care, and end of life be utilized in lieu of the CDC's Guideline for Prescribing Opioids for Chronic Pain as per the CDC's clarifying recommendation. (Directive to Take Action)

Your Reference Committee heard overwhelmingly positive testimony in support of Board of Trustees Report 22. Your Reference Committee also heard testimony in support of Resolution 229. Testimony indicated that BOT 22 and Resolution 229 each highlight the considerable frustration physicians and patients have experienced because of arbitrary thresholds on opioid prescribing. Your Reference Committee heard testimony that some of these frustrations have been the result of the misapplication of the CDC's Guideline for Prescribing Opioids for Chronic Pain, which has been used by health insurance companies, national pharmacy chains, pharmacy benefit management companies, and state legislatures to restrict opioid prescribing to arbitrary thresholds—limits that have been inappropriately used on many different patient populations, including those undergoing cancer treatment, palliative care, and end-of-life care. Your Reference Committee heard testimony that our Board of Trustees called for renewed balance between efforts to encourage judicious prescribing and protecting patients' access to opioid therapy when appropriate. Your Reference Committee heard testimony that the actions that have harmed patients were emphasized by U.S. Surgeon General Jerome A. Adams, MD, who testified to the Reference Committee that the CDC and others in the Administration know that the balance is not there, and patients are being harmed by the misapplication of the guidelines.

Dr. Adams called attention to the recent "Perspective" piece in the *New England Journal of Medicine* authored by the CDC, which noted that "Unfortunately, some policies and practices purportedly derived from the guideline have in fact been inconsistent with, and often go beyond, its recommendations…. Such misapplication has been reported for patients with pain associated with cancer, surgical procedures, or acute sickle cell crises. There have also been reports of misapplication of the guideline's dosage thresholds to opioid agonists for treatment of opioid use disorder. Such actions are likely to result in harm to patients." (Available at https://www.nejm.org/doi/full/10.1056/NEJMp1904190).

Your Reference Committee heard, at the same time, that the reduction in the nation's opioid supply—33 percent between 2013 and 2018, according to the company IQVIA—was generally a positive development, but state laws, pharmacy policies, and health insurance restrictions have not led to improvements in pain care. Your Reference Committee heard testimony that the recommendations in Board of Trustees Report 22 provide a strong measure of support for individualized patient care while also providing our AMA with the necessary guidance to further advocate for the removal of policies that have harmed patients. Your Reference Committee also heard that it is important to help protect vulnerable populations, including those with cancer or receiving hospice or palliative care. Accordingly, your Reference Committee recommends adoption of the recommendations in Board of Trustees Report 22 with the addition of the recommendations in Resolution 229 and the remainder of the report be filed.

(15) RESOLUTION 201 – ASSURING PATIENT ACCESS TO KIDNEY TRANSPLANTATION

RECOMMENDATION A:

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

RESOLVED, That our AMA actively oppose any legislative or regulatory effort that would create financial incentives that would curtail the access to ~~organ~~ kidney transplantation (Directive to Take Action); and be it further

RECOMMENDATION B:

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

Resolution 201 asks that our American Medical Association work with professional and patient-centered organizations to advance patient and physician-directed coordinated care for End Stage Renal Disease (ESRD) patients (Directive to Take Action); and be it further; that our AMA actively oppose any legislative or regulatory efforts to remove patient choice and physician involvement in ESRD care decisions (Directive to Take Action); and be it further; that our AMA actively oppose any legislative or regulatory effort that would create financial incentives that would curtail the access to organ transplantation (Directive to Take Action); and be it further; that our AMA House of Delegates be advised in a timely fashion regarding any legislative or regulatory efforts to abrogate patient and physician-advised decision-making regarding modality of care for ESRD. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 201. Your Reference Committee heard testimony that our Board of Trustees recently adopted a new policy to have our AMA work with Congress to ensure that any legislation regarding End-Stage Renal Disease (ESRD) does not inappropriately impinge on the patient-physician relationship and is in the best interests of ESRD patients. Your Reference Committee heard further testimony that kidney transplantation is often the best and most cost-effective treatment for patients with ESRD and that the focus of Resolution 201 is on kidney transplantation and not general organ

transplantation. Your Reference Committee agrees, and accordingly recommends that Resolution 201 be adopted with amendment.

(16) RESOLUTION 204 – HOLDING THE PHARMACEUTICAL INDUSTRY ACCOUNTABLE FOR OPIOID-RELATED COSTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 204 be amended by addition and deletion as follows:

RESOLVED, That our American Medical Association advocate that ~~the relevant pharmaceutical industry organizations be held financially responsible for the health care and other economic costs related to their~~ any monies paid to the states, received as a result of a settlement or judgment, or other financial arrangement or agreement as a result of litigation against pharmaceutical manufacturers, distributors, or other entities alleged to have engaged in unethical and deceptive misbranding, marketing, and advocacy of opioids, be used exclusively for research, education, prevention, and treatment of overdose, opioid use disorder, and pain. (Directive to Take Action)

RECOMMENDATION B:

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

Resolution 204 asks that our American Medical Association advocate that the relevant pharmaceutical industry organizations be held financially responsible for the health care and other economic costs related to their unethical and deceptive misbranding, marketing, and advocacy of opioids. (Directive to Take Action)

Your Reference Committee heard generally supportive testimony on Resolution 204. At the same time, your Reference Committee heard testimony that our AMA is not a court of law that adjudicates liability. Your Reference Committee appreciates the caution from colleagues in multiple states that our AMA is not well-served by assigning blame. Your Reference Committee heard testimony that if courts render judgments or if settlements are reached that a more appropriate role for our AMA is to provide public health recommendations in support of our patients. Your Reference Committee agrees with testimony in support of a recommendation to focus the resolution on directing any money from the opioid litigation to treatment. Your Reference Committee heard testimony that our AMA has policy to direct settlement funds to public health uses for the National Tobacco Settlement and that this policy should be used as guidance for any opioid-related settlements or judgments. Accordingly, your Reference Committee recommends Resolution 204 be adopted with amendment.

(17) RESOLUTION 208 – REPEAL OR MODIFICATION OF THE SUNSHINE ACT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that first Resolve of Resolution 208 be amended by deletion:

~~RESOLVED, That our American Medical Association adopt as policy opposition to the Physician Payments Sunshine Act as it currently is written and implemented (New HOD Policy); and be it further~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that first Resolve of Resolution 208 be amended by addition and deletion as follows:

RESOLVED, That our AMA support ~~either repeal of the current Sunshine Act or~~ significant modifications to the Sunshine Act, such as substantially increasing the monetary threshold for reporting, that will decrease the regulatory and paperwork burden on physicians, protect physician rights to challenge false and misleading reports, and provide a meaningful, accurate picture of the physician-industry relationship ~~and "hassle factor" and support efforts at administrative simplification for physicians~~, which the Centers for Medicare and Medicaid Services and the organized medical community has supported~~,~~ ~~if any portion of the Act is maintained~~. (New HOD Policy)

RECOMMENDATION C:

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

RECOMMENDATION D:

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

MODIFICATION OF THE SUNSHINE ACT

Resolution 208 asks that our American Medical Association adopt as policy opposition to the Physician Payments Sunshine Act as it currently is written and implemented (New HOD Policy); and be it further, that our AMA support either repeal of the current Sunshine Act or significant modifications to the Sunshine Act, such as substantially increasing the monetary threshold for reporting, that will decrease the burden and "hassle factor" and support efforts at administrative simplification for physicians, which the Center for Medicare and Medicaid Services and the organized medical community has supported, if any portion of the Act is maintained. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 208. Your Reference Committee heard testimony that physicians are frustrated with the implementation of the Sunshine Act known as the Open Payments program. Your Reference Committee further heard testimony that the Open Payments program increases administrative burden and does not adequately protect physician rights to challenge industry reports. However, your Reference Committee also heard testimony that our AMA supports transparency across the entire health care system including physicians' relationships with industry. Further testimony indicated that our AMA is advocating for transparency with drug pricing, pharmacy benefit managers, and data transparency, and that our AMA should not at the same time be supporting less transparency regarding the practice of medicine. Your Reference Committee heard testimony that small contributions or gifts can potentially change physician behavior. Your Reference Committee heard additional testimony that our AMA should continue to advocate for substantial modifications to the Sunshine Act to reduce burden, protect patients, and increase accuracy. Accordingly, your Reference Committee recommends that Resolution 208 be adopted as amended.

(18) RESOLUTION 211 – USE OF FAIR HEALTH

RECOMMENDATION A:

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

RESOLVED, that our American Medical Association advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges ~~FAIR Health usual and customary data and not all payer database data~~.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the title of Resolution 211 be changed as follows:

OUT-OF-NETWORK PAYMENT DATABASE

Resolution 211 asks that our American Medical Association advocate that any legislation addressing surprise out of network medical bills use FAIR Health usual and customary data and not all payer database data. (Directive to Take Action)

Your Reference Committee heard positive comments regarding the use of FAIR Health data to help establish out-of-network payment rates. Your Reference Committee also heard concerns about the negative impact of narrowing the scope of current AMA policy by identifying FAIR Health as the only appropriate database for such purposes. Your Reference Committee heard similar concerns about opposing the use of all-payer claims databases (APCDs). Your Reference Committee heard testimony that several states are currently interested in referencing their state APCDs in pending state legislation, and that Washington state enacted legislation this year that will rely on the state APCD as an independent data source. Your Reference Committee heard testimony that adoption of Resolution 211 would compel our AMA to oppose these state-desired initiatives. Your Reference Committee heard testimony that limiting AMA policy on independent data sources for out-of-network

benchmarks could be detrimental to our advocacy efforts on surprise billing legislation. Testimony from several witnesses focused on the need to use independent, charge-based data as the basis for out-of-network payments. Your Reference Committee therefore recommends that Resolution 211 be amended by addition and deletion to reflect the concerns that were raised during the hearing.

(19) RESOLUTION 212 – PHARMACY BENEFIT MANAGERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 212 be amended by addition and deletion as follows:

RESOLVED, That our American Medical Association advocate through all appropriate means to ensure that medications and other treatments used to stabilize palliative and hospice patients for pain, ~~and~~ delirium, and related conditions in the hospital continue to be covered by pharmacy benefit management companies ~~plans~~, health insurance companies, hospice programs, and other entities after patients are transitioned out of the hospital. and be it further (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 212 be amended by addition of a second Resolve as follows:

RESOLVED, That our AMA advocate to ensure that medications prescribed during hospitalization with ongoing indications for the outpatient and other non-hospital-based care settings continue to be covered by pharmacy benefit management companies, health insurance companies, and other payers after hospital discharge.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 212 be adopted as amended.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the title of Resolution 212 be changed as follows:

CONTINUITY OF CARE FOR PATIENTS DISCHARGED FROM A HOSPITAL SETTING

Resolution 212 asks that our American Medical Association advocate through all appropriate means to ensure that medications used to stabilize palliative and hospice patients for pain

and delirium in the hospital continue to be covered by pharmacy benefit plans after patients are transitioned out of the hospital. (Directive to Take Action)

Your Reference Committee heard positive testimony on Resolution 212. Your Reference Committee heard testimony that our AMA has broad policy supporting comprehensive care for hospice and palliative care, and that Resolution 212 is aligned with recommendations of the AMA Opioid Task Force to ensure comprehensive care for pain for hospice and palliative care. Your Reference Committee heard testimony that our AMA opposes the interference of pharmacy benefit management companies—or any other non-health care entity—in the patient-physician relationship. Your Reference Committee heard further testimony that our AMA should oppose interference not only with pharmaceutical benefits, but also any other treatment recommended by a hospice or palliative care physician.

Your Reference Committee heard further testimony that the barriers faced by hospice and palliative care patients are not limited to hospice and palliative care. Testimony indicated that the barriers, moreover, are not just imposed by pharmacy benefit management companies. Your Reference Committee notes that the common denominator is that continuity of care for treatments begun in the hospital setting should not be interrupted by health insurance companies or other payers when the patient is discharged. Accordingly, your Reference Committee recommends that Resolution 212 be adopted with amendment.

(20) RESOLUTION 214 – THE TERM PHYSICIAN
RESOLUTION 216 – ELIMINATE THE WORD PROVIDER FROM HEALTHCARE CONTRACTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the alternate resolution be adopted in lieu of Resolutions 214 and 216.

DEFINITION AND USE OF THE TERM PHYSICIAN

1. Our AMA affirms that the term physician be limited to those people who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency.
2. Our AMA will, in conjunction with the Federation, aggressively advocate for the definition of physician to be limited as defined above:
a. In any federal or state law or regulation including the Social Security Act or any other law or regulation that defines physician;
b. To any federal and state legislature or agency including the Department of Health and Human Services, Federal Aviation Administration, the Department of Transportation, or any other federal or state agency that defines physician; and
c. To any accrediting body or deeming authority including the Joint Commission, Health Facilities Accreditation Program, or any other potential body or authority that defines physician.

3. The AMA urges all physicians to insist on being identified as a physician, to sign only those professional or medical documents identifying them as physicians, and to not let the term physician be used by any other organization or person involved in health care.
4. That our AMA ensure that all references to physicians by government, payers, and other health care entities involving contracts, advertising, agreements, published descriptions, and other communications at all times distinguish between physician, as defined above, and non-physicians and to discontinue the use of the term provider.
5. AMA policy requires any individual who has direct patient contact and presents to the patient as a doctor, and who is not a physician, as defined above, must specifically and simultaneously declare themselves a non-physician and define the nature of their doctorate degree.
6. The AMA will review and revise its own publications as necessary to conform with the House of Delegates' policies on physician identification and physician reference and will refrain from any definition of physicians as providers that is not otherwise covered by existing Journal of the American Medical Association (JAMA) Editorial Governance Plan, which protects the editorial independence of JAMA.
7. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends Policies H-405.969, H-405.976, D-405.989, H-330.986, and H-405.968 be rescinded.

Resolution 214 asks that That our American Medical Association seek the passage of federal regulation and/or legislation that mandates that the term physician be limited to those people trained in accordance with Accreditation Council for Graduate Medical Education guidelines and have an MD, DO or a recognized equivalent physician degree and that the term not be used by any other organization or person involved in healthcare. (Directive to Take Action) Resolution 216 asks that our American Medical Association seek legislation to ensure that all references to physicians in government and insurance contracts, agreements, published descriptions, and printed articles eliminate the word “provider” and substitute the accurate and proper term “physician”. (Directive to Take Action)

Your Reference Committee heard positive testimony on Resolutions 214 and 216. Your Reference Committee heard testimony that transparency is needed for patients to know who is providing treatment and to be able to evaluate the credential of an individual. Your Reference Committee further heard testimony that our AMA already has multiple policies defining the term physician and the use of the term physician. Your Reference Committee heard testimony that our AMA should consolidate our existing policies and Resolutions 214 and 216 into one, comprehensive policy. Your Reference Committee also heard testimony that the consolidated policy should define the term physician to be limited to those people who have an Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent

physician degree, and who would be eligible for an ACGME residency. Your Reference Committee heard testimony that our AMA will continue to advocate for this definition to be used in any federal or state definition, in front of any federal or state legislative body or agency, and with any accrediting authority. Further testimony also indicated that our AMA will also ask at all times and in all publications including contracts to distinguish between physician, as defined above, and non-physicians and to discontinue the use of the term “provider.” Your Reference Committee heard further testimony that the existing policies should be rescinded because the consolidated alternate resolution includes the relevant aspects of the existing policy. Your Reference Committee believes that having a single reference point in our AMA policy defining the term of physician and use of that term would be beneficial. Accordingly, your Reference Committee recommends that an alternative resolution be adopted in lieu of Resolutions 214 and 216 and existing AMA policy should be rescinded.

Definition of a Physician H-405.969
1. The AMA affirms that a physician is an individual who has received a “Doctor of Medicine” or a “Doctor of Osteopathic Medicine” degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine. 2. AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a “doctor,” and who is not a “physician” according to the AMA definition above, must specifically and simultaneously declare themselves a “non-physician” and define the nature of their doctorate degree. 3. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign. (CME Rep. 4-A-94 Reaffirmed by Sub. Res. 712, I-94 Reaffirmed and Modified: CME Rep. 2, A-04 Res. 846, I-08 Reaffirmed in lieu or Res. 235, A-09 Reaffirmed: Res. 821, I-09 Appended: BOT Rep. 9, I-09 Reaffirmed: BOT Rep. 9, I-11 Reaffirmation A-13 Reaffirmation A-15 Reaffirmed in lieu of: Res. 225, A-17)

Definition of a Physician H-405.976
The AMA urges all physicians to insist on being identified as a physician and to sign only those professional or medical documents identifying them as physicians. The AMA will review and revise its own publications as necessary to conform with the House of Delegates' policies on physician identification and physician reference and will refrain from any definition of physicians as health care providers. The AMA supports seeking immediate modification of the social security laws to change the definition of a physician to conform with AMA policy. The AMA will seek legislation prohibiting the use of the term “physician” as a descriptor other than in the context of a medical doctor (MD) or doctor of osteopathy (DO). (Res. 243, A-91 Reaffirmed BOT Rep. I-93-25 Reaffirmed Sub. Res. 712, I-94 Res. 241, A-97 Reaffirmed in lieu of Res. 615, A-05 Reaffirmation I-09 Reaffirmed: Res. 821, I-09 Reaffirmation A-13)

Definition of a Physician D-405.989
1. Our American Medical Association Commissioners to The Joint Commission will be urged to request and continue to work to have The Joint Commission's “Glossary” definition of physician limited to Doctors of Medicine and Osteopathy. 2. Our AMA Commissioners to The Joint Commission will be urged to request The Joint Commission delete any changes made and all references to the Social Security Act definition of physician added to the Elements of Performance with their July 1, 2009 change in the “Glossary” definition of physician. 3. Our AMA will advocate with the American Osteopathic Association Health Facilities Accreditation Program, DNV and other potential deeming authorities to maintain a definition of physician as a Doctor of

Medicine or Osteopathy. 4. Our AMA will, in conjunction with the Federation, aggressively pursue revision of the Social Security Act and state law definitions of physician to be limited to Doctors of Medicine and Osteopathy. 5. Our AMA will advocate for the Federal Aviation Administration, the Department of Transportation, and Congress to define a "physician" as an individual possessing degree of either a Doctor of Medicine or Doctor of Osteopathic Medicine. (Res. 821, I-09 Appended: Res. 256, A-18)

Physician ("Doctors") Services Costs as Reported by HHS and Medicare H-330.986
Our AMA urges HHS and CMS to, at all times, distinguish between MDs/DOs and non-MDs/DOs, and to discontinue the use of the broad term "provider" when reporting or referring to the cost of physician services. (Res. 71, A-88 Reaffirmed: Sunset Report, I-98 Reaffirmation I-99 Reaffirmation A-02 Reaffirmation I-09)

Clarification of the Term "Provider" in Advertising, Contracts and Other Communications H-405.968
1. Our AMA supports requiring that health care entities, when using the term "provider" in contracts, advertising and other communications, specify the type of provider being referred to by using the provider's recognized title which details education, training, license status and other recognized qualifications; and supports this concept in state and federal health system reform. 2. Our AMA: (a) considers the generic terms "health care providers" or "providers" as inadequate to describe the extensive education and qualifications of physicians licensed to practice medicine in all its branches; (b) will institute an editorial policy prohibiting the use of the term "provider" in lieu of "physician" or other health professionals for all AMA publications not otherwise covered by the existing JAMA Editorial Governance Plan, which protects editorial independence of the Editor in Chief of JAMA and The JAMA Network journals; and (c) will forward to the editorial board of JAMA the recommendation that the term "physician" be used in lieu of "provider" when referring to MDs and DOs. (Sub. Res. 712, I-94 Reaffirmed: Res. 226, I-98 Reaffirmation I-99 Res. 605, A-09 Reaffirmed: CLRPD Rep. 1, A-09 Modified: Speakers Rep., A-15)

(21) RESOLUTION 217 – MEDICARE VACCINE BILLING

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 217 be <u>amended by addition</u> as follows:

RESOLVED, That our American Medical Association advocate that a physician's office can bill Medicare for all vaccines <u>administered to Medicare beneficiaries</u> and that the patient shall only pay the applicable copay to prevent fragmentation of care. (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 217 be <u>adopted as amended</u>.

Resolution 217 asks that our American Medical Association advocate that a physician's office can bill Medicare for all vaccines and that the patient shall only pay the applicable copay to prevent fragmentation of care. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolutions 217, which was heard with Resolution 203 at the Reference Committee Hearing. Your Reference Committee further heard substantial support for adoption of Resolution 217. Your Reference Committee agrees that Medicare should reimburse physicians for the cost of vaccines for Medicare beneficiaries. Accordingly, your Reference Committee recommends adopting Resolution 217 with amendment.

(22) RESOLUTION 218 – PAYMENT FOR MEDICATIONS USED OFF LABEL FOR TREATMENT OF PAIN
RESOLUTION 235 – PRESCRIPTION COVERAGE OF THE LIDOCAINE TRANSDERMAL PATCH

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the alternate resolution be adopted in lieu of Resolutions 218 and 235.

IMPROVED ACCESS AND COVERAGE TO NON-OPIOID MODALITIES TO ADDRESS PAIN

RESOLVED, That our American Medical Association advocate for increased access and coverage of non-opioid treatment modalities including pharmaceutical pain care options, interventional pain management procedures, restorative therapies, behavioral therapies, physical and occupational therapy, and other evidence-based therapies recommended by the patient's physician; (Directive to Take Action), and be it further

RESOLVED, That our AMA advocate for non-opioid treatment modalities being placed on the lowest cost-sharing tier for the indication of pain so that patients have increased access to evidence-based pain care as recommended by the HHS Interagency Pain Care Task Force (Directive to Take Action), and be it further

RESOLVED, That our AMA encourage the manufacturers of pharmaceutical pain care options to seek United States Food and Drug Administration approval for additional indications related to non-opioid pain management therapy. (Directive to Take Action)

Resolution 218 asks that our American Medical Association petition the Centers for Medicare and Medicaid Services to allow reimbursement for off label use of medications like gabapentin or lidocaine patches at the lowest copayment tier for the indication of pain so that patients can be effectively treated for pain and decrease the number of opioid prescriptions written.

(Directive to Take Action) Resolution 235 asks that our American Medical Association encourage the US Food and Drug Administration to consider approving other indications in addition to post-herpetic neuralgia for transdermal lidocaine patches (Directive to Take Action); and be it further, that our AMA urge the Centers for Medicare and Medicaid Services and third-party payers to provide insurance coverage of lidocaine transdermal patches for other indications in addition to post-herpetic neuralgia. (Directive to Take Action)

Your Reference Committee heard considerable testimony on Resolutions 218 and 235. Your Reference Committee heard testimony that introduced an "omnibus" alternate resolution to try to address the multiple different issues, indications, disease states, procedures, and therapies offered in the original resolutions. Your Reference Committee heard testimony in strong support of the omnibus given its support to increase access and coverage to non-opioid treatment modalities. Your Reference Committee heard testimony that the omnibus provided a strong framework for AMA advocacy in support for an evidence-based framework, much like the framework and recommendations contained in the recent U.S. Department of Health and Human Services "Pain Management Best Practices Inter-Agency Task Force Report" that was released in May 2019.

Your Reference Committee also heard testimony that Resolution 235 should reflect the fact that manufacturers—and not our AMA—can submit an application to the U.S. Food and Drug Administration to ask for other indications and be broadened to include all pharmaceutical pain options for additional indications related to pain management therapy generally. Accordingly, your Reference Committee recommends adoption of an alternate resolution in lieu of Resolutions 218 and 235.

(23) RESOLUTION 220 – STUDY OF CONFIDENTIALITY AND PRIVACY PROTECTION IN THE TREATMENT OF SUBSTANCE DISORDERS
RESOLUTION 231 – ALIGNMENT OF FEDERAL PRIVACY LAW AND REGULATIONS GOVERNING SUBSTANCE USE DISORDER TREATMENT (42 CFR PART 2) WITH THE HEALTH INSURANCE PORTABILITY AND ACOUNTABILITY ACT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the alternate resolution <u>be adopted in lieu of Resolutions 220 and 231</u>.

CONFIDENTIALITY AND PRIVACY PROTECTIONS ENSURING CARE COORINATION AND THE PATIENT-PHYSICIAN RELATIONSHIP

RESOLVED, That our American Medical Association support amendments to HIPAA and 42 CFR Part 2 that allow for, without penalty, comprehensive care coordination and consultation between health care professionals that permit disclosure between health care professionals of a patient's medical history to enhance patient safety (New HOD Policy); and

RESOLVED, That our AMA oppose amendments to HIPAA and 42 CFR Part 2 that would lead to increased access to patients' personal health information by law enforcement, health insurers, data clearinghouses, employers, or other entities outside the patient-physician relationship. (Directive to Take Action)

Resolution 220 asks that our American Medical Association study whether the confidentiality protections of 42 CFR Part 2 outweigh the potential benefits of coordinating care with HIPAA privacy protections in the treatment of substance related disorders. (Directive to Take Action) Resolution 231 asks that our American Medical Association support the alignment of federal privacy law and regulations (42 CFR Part 2) with the Health Insurance Portability and Accountability Act (HIPAA) for the purposes of treatment, payment and health care operations, while ensuring protections are in place against the use of "Part 2" substance use disorder records in criminal proceedings (New HOD Policy); and be it further; that our AMA support the sharing of substance use disorder patient records as required by the HIPAA Privacy Rule for uses and disclosures of protected health information for treatment, payment and health care operations to improve patient safety and enhance the quality and coordination of care. (New HOD Policy)

Your Reference Committee heard extensive testimony on Resolutions 220 and 230. Testimony in support of Resolution 220 stated that 42 CFR Part 2 prohibits sharing of information that could identify a patient seeking treatment for a substance use disorder (SUD), help treat a patient with an SUD, or mitigate harm for a patient with an SUD receiving care for another medical condition or acute injury. Your Reference Committee heard testimony that, because of 42 CFR Part 2, treatment records for SUD are separated from a patient's medical record, acting as a life-threatening barrier preventing physicians and other health care professionals from effective care coordination, consultations, and having access to patients' full medical histories, limiting integration, hindering coordination, and resulting in less safe and less effective care. Further testimony demonstrated that there may be an abundance of confusion and misunderstanding on the part of many patients, physicians, and other stakeholders of what is—and is not—allowed to be shared under 42 CFR Part 2.

Your Reference Committee heard testimony that, when considering the balance between patient privacy and patient confidentiality, the balance tips toward reducing risk and ensuring patient safety. Testimony in support of adopting Resolution 231 also argued that the federal regulations mandating privacy protections contained in 42 CFR Part 2 serve an important purpose but may inadvertently reinforce stigma against patients by reinforcing the belief that SUD is different from other health problems and must be kept siloed. Additional testimony was provided that this stigma may inhibit the delivery of comprehensive integrated care. Your Reference Committee heard testimony that aligning 42 CFR Part 2 with the Health Insurance Portability and Accountability Act (HIPAA) would resolve these problems.

Your Reference Committee heard testimony supporting that our AMA to have the ability to take action to help resolve the thorny issues presented by alignment of HIPAA and 42 CFR Part 2. Your Reference Committee appreciates that there is a need to provide our AMA with sufficient direction and not simply call on our Board of Trustees to study the issue. Your Reference Committee notes that changes to HIPAA and 42 CFR Part 2 may be coming soon from the Administration, and that "alignment" of moving targets presents unique challenges. Moreover, your Reference Committee does not want to discount the significant concerns raised that removing privacy protections could have immediate and irreversible adverse

effects on a patient's employment, housing, parenting, and other socio-economic issues important to help maintain one's recovery. Your Reference Committee strongly supports providing our AMA with the flexibility to advocate for increased patient care coordination for patients with a SUD while protecting patients' personal health information from inappropriate use outside the patient-physician relationship.

Testimony was presented that, while our AMA supports information sharing and care coordination in the treatment of SUD, our AMA also believes that there need to be guardrails to protect patient confidentiality. Your Reference Committee agrees that simply "aligning Part 2 with HIPAA" (which Resolution 231 asks for) or conducting a study (which Resolution 220 calls for) are not sufficient solutions to the concerns the sponsors of these resolutions intend to address—particularly when there was no testimony in support of removing patient privacy protections for payment or health care operations.

To address the numerous and competing issues, your Reference Committee recommends a alternate resolution that will provide our AMA with the direction to actively engage in discussions about revisions to HIPAA and 42 CFR Part 2 that support increased patient care coordination while also protecting patients' personal health information from inappropriate access by law enforcement, health insurers, data clearinghouses, employers, or other entities outside the patient-physician relationship. By focusing on the patient-physician relationship, your Reference Committee believes that the appropriate balance has been met. Accordingly, your Reference Committee recommends an alternate resolution be adopted in lieu of Resolutions 220 and 231.

(24) RESOLUTION 221 – EXTENDING MEDICAID COVERAGE TO 12-MONTHS POSTPARTUM
RESOLUTION 224 – EXTENDING PREGNANCY MEDICAID TO ONE YEAR POSTPARTUM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the alternate resolution <u>be adopted in lieu of Resolutions 221 and 224</u>.

EXTENDING MEDICAID COVERAGE FOR ONE YEAR POSTPARTUM

RESOLVED, That our American Medical Association work with relevant stakeholders to support extension of Medicaid coverage to 12 months postpartum. (Directive to Take Action)

Resolution 221 asks that our American Medical Association support and actively work toward enactment of state legislation, Section 1115 waiver applications, and federal legislation to extend Medicaid coverage to 12-months postpartum. (Directive to Take Action) Resolution 224 asks that our American Medical Association petition the Centers for Medicare and Medicaid Services to extend pregnancy Medicaid to a minimum of one year postpartum. (Directive to Take Action)

Your Reference Committee heard positive testimony on Resolutions 221 and 224. Your Reference Committee heard testimony that extending Medicaid coverage to 12 months

postpartum is an important strategy to reduce maternal mortality rates and address disparities. Your Reference Committee also heard testimony that our AMA has already supported extending Medicaid coverage 12 months postpartum as proposed in the Mothers and Offspring Mortality & Morbidity Awareness (MOMMA) Act. Your Reference Committee received an amendment that offered clarification as to the application of the Resolutions 221 and 224 in the form of an alternate resolution. Accordingly, your Reference Committee recommends adopting the alternate resolution in lieu of Resolutions 221 and 224.

(25) RESOLUTION 228 – TRUTH IN ADVERTISING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 228 be amended by deletion as follows:

RESOLVED, That our AMA oppose any misappropriation of medical specialties' titles and work with state medical societies to advocate for states and administrative agencies overseeing nonphysician providers to authorize only the use of titles and descriptors that align with the nonphysician providers' state issued licenses ~~and national board certification~~. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 228 be adopted as amended.

Resolution 228 asks that that our American Medical Association reaffirm support of the Scope of Practice Partnership's Truth in Advertising Campaign to ensure patients receive accurate information about who is providing their care (AMA Policy H-405.969) (Reaffirm HOD Policy); and be it further, that our AMA oppose any misappropriation of medical specialties' titles and work with state medical societies to advocate for states and administrative agencies overseeing nonphysician providers to authorize only the use of titles and descriptors that align with the nonphysician providers' state issued licenses and national board certification. (Directive to Take Action)

Your Reference Committee heard positive testimony on Resolution 228. Your Reference Committee heard testimony that there is a need to protect physician specialty titles such as anesthesiologist, dermatologist, and cardiologist, particularly as Advanced Practice Registered Nurses, such as Certified Registered Nurse Anesthetists, are aggressively pushing to use the term "nurse anesthesiologist." Your Reference Committee further heard testimony that our AMA has existing policy on truth in advertising and a robust multi-faceted truth in advertising campaign including model state legislation. Your Reference Committee heard testimony that the second resolve of Resolution 228 should be amended by deleting the term "national board certification." Specifically, concern was raised that AMA policy should not support titles and descriptors of non-physician providers' national board-certifying bodies as to do so could potentially call on our AMA to support terms and descriptors that misalign and even directly contradict our policy and broader advocacy objectives. Accordingly, your Reference Committee recommends that Resolution 228 be adopted as amended.

(26) RESOLUTION 232 – COPD NATIONAL ACTION PLAN

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 232 be amended by deletion as follows:

Resolved, that our American Medical Association support funding for the National Heart, Lung, and Blood Institute and the CDC, for the purpose of implementing the COPD National Action Plan. ~~the inclusion of $25 million at NHLBI and an additional $2 million at CDC in the FY2020 Labor Health and Human Services and Education Appropriations bill to implement the COPD National Action Plan, and be it further,~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 232 be deleted:

~~RESOLVED, that our AMA send a letter to House and Senate Appropriators convey its support for the COPD National Action Plan funding for fiscal year 2020.~~

RECOMMENDATION C:

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

Resolution 232 asks that our American Medical Association support the inclusion of $25 million at NIH's National Heart, Lung, and Blood Institute (NHLBI) and an additional $2 million at the Centers for Disease Control and Prevention in the FY2020 Labor Health and Human Services and Education Appropriations Bill to implement the Chronic Obstructive Pulmonary Disease (COPD) National Action Plan (Directive to Take Action); and be it further; that our AMA send a letter to House and Senate Appropriators conveying its support for the COPD National Action Plan funding for fiscal year 2020. (Directive to Take Action)

Your Reference Committee heard largely positive testimony in support of Resolution 232. Your Reference Committee heard testimony that many physicians treat patients with COPD and note the significant burden of this chronic disease. Your Reference Committee further heard testimony that the AMA has committed time and resources to combatting chronic disease and preventing tobacco use, in line with calls to support the COPD National Action Plan. Your Reference Committee heard testimony that our AMA tries to avoid including specific funding level requests in policy to allow flexibility in our advocacy efforts at the local, state, and federal levels. Your Reference Committee also heard testimony that calling for our AMA to send a letter to House and Senate Appropriators is not timely, as the House has already released their FY2020 Appropriations recommendations with a proposed increase of over $650 million to the NIH, the agency charged with implementation of the COPD National Action Plan in conjunction with the CDC. Accordingly, your Reference Committee recommends that Resolution 232 be adopted as amended.

(27) RESOLUTION 233 – GME CAP FLEXIBILITY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy D-305.967 be amended by addition and deletion to read as follows:

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967

31. Our AMA will advocate to the Centers for Medicare & Medicaid Services ~~for flexibility beyond the current maximum of five years for the Medicare graduate medical education cap-setting deadline for new residency programs in underserved areas and/or economically depressed areas.~~to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy D-305.967 be adopted as amended in lieu of Resolution 233.

Resolution 233 asks that our American Medical Association advocate for the Centers for Medicare and Medicaid Services (CMS) to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to primary care residencies (Directive to Take Action); and be it further; that our AMA advocate for CMS to provide funding to hospitals and/or universities prior to the arrival of any residents, removing the clause where "Medicare funding does not begin until the first resident is 'on-duty' at the hospital." (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 233. Your Reference Committee heard testimony that our AMA has existing policy in support of cap-flexibility. Your Reference Committee further heard testimony that our AMA has been actively advocating for cap-flexibility both with the Centers for Medicare and Medicaid Services (CMS) as well as the U.S. Congress. Your Reference Committee heard testimony that direct GME (DGME) payments are based on a hospital's submission of a cost report and its residents on duty. Your Reference Committee heard further testimony that removing the residents-on-duty provision would require CMS to develop a new comprehensive formula for DGME payments and may result in less funding for GME. Testimony also indicated that, given that AMA policy on GME is based on the current formula, all existing AMA GME-related policy would need to be reviewed in light of any changes to the funding formula. Accordingly, your Reference Committee recommends amending existing policy on GME in lieu of Resolution 233.

(28) RESOLUTION 237 – OPPORTUNITIES IN BLOCKCHAIN FOR HEALTHCARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 237 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work with public or private sector standard-setting organizations ~~the Office of the National Health Information Technology~~ to create ~~official~~ standards for the development and implementation of blockchain technologies in health care, and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Resolution 237 be adopted as amended.

Resolution 237 asks that our American Medical Association work with the Office of the National Health Information Technology to create official standards for the development and implementation of blockchain technologies in healthcare (Directive to Take Action); and be it further; that our AMA monitor the evolution of blockchain technologies in healthcare and engage in discussion with appropriate stakeholders regarding blockchain development. (Directive to Take Action)

Your Reference Committee heard positive testimony on Resolution 237. Your Reference Committee heard testimony that blockchain is a distributed database that stores records of all transactions and digital events performed by its participants. Testimony also stated that blockchain technology may help drive transparency, data integrity, and authenticity. Your Reference Committee also heard testimony that in the health care context, many use cases of blockchain exist including medical records, supply chain management, consent management, clinical trials, claims adjudication, precision medicine, and provider directory management. Your Reference Committee further heard testimony raising concerns regarding the first Resolve because the naming of a specific entity may hamper our AMA's ability to advocate in this area. Your Reference Committee also heard testimony that this amended policy would provide greater flexibility for our AMA to work with public or private sector standard-setting organizations to allow for innovation and growth in this emerging technology. Accordingly, your Reference Committee recommends that Resolution 237 be adopted with amendment.

(29) RESOLUTION 241 – FACILITATION OF RESEARCH WITH MEDICARE CLAIMS DATA

RECOMMENDATION A:

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

RESOLVED, That our American Medical Association, in an effort to advance the feasibility of population health research to fulfill the promise of value based care, will request that CMS ~~and CMMI~~ eliminate the prohibitions on sharing data outside of any CMS model including Accountable Care Organizations that are ~~the ACO~~ contained in the CMS Data Use Agreement and allow sharing of that data: (1) in the form of de-identified data sets as permitted by ~~HIPAA~~ federal, state, and local privacy laws; and (2) for purposes of research as permitted by ~~HIPAA~~ federal, state, and local privacy laws.

RECOMMENDATION B:

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

Resolution 241 asks that our American Medical Association, in an effort to advance the feasibility of population health research to fulfill the promise of value based care, request that the Centers for Medicare and Medicaid Services (CMS) and CMS's Centers for Medicare and Medicaid Innovation (CMMI) eliminate the prohibitions on sharing data outside of the accountable care organization contained in the CMS Data Use Agreement and allow sharing of that data: (1) in the form of de-identified data sets as permitted by HIPAA; and (2) for purposes of research as permitted by HIPAA. (Directive to Take Action)

Your Reference Committee heard positive testimony on Resolution 241. Your Reference Committee heard testimony in support of increasing access to valuable data from Accountable Care Organizations for the purposes of globally increasing program transparency and accountability. Your Reference Committee heard testimony that the CMS is using data-use agreements for value-based models that pose a barrier to research. Your Reference Committee heard testimony that value-based models, governmental payers, academics, health care providers, and patients would benefit from efficacy research and improve quality improvement literature. Your Reference Committee further heard testimony that Resolution 241 should refer more broadly to CMS considering other Centers within CMS administer value-based programs; should be made broader to cover models outside of Accountable Care Organizations; and should clarify that data should be shared in accordance with all federal, state, and local privacy laws. Accordingly, your Reference Committee recommends that Resolution 241 be adopted as amended.

(30) RESOLUTION 246 – CALL FOR TRANSPARENCY REGARDING THE ANNOUNCEMENT OF 17,000 CUTS TO MILITARY HEALTH PROVIDERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy D-305.967 be amended by addition and deletion as follows:

Graduate Medical Education in the Military H-40.995

Our AMA: (1) strongly supports and endorses the graduate medical education programs of the military services and recognizes the potential benefit to the military services of recruitment, retention and readiness programs; ~~and~~ (2) is gravely concerned that closures of military medical centers and subsequent reduction of graduate medical education programs conducted therein will not only impede the health care mission of the Department of Defense, but also harm the health care of the nation by increasing the drain on trained specialists available to the civilian sector; (3) urge the U.S. Department of Defense (DOD) to release any assessments or pertinent information used by the DOD to propose any reductions in the overall uniformed medical positions including but not limited to the number of medical provider billet cuts and their distribution amongst specialties and services; (4) advocate to the U.S. Congress to implement legislation mandating a study in the next National Defense Authorization Act to assess the impact of potential cuts on cost and healthcare quality outcomes for military service members, dependents, and retirees before drastic cuts are executed; and (5) oppose any reductions to military GME residency or fellowship positions without dedicated congressional funding for an equal number of civilian residency positions in addition to any other planned increases to civilian GME to avoid further exacerbating the United States' physician shortage. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-40.995 be adopted as amended in lieu of Resolution 246.

Resolution 246 asks that our AMA urge the Department of Defense to immediately and publicly release the required assessments that the Military Departments, the Joint Staff, and organizations within the Office of the Secretary of Defense reportedly conducted as submitted in writing by the US Army Surgeon General in Congressional testimony to Senate Appropriations Committee regarding the operational medical requirements needed to support the National Defense Strategy that the Military Departments used in planning to reduce overall uniformed medical positions, as well as provide immediate clarification regarding the proposed cuts including the number of medical provider billet cuts and their distribution amongst specialties and services; and be it further, that if no such Department of Defense assessments exist, are immediately released, or appear inadequate to the AMA to justify the proposed cuts to military billets, that the AMA will urgently lobby the US Congress to implement legislation mandating a study in the next National Defense Authorization Act to assess the impact of potential cuts on cost and healthcare quality outcomes for military service members, dependents, and retirees before drastic cuts are executed; and be it further, that the AMA strongly oppose any reductions to military GME residency or fellowship positions without dedicated congressional funding for parity civilian residency positions in addition to any other planned increases to civilian GME to avoid further exacerbating the United States' physician shortage.

Your Reference Committee heard supportive testimony for Resolution 246. Your Reference Committee heard testimony that the U.S. Department of Defense has recently announced plans to decrease the number of military health care provider billets threatening the success and impact of healthcare services for certain service members and their beneficiaries. Your Reference Committee heard further testimony that our AMA has strong existing policy opposing any arbitrary attempt to limit the percentage of resident physicians in military graduate education or training programs. Your Reference Committee heard testimony that our AMA strongly supports and endorses Graduate Medical Education programs of the military services. Your Reference Committee also heard that Resolution 246 brings forth an important issue that needs to be addressed and added to existing policy. Accordingly, your Reference Committee recommends that existing policy be amended in lieu of Resolution 246.

(31) RESOLUTION 203 – MEDICARE PART B AND PART D DRUG PRICE NEGOTIATION

RECOMMENDATION:

Your Reference Committee recommends that Resolution 203 be referred.

Resolution 203 asks that our American Medical Association advocate for Medicare to cover all physician-recommended adult vaccines in both the Medicare Part D and the Medicare Part B programs (Directive to Take Action); and be it further; that our AMA make it a priority to advocate for a mandate on pharmaceutical manufacturers to negotiate drug prices with the Centers for Medicare and Medicaid Services for Medicare Part D and Part B covered drugs (Directive to Take Action); and be it further; that our AMA explore all options with the state and national specialty societies to ensure that physicians have access to reasonable drug prices for the acquisition of Medicare Part B physician-administered drugs and that Medicare reimburse physicians for their actual drug acquisition costs, plus appropriate fees for storage, handling, and administration of the medications, to ensure access to high-quality, cost-effective care in a physician's office. (Directive to Take Action) Resolution 217 asks that our American Medical Association advocate that a physician's office can bill Medicare for all vaccines and that the patient shall only pay the applicable copay to prevent fragmentation of care. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolutions 203. Your Reference Committee heard testimony that our AMA should seek coverage of vaccines under Medicare Part B while others advocated that our AMA seek coverage under both Part B and Part D. Your Reference Committee heard testimony that advocating for coverage under both Part B and Part D could have unintended consequences and referral was recommended for Resolution 203. Accordingly, your Reference Committee recommends referring Resolution 203 for study.

(32) RESOLUTION 207 – DIRECT-TO-CONSUMER GENETIC TESTS

RECOMMENDATION:

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

Resolution 207 asks that our American Medical Association regard research using consumer genome data derived from saliva or cheek swab samples as research on human subjects requiring consents in compliance with the Health and Human Services (HHS) Office for Human Research Protection (OHRP), and recommend an “opt in” option to allow more consumer choice in the consent process (Directive to Take Action); and be it further, that our AMA amend Policy H-315.983, “Patient Privacy and Confidentiality,” by addition to align with current research and privacy infringement findings, as follows: 1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received, <u>while working with the Department of Health and Human Services (HHS) to stop the transfer of birthdates and state of residence by genetic testing companies and their affiliates, unless there is explicit user approval, to prevent re-identification of the test user by way of surname inference methods</u>. 2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law. 3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure. 4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review. 5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use. 6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained. 7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual. <u>Our AMA regards studies using consumer genome data derived from saliva, cheek swab, or other human tissue samples as research on human subjects requiring consents in compliance with the HHS Office</u>

for Human Research Protections (OHRP). An “opt in” option is recommended to allow more consumer choice in the consent process. 8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end. 9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures. 10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of 43 identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB. 11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures. 12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights. 13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned. 14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance. 15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands. 16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine. 17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing. The AMA will work with Congress and HHS to modify the Genetic Information Nondiscrimination Act of 2008 (GINA), which bans genome-based policy and hiring decisions by health insurance companies and

employers, by adding Long-Term Care, Life Insurance, and Disability Insurance to the Act to prevent applicant rejection based on their genetic make up. 18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes. a. Our AMA supports privacy standards that would prohibit pharmaceutical companies, biotechnology companies, universities, and all other entities with financial ties to the genetic testing company from sharing identified information with other parties without the consent of the user. An exception would be made when requested by law enforcement authorities or when keeping the information would seriously threaten their health or that of others. If a data security breach occurs with the Direct-To –Consumer genetic company or its collaborators, then the company has the responsibility to inform all users of the breach and the impact of the unprotected private data on those individuals; 19. Our AMA supports privacy standards that require pharmacies and drug store chains to 50 disclose the source of financial support for drug mailings or phone calls. 20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes. 21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation (Modify Current HOD Policy); and be it further, that our AMA work with the Department of Health and Human Services or other relevant parties to modify the rules to prevent genetic testing entities from transferring information about the user's date of birth and state of residence to third parties which may result in the re-identification of the user based on surname inference (Directive to Take Action); and be it further, that our AMA work with Congress and the Department of Health and Human Services to extend the consumer protections of the Genetic Information Non-Discrimination Act (GINA) of 2008 by adding long-term care, disability insurance, and life insurance to the Act, modeled after the laws of other states, such as California. (Directive to Take Action)

Your Reference Committee heard robust testimony on Resolution 207 largely in support of referral. Your Reference Committee heard testimony that legislative action would be needed to provide consumers of Direct-to-Consumer (DTC) genetic testing with the same type of protections afforded to human research subjects available under the U.S. Department of Health and Human Services (HHS) jurisdiction. Your Reference Committee further heard testimony that the revised HHS Common Rule, which governs human subject research, may not be adequate. Your Reference Committee heard additional testimony that the suggested language concerning releasing information to law enforcement is not consistent with existing AMA Code of Medical Ethics, 4.1.4 Forensic Genetics. Your Reference Committee heard testimony that appreciated the consideration given to privacy and confidentiality, but noted that evaluating the source, quality, and accuracy of genetic information is also an important component to assess and interrogate when developing policy related to DTC genetic tests. Your Reference Committee also heard testimony that strongly encouraged referral for report given the rising use of genetic testing both in the clinical setting and DTC marketplace. Lastly, your Reference Committee heard that there is growing evidence suggesting that de-identified genetic information can become increasingly re-identified through genetic testing databases and data sources. Your Reference Committee heard significant concerns about the Genetic Information Nondiscrimination (GINA) Act of 2008, which bans genome-based policy and hiring decisions by health insurance companies and employers, but does not include protections for Long-Term Care, Life Insurance, and Disability Insurance. Your Reference Committee heard testimony that the inclusion of life insurance provisions in the GINA Act may lead to adverse selection and that this issue is complex, requiring additional study and consideration. Accordingly, your Reference Committee recommends that Resolution 207 be referred.

(33) RESOLUTION 219 – MEDICAL MARIJUANA LICENSE SAFETY

RECOMMENDATION:

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

Resolution 219 asks that our American Medical Association draft model state legislation to amend states' prescription drug monitoring programs to include a medical marijuana license registry. (Directive to Take Action)

Your Reference Committee heard engaging testimony regarding Resolution 219. Your Reference Committee heard testimony that states have moved quickly to embrace medical marijuana for a wide variety of reasons, and that a growing number of states have also supported recreational marijuana despite the known risks of recreational use. Your Reference Committee heard further testimony that a need exists for physicians and other health care professionals to know what—if any—mind-altering substances their patients may be eating, smoking, vaping, inhaling, or ingesting. However, your Reference Committee heard testimony that there exists little guidance regarding appropriate dosing for a variety of marijuana modalities, such as edible products containing CBD, THC, and other products that might have psychoactive components (e.g., gummies, brownies, and chocolates). Further testimony indicated that on the surface, it seems to make a modicum of sense to include medical marijuana in a state prescription drug monitoring program (PDMP). However, your Reference Committee heard testimony identifying multiple potential issues related to distribution, licensing, and access: dispensaries are not operated by licensed health care professionals subject to professional and ethical obligations to safeguard patients' personal health information; the products offered in dispensaries are far from uniform; and it is unclear how a CBD gummy or strain of cannabis would be entered into a PDMP. Your Reference Committee believes these issues are among those that need further study. Accordingly, your Reference Committee recommends referral of Resolution 219.

(34) RESOLUTION 226 – PHYSICIAN ACCESS TO THEIR MEDICAL AND BILLING RECORDS

RECOMMENDATION:

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

Resolution 226 asks that that our American Medical Association advocate that licensed physicians must always have access to all medical and billing records for their patients from and after date of service including after physician termination (Directive to Take Action); and be it further; that our AMA press for legislation or regulation to eliminate contractual language that bars or limits the treating physician's access to the medical and billing records such as treating these records as trade secrets or proprietary. (Directive to Take Action)

Your Reference Committee heard positive testimony on Resolution 226. Your Reference Committee heard testimony that our AMA has strong policy regarding physician access and management of medical records. Your Reference Committee further heard testimony that our

AMA has model state legislation regarding physician employment including a provision that a "physician is entitled to copies of patient charts and any other records relating to the physician's provision of physician services." Your Reference Committee also heard testimony that the Council on Legislation is examining the issue of data ownership and stewardship and the rapid advancement in the collection, transferability, and use of health care information. Your Reference Committee heard testimony that our AMA should establish more understanding of health care data within and outside the physician-patient relationship and that the resolves of Resolution 226 touch upon the Council's work. Accordingly, your Reference Committee recommends that Resolution 226 be referred.

(35) RESOLUTION 243 – IMPROVING THE QUALITY PAYMENT PROGRAM AND PRESERVING PATIENT ACCESS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 243 be referred for report back at Interim 2019.

Resolution 243 asks that our American Medical Association strongly advocate for Congress to make participation in the Merit-Based Incentive Payment System and alternative payment models under the Quality Payment Program completely voluntary (Directive to Take Action); and be it further; that our AMA strongly advocate for Congress to eliminate budget neutrality in the Merit-Based Incentive Payment System and to finance incentive payments with supplemental funds that do not come from Medicare Part B payment cuts to physicians and other clinicians (Directive to Take Action); and be it further; that our AMA call on the Centers for Medicare & Medicaid Services (CMS) to provide a transparent, accurate, and complete Quality Payment Program Experience Report on an annual basis so physicians and medical societies can analyze the data to advocate for additional exemptions; flexibilities; and reductions in reporting burdens, administrative hassles, and costs (Directive to Take Action); and be it further; that our AMA advocate that CMS increase the low-volume threshold for the 2020 Quality Payment Program and future years of the program for all physicians and continue to offer them the opportunity to opt in or voluntarily report (Directive to Take Action); and be it further; that our AMA reaffirm Policy H-390.838, "MIPS and MACRA Exemption," and advocate to preserve patient access by exempting small practices (one to 15 clinicians) from required participation in the Merit-Based Incentive Payment System and continue to offer them the opportunity to opt in or voluntarily report (Reaffirm HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 243. Your Reference Committee heard testimony that many physician practices that serve Medicare beneficiaries cannot sustain additional reductions in their Medicare payments. Your Reference Committee heard testimony that our AMA continues to work closely with CMS to recommend a variety of improvements to the Merit-based Incentive Payment System (MIPS) program. Your Reference Committee also heard testimony that our AMA strongly believes that we should continue working to simplify and improve the MIPS program to make it easier for physicians to avoid a penalty. Your Reference Committee heard testimony that our AMA advocacy efforts are a main reason that CMS developed the policy for the first year of MIPS that allowed any physician who reported on one measure, one time, for one patient avoid a penalty. Furthermore, your Reference Committee heard testimony that at the last interim meeting, our AMA had two similar resolutions asking our AMA to advocate for substantial changes to the MIPS program that were referred for a Board Report due at the Interim Meeting in 2019. Your Reference Committee believes that Resolution 243 should be a part of this forthcoming Board

Report as it would be premature for the House of Delegates to weigh in prior to the Board of Trustees' deliberations. Accordingly, your Reference Committee recommends that Resolution 243 be referred for study for report back at Interim 2019 with the report that is pending from Resolutions 206-I-18 and 231-I-18.

(36) RESOLUTION 245 – SENSIBLE APPROPRIATE USE CRITERIA IN MEDICARE
RESOLUTION 247 – SENSIBLE APPROPRIATE USE CRITERIA IN MEDICARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolutions 245 and 247 be referred.

Resolution 245 asks that our American Medical Association policy H-320.940, "Medicare's Appropriate Use Criteria Program," be amended by addition as follows: Our AMA will continue to advocate to delay the effective date of the Medicare AUC Program until the Centers for Medicare & Medicaid Services can adequately address technical and workflow challenges with its implementation and any interaction between the Quality Payment Program (QPP) and the use of advanced diagnostic imaging appropriate use criteria, and support regulatory change that resolves technical and workflow challenges and/or removes barriers to modifying or aligning the AUC Program and the QPP. (Modify HOD Policy). Resolution 247 asks that our American Medical Association policy H-320.940, "Medicare's Appropriate Use Criteria Program," be amended by addition as follows: our AMA will continue to advocate to delay the effective date of the Medicare AUC Program until the Centers for Medicare & Medicaid Services can adequately address technical and workflow challenges with its implementation and any interaction between the Quality Payment Program (QPP) and the use of advanced diagnostic imaging appropriate use criteria, and support legislation that resolves technical and workflow challenges and/or removes barriers to modifying or aligning the AUC Program and the QPP. (Modify HOD Policy)

Your Reference Committee heard mixed testimony on Resolutions 245 and 247. Your Reference Committee heard testimony that the statute regarding appropriate use criteria sets up a rigid system, a complex exchanging of information between ordering and referring providers, and burdensome documentation requirements. Your Reference Committee also heard testimony that appropriate use criteria has been shown to improve quality, reduce unnecessary imaging, and lower costs. Your Reference Committee heard testimony that the Centers for Medicare and Medicaid Services should exempt physicians from the appropriate use criteria requirements when the physician is participating in the QPP. Testimony also indicated that physicians participating in Alternative Payment Models (APM) and MIPS APMs should be exempted because those physicians are already being held accountable for costs and outcomes and are assuming risk. Your Reference Committee heard further testimony that the Resolutions should not be adopted and that existing policy is sufficient. Accordingly, given the disagreement, your Reference Committee recommends that Resolutions 245 and 247 be referred.

(37) RESOLUTION 227 – CONTROLLED SUBSTANCE MANAGEMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 227 not be adopted.

Resolution 227 asks that our American Medical Association work with the Centers for Medicare and Medicaid Services (CMS) and interested physician groups to strongly advocate for a mechanism by which physicians may be compensated for controlled substance management (Directive to Take Action); and be it further; that our AMA strongly encourage CMS and private payers to recognize and establish equitable payment for controlled substance management. (Directive to Take Action)

Your Reference Committee heard limited testimony on Resolution 227. Your Reference Committee heard supportive testimony for increased payment for conducting activities for controlled substance management. Your Reference Committee also heard testimony that this could include payment, for example, when a physician checks a state's prescription monitoring program (PDMP). Your Reference Committee heard testimony that this example, moreover, is only one of many that could be implicated by the somewhat vague "controlled substance management," which could conceivably include any and all controlled substance discussion with a patient, test result, pill count, practice-related medication adherence, drug utilization review, or refill protocol. Accordingly, while your Reference Committee is sympathetic to the added administrative burdens associated with all of the Evaluation and Management and other work physicians do when a patient receives a controlled substance as part of the treatment care plan, your Reference Committee recommends that Resolution 227 not be adopted.

(38) RESOLUTION 239 – IMPROVING ACCESS TO MEDICAL CARE THROUGH TAX TREATMENT OF PHYSICIANS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 239 not be adopted.

Resolution 239 asks that our American Medical Association seek legislation and/or regulation that would permit physician practices to utilize 'pass through' tax treatment of practice income in the manner of other small businesses and professionals. (Directive to Take Action)

Your Reference Committee heard limited but mixed testimony on Resolution 239. Your Reference Committee heard testimony in support of this resolution to provide physicians with the same tax benefits that other small businesses receive through the new tax law regarding so-called "pass through" entities. Your Reference Committee heard testimony against adoption of this resolution because it is based on a misunderstanding of the purpose of the tax law change for pass-through entities, which is to provide relief for small businesses that rely on capital investment to generate their income (rather than their own professional expertise). Your Reference Committee heard that physicians were not singled out for exclusion from this tax benefit; other professionals, such as attorneys, accountants, consultants, financial advisors, and other professionals are treated the same way. Your

Reference Committee further considered that the exclusion phases in over specified income levels, so that some physicians whose income is below a certain threshold are still qualified for the deduction. Your Reference Committee also considered that some individual physicians may realize an overall net benefit from the new tax law through other provisions that reduced most individual tax brackets and provide other tax benefits. Your Reference Committee believes that Resolution 239 raises a number of questions regarding complex tax issues that may impact individual physicians in different ways. Accordingly, your Reference Committee recommends that Resolution 239 not be adopted.

(39) RESOLUTION 206 – CHANGING THE PARADIGM: OPPOSING PRESENT AND OBVIOUS RESTRAINT OF TRADE
RESOLUTION 240 – FORMATION OF COLLECTIVE BARGAINING WORKGROUP

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies D-383.981, D-383.982, D-383.983, D-383-985, D-383.988, D-383.990, H-165.833, H-180.975, H-380.987, H-383.988, H-383.990, H-383.992, H-383.993, H-385.946, H-385.973, and H-385.976 be reaffirmed in lieu of Resolutions 206 and 240.

Resolution 206 asks that our American Medical Association seek legislative or regulatory changes to allow physicians to collectively negotiate professional fees, compensation and contract terms without integration. (Directive to Take Action) Resolution 240 asks that that our American Medical Association form a workgroup to outline the legal challenge to federal antitrust statute for physicians (Directive to Take Action); and be it further; that this workgroup engage the state medical associations and other physician groups as deemed appropriate (Directive to Take Action); and be it further; that our AMA report by the 2020 Annual Meeting on the viability of a strategy for the formation of a federal collective bargaining system for all physicians and, to the extent viable, a related organizational plan. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 206. Your Reference Committee heard testimony that large health insurers have substantially more bargaining power over physicians that allowing insurers to force bad contract terms and unfair payment rates on physicians. On the other hand, your Reference Committee heard testimony that aggressively pursuing a special antitrust exemption for physicians would stretch our antitrust advocacy agenda. Our AMA has worked hard to earn a reputation for credibility through its aggressive and evidence-based antitrust campaign against various proposed mergers, most recently Anthem-Cigna, Aetna-Humana, and now, CVS-Aetna.

Testimony also indicated that our AMA already has extensive policy making antitrust reform a high priority for our AMA. For example, that our AMA make passage of legislation in Congress to exempt physicians from antitrust actions in their negotiations with insurance companies a top legislative priority of our AMA and that our AMA continue to aggressively advocate for a level playing field for negotiations between physicians and health insurers by pursuing legislative relief at the federal level and providing support to state medical society efforts to pass legislation are based on the state action doctrine. Our AMA already has developed a sophisticated model bill that any medical association can use that would enable

independent physicians to collectively negotiate with health insurers under the state action exemption to federal and state antitrust laws. Through our AMA state Advocacy Resource Center, all interested states and national medical specialty societies have access to antitrust experts and the ability to develop strategies, state roadmaps, and related tools for enacting legislation on the issues raised in Resolution 240. Together with the Advocacy Resource Center, our AMA antitrust advocacy team monitors these issues closely as well. Based on all of the above, your Reference Committee recommends reaffirming policy in lieu of Resolutions 206 and 240.

Employee Associations and Collective Bargaining for Physicians D-383.981
Our AMA will study and report back on physician unionization in the United States. (Res. 601, I-14)

A Level Playing Field in Negotiations Between Health Insurance Companies and Physicians D-383.982
Our AMA will make passage of legislation in the US Congress to exempt physicians from antitrust actions in their negotiations with insurance companies a top legislative priority of the AMA, remain vigilant on this issue, continue to regularly provide updates on our AMA Web site and through other AMA communication tools, request sponsors nationally, and allocate appropriate funding and resources necessary to successfully advocate its passage into law. (Res. 202, I-11)

Collective Bargaining: Antitrust Immunity D-383.983
Our AMA will: (1) continue to pursue an antitrust advocacy strategy, in collaboration with the medical specialty stakeholders in the Antitrust Steering Committee, to urge the Department of Justice and Federal Trade Commission to amend the "Statements of Antitrust Enforcement Policy in Health Care" (or tacitly approve expansion of the Statements) and adopt new policy statements regarding market concentration that are consistent with AMA policy; and (2) execute a federal legislative strategy. (BOT Action in response to referred for decision Res. 209, A-07 and Res. 232, A-07Reaffirmed: Res. 215, A-11)

Fair Valuation of Physician Services in Third Party Payer Contracting with Hospitals and Health Care Systems D-383.985
Our AMA will: (1) continue to advocate for fair payment for physician services regardless of the employment status of physicians on organized medical staffs; (2) develop a new federal antitrust legislative strategy, and reopen a dialogue with the Department of Justice and the Federal Trade Commission concerning more flexible approaches to physician network joint ventures; (3) continue to encourage all physicians who would like to report the unfair business practices of health insurers and other payers to complete the AMA online health plan complaint form; and (4) work to ultimately eliminate the need for cross subsidization practices between third party payers and hospital systems that result in: (a) a decrease in physician market power, (b) a devaluation of physician services, and (c) harm to competition. (BOT Rep. 13, I-06 Reaffirmation A-08 Reaffirmation I-10)

Collective Bargaining and the Definition of Supervisors D-383.988
Our AMA will support legislative efforts by other organizations and entities that would overturn the Supreme Court's ruling in *National Labor Relations Board v. Kentucky River Community Care, Inc., et al*. (BOT Action in response to referred for decision Res. 248, A-01 Modified: BOT Rep. 22, A-11)

AMA's Aggressive Pursuit of Antitrust Reform D-383.990
Our AMA will: (1) place a high priority on the level of support provided to AMA's Public and Private Sector Advocacy Units, which are key to successfully addressing the problems physicians face as a result of the current application of federal antitrust laws; (2) through its private and public sector advocacy efforts, continue to aggressively advocate for a level playing field for negotiations between physicians and health insurers by aggressively pursuing legislative relief at the federal level and providing support to state medical society efforts to pass legislation based on the "state action doctrine"; (3) continue to advocate to the Federal Trade Commission and Department of Justice for more flexible and fair treatment of physicians under the antitrust laws and for greater scrutiny of insurers; (4) continue to develop and publish objective evidence of the dominance of health insurers through its comprehensive study, Competition in Health Insurance: Comprehensive Study of US Markets, and other appropriate means; (5) identify consequences of the concentration of market power by health plans to enlist a Senate sponsor for a bill allowing collective negotiation by physicians; and (6) develop practical educational resources to help its member physicians better understand and use the currently available, effective modalities by which physician groups may legally negotiate contracts with insurers and health plans. (Res. 908, I-03 Reaffirmation, A-05 Reaffirmed: BOT Rep. 10, I-05 Reaffirmation A-06 Reaffirmation A-08 Reaffirmed: BOT Rep. 09, A-18)

Amend the Patient Protection and Affordable Care Act (PPACA) H-165.833
1. Our AMA continues to advocate to achieve needed reforms of the many defects of the federal Patient Protection and Affordable Care Act (PPACA) law so as to protect the primacy of the physician-patient relationship. These needed changes include but are not limited to: repeal of the Independent Payment Advisory Board (IPAB); study of the Medicare Cost/Quality Index; repeal of the non-physician provider non-discrimination provision; enactment of comprehensive medical liability reform; enactment of long term Medicare physician payment reform including permitting patients to privately contract with physicians not participating in the Medicare program; enactment of antitrust reform to permit independently practicing physicians to collectively negotiate with health insurance companies; and expanding the use of health savings accounts as a means to provide health insurance coverage. 2. Our AMA will vigorously work to change the PPACA to accurately represent our AMA Policy. (Res. 217, A-11 Reaffirmation A-12 Reaffirmed: Res. 239, A-12 Reaffirmed: CMS Rep. 5, I-12 Reaffirmed: CMS Rep. 9, A-14 Reaffirmed in lieu of Res. 215, A-15)

Insurance Industry Antitrust Exemption H-180.975
It is the policy of the AMA to: (1) to continue efforts to have the insurance industry be more responsive to the concerns of physicians, including collective negotiations with physicians and their representatives regarding delivery of medical care; (2) to continue efforts to have the insurance industry be more responsive to the concerns of physicians and their representatives regarding reasonable requests for appropriate information and data; (3) to analyze proposed amendments to the McCarran-Ferguson Act to determine whether they will increase physicians' ability to deal with insurance companies, or increase appropriate scrutiny of insurance industry practices by the courts; and (4) to continue to monitor closely and support appropriate legislation to accomplish the above objectives. (BOT Rep. DD, I-91 Reaffirmed: Res. 213, I-98 Reaffirmation A-00 Reaffirmation I-00 Reaffirmation A-01 Reaffirmation I-03

Reaffirmed: BOT Rep. 10, I-05 Reaffirmation A-06 Reaffirmation A-08 Reaffirmed: BOT action in response to referred for decision Res. 201, I-12)

Antitrust Relief as a Priority of the AMA H-380.987
Our AMA will continue its aggressive efforts to achieve appropriate negotiations rights and opportunities and necessary antitrust relief for physicians, by whatever means. Achieving this important goal will remain a top priority for the Association. (Sub. Res. 223, A-93 Reaffirmed by BOT Rep. 33, A-96 Reaffirmation A-97 Reaffirmation A-00 Reaffirmation I-00 Reaffirmation A-04 Reaffirmation A-05 Reaffirmed: BOT Rep. 10, I-05 Reaffirmation A-06 Reaffirmation A-08 Reaffirmation I-10 Reaffirmed: Res. 215, A-11 Reaffirmed: BOT action in response to referred for decision Res. 201, I-12 Reaffirmed in lieu of Res. 218, A-15 Reaffirmed: CMS Rep. 05, A-17)

Physicians' Ability to Negotiate and Undergo Practice Consolidation H-383.988
Our AMA will: (1) pursue the elimination of or physician exemption from anti-trust provisions that serve as a barrier to negotiating adequate physician payment; (2) work to establish tools to enable physicians to consolidate in a manner to insure a viable governance structure and equitable distribution of equity, as well as pursuing the elimination of anti-trust provisions that inhibited collective bargaining; and (3) find and improve business models for physicians to improve their ability to maintain a viable economic environment to support community access to high quality comprehensive healthcare. (Res. 229, A-12)

Antitrust Relief for Physicians Through Federal Legislation H-383.990
Our AMA: (1) encourages state medical associations and national medical specialty societies to support federal antitrust reform bills, such as H.R. 1409, as originally introduced in the 112th Congress, and consider sending in letters of support for such antitrust reform legislation to their respective Congressional delegations and select Congressional leaders; (2) supports the intent of antitrust reform bills, such as H.R. 1409, as originally introduced in the 112th Congress, that put access to quality patient medical care and patient rights ahead of health insurer profits; (3) continues to advocate for the principles that support that any health care professional, including a physician or a physician group, which is engaged in negotiations with a health plan regarding the terms of any contract under which the professional provides health care items or services for which benefits are provided shall, in connections with such negotiations, be exempt from federal antitrust laws; (4) continues to advocate for the concepts and limitations incorporated in H.R. 1409, as originally introduced in the 112th Congress, including: no new rights for collective cessation of service to patients, no amendments to the National Labor Relations Act; and no application of H.R. 1409, as originally introduced in the 112th Congress, to the Medicare program under Title XVIII, the Medicaid program under Title IX, the SCHIP program under Title XXI of the Social Security Act; or programs related to medical services for members of the uniformed service, veterans, federal employees health benefit program or Indian Health Services; (5) will send a letter of support to Congress of the principles contained in H.R. 1409 as originally introduced in the 112th Congress; and (6) will work with members of Congress to promote antitrust reform in light of Accountable Care Organization (ACO) development. (Res. 212, A-11 Reaffirmed: BOT action in response to referred for decision Res. 201, I-12)

Antitrust Relief H-383.992

Our AMA will: (1) redouble efforts to make physician antitrust relief a top legislative priority, providing the necessary foundation for fair contract negotiations designed to preserve clinical autonomy and patient interest and to redirect medical decision making to patients and physicians; and (2) affirm its commitment to undertake all appropriate efforts to seek legislative and regulatory reform of state and federal law, including federal antitrust law, to enable physicians to negotiate effectively with health insurers. (Sub. Res. 905, I-07 Reaffirmation A-08 Reaffirmed: Res. 215, A-11 Reaffirmed: BOT action in response to referred for decision Res. 201, I-12 Reaffirmed in lieu of Res. 218, A-15)

Negotiations Issue H-383.993

Our AMA: (1) will continue its efforts to promote the involvement of physician organizations in health policy decisions by public and private institutions pursuant to health system reform; (2) will continue its efforts to enhance the involvement of physician organizations in the current health system, including the Medicare program and private sector payers and institutions; (3) will continue with its efforts to support and enhance the self regulatory structure of the profession, and will continue to review the development of new self regulatory efforts that may be needed to meet the challenges of the new environment; (4) working through a consortium of appropriate interested organizations (i.e., specialties, groups), may act as the negotiator on behalf of, and with active input from, physicians and physician groups, for reimbursement of physician services, practice-related issues (including quality improvement), utilization review, physician supply and professional liability reform; (5) believes that at the state and local level, physician-directed organizations (i.e. state or county associations) may act as a negotiator on behalf of member physicians after antitrust relief has been obtained; and (6) will continue to pursue enhanced roles for physicians in private sector health plans, including lobbying for appropriate modification of the antitrust laws to facilitate physician negotiation with managed care plans and for legislation requiring managed care plans to allow participating physicians to organize for the purpose of commenting on medical review criteria, and including the development of an AMA team to develop the information and networks of consultants necessary to assist physicians in their interactions with managed care plans.
BOT Rep. QQ, I-92 BOT Rep. HHH, A-93 Reaffirmed: BOT Rep. 40, I-93 Reaffirmed: BOT Reps. 25 and 40, I-93 Reaffirmed: Sub. Res. 110, A-94 Reaffirmation I-98 Reaffirmation A-00 Reaffirmation I-00 Reaffirmation A-04 Reaffirmation A-05 Reaffirmed: BOT Rep. 10, I-05 Consolidated and Renumbered: CMS Rep. 7, I-05 Reaffirmation A-06 Reaffirmation A-08 Reaffirmation I-08 Reaffirmation I-10 Reaffirmed: Sub. Res. 222, I-10 Reaffirmed: BOT action in response to referred for decision Res. 201, I-12

Collective Bargaining for Physicians H-385.946

The AMA will seek means to remove restrictions for physicians to form collective bargaining units in order to negotiate reasonable payments for medical services and to compete in the current managed care environment; and will include the drafting of appropriate legislation. (Res. 239, A-97 Reaffirmation I-98 Reaffirmation A-01 Reaffirmation A-05 Reaffirmation A-06 Reaffirmation A-08 Reaffirmation I-10)

Collective Negotiations H-385.973

It is the policy of the AMA to seek amendments to the National Labor Relations Act and other appropriate federal antitrust laws to allow physicians to negotiate collectively with payers who have market power. (Res. 95, A-90 Reaffirmed by BOT Rep. 33, A-

96 Reaffirmation A-97 Reaffirmation I-98 Reaffirmation A-00 Reaffirmation I-00 Reaffirmation A-01 Reaffirmation A-04 Reaffirmation A-05 Reaffirmation A-06 Reaffirmation A-08 Reaffirmation I-10 Reaffirmed: Res. 215, A-11 Reaffirmed: BOT action in response to referred for decision Res. 201, I-12)

Physician Collective Bargaining H-385.976
Our AMA's present view on the issue of physician collective negotiation is as follows: (1) There is more that physicians can do within existing antitrust laws to enhance their collective bargaining ability, and medical associations can play an active role in that bargaining. Education and instruction of physicians is a critical need. The AMA supports taking a leadership role in this process through an expanded program of assistance to independent and employed physicians. (2) Our AMA supports continued intervention in the courts and meetings with the Justice Department and FTC to enhance their understanding of the unique nature of medical practice and to seek interpretations of the antitrust laws which reflect that unique nature. (3) Our AMA supports continued advocacy for changes in the application of federal labor laws to expand the number of physicians who can bargain collectively. (4) Our AMA vigorously opposes any legislation that would further restrict the freedom of physicians to independently contract with Medicare patients.(5) Our AMA supports obtaining for the profession the ability to fully negotiate with the government about important issues involving reimbursement and patient care. (BOT Rep. P, I-88 Modified: Sunset Report, I-98 Reaffirmation A-00 Reaffirmation I-00 Reaffirmation A-01 Reaffirmation I-03 Reaffirmation A-04 Reaffirmed in lieu of Res. 105, A-04 Reaffirmation A-05 Reaffirmation A-06 Reaffirmation A-08 Reaffirmed: BOT Rep. 17, A-09 Reaffirmation I-10 Reaffirmed: Sub. Res. 222, I-10 Reaffirmed: Res. 215, A-11 Reaffirmed: BOT action in response to referred for decision Res. 201, I-12)

(40) RESOLUTION 210 – AIR AMBULANCES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-285.904 be reaffirmed in lieu of Resolution 210.

Resolution 210 asks that that our American Medical Association support federal legislation which would: 1. Establish an expedited independent dispute resolution system to resolve payment disputes between emergency air ambulance providers and health insurers; and 2. Ensure that such independent dispute resolution process would ensure the patient be “held harmless” except for applicable insurance policy in-network cost-sharing requirements. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 210. Your Reference Committee heard testimony in support of protecting patients from unanticipated out-of-network costs incurred as result of out-of-network air ambulances. Your Reference Committee agrees that air ambulance costs can be financially devastating for patients in the same way as other major medical services, especially when those services are provided out of network. Your Reference Committee heard testimony that our AMA policy (D-130.962—Air Ambulance Regulations and Payments) adopted at the 2018 Interim Meeting that calls for greater price and data transparency for air ambulances. Your Reference Committee also heard testimony that current AMA policy (H-285.904—Out-of-Network Care) on out-of-network services

encompasses unanticipated bills from air ambulances, and would protect patients in the manner called for in Resolution 210. Accordingly, your Reference Committee therefore recommends that existing policy be reaffirmed in lieu of adopting Resolution 210.

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 physician's 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 Reaffirmed in lieu of: Res. 225, I-18)

(41) RESOLUTION 236 – SUPPORT FOR UNIVERSAL BASIC INCOME PILOT STUDIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-160.909, H-160.896, H-65.963, and D-165.966 be reaffirmed in lieu Resolution 236.

Resolution 236 asks that That our American Medical Association support federal, state, local, and/or private Universal Basic Income pilot studies in the United States which intend to measure health outcomes and access to care for participants. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 236. Your Reference Committee heard testimony that our AMA strongly supports protections that seek to alleviate

the effects of poverty on health income including Medicaid, Supplemental Nutrition Assistance Program (SNAP), Children's Health Insurance Program (CHIP), and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Your Reference Committee heard testimony that Universal Basic Income pilot programs can be considered contentious policy proposals, particularly when social safety net programs such as Medicaid, SNAP, CHIP, and the WIC may be compromised or replaced during implementation efforts. Your Reference Committee heard further testimony outlining our AMA's comprehensive policy related to addressing health disparities and improving access to care including the establishment of our AMA's Center for Health Equity and subsequent hiring of our AMA's first Chief Health Equity Officer. Your Reference Committee believes that advocacy efforts focused on tackling the asks of this resolution are currently in place in support of our AMA's organizational efforts to address disparities in health outcomes and access to care. Accordingly, your Reference Committee recommends that existing policies H-160.909, H-160.896, H-65.963, and D-165.966 be reaffirmed in lieu of Resolution 236.

Poverty Screening as a Clinical Tool for Improving Health Outcomes H-160.909
Our AMA encourages screening for social and economic risk factors in order to improve care plans and direct patients to appropriate resources. (Res. 404, A-13, Reaffirmed: BOT Rep. 39, A-18)

Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896
Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems. (BOT Rep. 39, A-18)

Discriminatory Policies that Create Inequities in Health Care H-65.963
Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation. (Res. 001, A-18)

Giving States New Options to Improve Coverage for the Poor D-165.966
Our AMA will (1) advocate that state governments be given the freedom to develop and test different models for improving coverage for patients with low incomes, including combining refundable, advanceable tax credits inversely related to income to purchase health insurance coverage with converting Medicaid from a categorical eligibility program to one that allows for coverage of additional low-income persons based solely on financial need; (2) advocate for changes in federal rules and federal financing to support the ability of states to develop and test such alternatives without incurring new and costly unfunded federal mandates or capping federal funds; and (3) continue to work with interested state medical associations, national medical specialty societies, and other relevant organizations to further develop such state-based options for improving health insurance coverage for low-income persons. (Res. 118, A-04 Reaffirmed: CMS Rep. 1, A-05 Modified: CMS Rep. 8, A-08 Reaffirmed: CMS Rep. 9, A-11 Reaffirmed: CMS Rep. 5, I-11 Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-18)

Madam Speaker, this concludes the report of Reference Committee B. I would like to thank Jenni Bartlotti Telesz, MD; Michael Hoover, MD; Steve Lee, MD; Michael Medlock, MD; Chris Pittman, MD; and Stephen Rockower, MD; all those who testified before the Committee; and our AMA staff.

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